

Idaho

**UNIFORM APPLICATION
FY2011**

**SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT**

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

OMB - Approved 09/20/2007 - Expires 09/30/2011

(generated on 8/19/2010 5:01:24 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-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

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

DUNS Number: 08-816-56-18-

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

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

Agency Name: Department of Health and Welfare
Organizational Unit: Division of Behavioral Health
Mailing Address: 450 W. State Str. , POB 83720, 3rd Floor
City: Boise Zip Code: 83720-0036

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

Name: Terry Pappin
Agency Name: Department of Health and Welfare
Mailing Address: 450 W. State Str., POB 83720, 3rd Floor
City: Boise Code: 83720-0036
Telephone: 208-334-6542 FAX: 208-334-0667
Email Address: pappint@dhw.idaho.gov

3. State Expenditure Period:

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

4. Date Submitted:

Date: 9/29/2009 7:02:52 PM Original: ● Revision: ●

5. Contact Person Responsible for Application Submission:

Name: Jodi Osborn Telephone: 208-334-0679
Email Address: osbornj@dhw.idaho.gov FAX: 208-334-5694

Form 2 (Table of Contents)

Form 1	pg.3	Charitable Choice (formerly Attachment I)	pg.141
Form 2	pg.4	Waivers (formerly Attachment J)	pg.143
Form 3	pg.5	Waivers	pg.144
1. Planning	pg.15	Form 8 (formerly Form 4)	pg.146
Planning Checklist	pg.26	Form 8ab (formerly Form 4ab)	pg.147
Form 4 (formerly Form 8)	pg.27	Form 8c (formerly Form 4c)	pg.148
Form 5 (formerly Form 9)	pg.28	Form 9 (formerly Form 6)	pg.149
How your State determined the estimates for Form 4 and Form 5 (formerly Forms 8 and 9)	pg.29	Provider Address Table	pg.153
Form 6 (formerly Form 11)	pg.31	Form 9a (formerly Form 6a)	pg.157
Form 6ab (formerly Form 11ab)	pg.32	Form 10a (formerly Form 7a)	pg.160
Form 6c (formerly Form 11c)	pg.33	Form 10b (formerly Form 7b)	pg.161
Purchasing Services	pg.35	Description of Calculations	pg.162
PPM Checklist	pg.36	SSA (MOE Table I)	pg.164
Form 7	pg.37	TB (MOE Table II)	pg.165
Goal #1: Improving access to prevention and treatment services	pg.38	HIV (MOE Table III)	pg.167
Goal #2: Providing Primary Prevention services	pg.42	Womens (MOE TABLE IV)	pg.168
Goal #3: Providing specialized services for pregnant women and women with dependent children	pg.50	Form T1	pg.169
Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)	pg.54	Form T2	pg.171
Goal #4: Services to intravenous drug abusers	pg.60	Form T3	pg.173
Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)	pg.64	Form T4	pg.175
Program Compliance Monitoring (formerly Attachment D)	pg.66	Form T5	pg.180
Goal #5: TB Services	pg.70	Form T6	pg.185
Goal #6: HIV Services	pg.74	Form T7	pg.187
Tuberculosis (TB) and		Treatment Performance Measures (Overall Narrative)	pg.189
		Corrective Action Plan for Treatment NOMS	pg.191
		Form P1	pg.193
		Form P2	pg.194
		Form P3	pg.195
		Form P4	pg.196
		Form P5	pg.197
		Form P6	pg.198
		Form P7	pg.199
		Form P8	pg.200

Early Intervention Services for HIV (formerly Attachment E)	pg.78
Goal #7: Development of Group Homes	pg.80
Group Home Entities and Programs (formerly Attachment F)	pg.84
Goal #8: Tobacco Products	pg.86
Goal #9: Pregnant Women Preferences	pg.88
Capacity Management and Waiting List Systems (formerly Attachment G)	pg.93
Goal #10: Process for Referring	pg.96
Goal #11: Continuing Education	pg.100
Goal #12: Coordinate Services	pg.111
Goal #13: Assessment of Need	pg.117
Goal #14: Hypodermic Needle Program	pg.121
Goal #15: Independent Peer Review	pg.125
Independent Peer Review (formerly Attachment H)	pg.130
Goal #16: Disclosure of Patient Records	pg.133
Goal #17: Charitable Choice	pg.137

Form P9	pg.201
Form P10	pg.202
Form P11	pg.203
P-Forms 12a- P-15 – Reporting Period	pg.204
Form P12a	pg.205
Form P12b	pg.206
Form P13 (Optional)	pg.208
Form P14	pg.210
Form P15	pg.211
Corrective Action Plan for Prevention NOMS	pg.212
Prevention Attachments A, B, and C (optional)	pg.214
Prevention Attachment D (optional)	pg.215
Description of Supplemental Data	pg.217
Attachment A, Goal 2	pg.219
Addendum - Additional Supporting Documents (Optional)	pg.221

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.
 SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended “only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities” as authorized.

II. Certain Allocations, Section 1922

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

III. Intravenous Drug Abuse, Section 1923

- Capacity of Treatment Programs, Section 1923(a)
- Outreach Regarding Intravenous Substance Abuse, Section 1923(b)

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

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

The State “has established, and is providing for the ongoing operation of a revolving fund” in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

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

- The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).
- The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).
- The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).

VII. Treatment Services for Pregnant Women, Section 1927

The State “...will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant.”

VIII. Additional Agreements, Section 1928

- Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)
- Continuing Education, Section 1928(b)
- Coordination of Various Activities and Services, Section 1928(c)
- Waiver of Requirement, Section 1928(d)

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Funding Agreements/Certifications

As required by Title XIX , Part B, Subpart II and Subpart III of the PHS Act (continued)

IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929

X. Maintenance of Effort Regarding State Expenditures, Section 1930

With respect to the principal agency of a State, the State “will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.”

XI. Restrictions on Expenditure of Grant, Section 1931

XII. Application for Grant; Approval of State Plan, Section 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

The plan required under Section 1932 will be made “public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.”

XIV. Requirement of Reports and Audits by States, Section 1942

XV. Additional Requirements, Section 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Services Provided By Nongovernmental Organizations, Section 1955

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

State: Idaho

Name of Chief Executive Officer or Designee: Richard M. Armstrong

Signature of CEO or Designee:

Title: Director

Date Signed:

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

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

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

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

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

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

3. CERTIFICATION REGARDING LOBBYING

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

The undersigned (authorized official signing for the

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

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

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

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

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION Idaho Department of Health and Welfare	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

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

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

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

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

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

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

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

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

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Idaho Department of Health and Welfare		DATE SUBMITTED

1. Planning

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

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

1. Planning

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

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

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

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

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

- 42 U.S.C. §300x-51 and 45 C.F. R. §96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

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

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the

Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

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

Problem Assessment (Epidemiological Profile)

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

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)

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

Prevention System Capacity Development

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

Implementation of a Data-Driven Prevention System

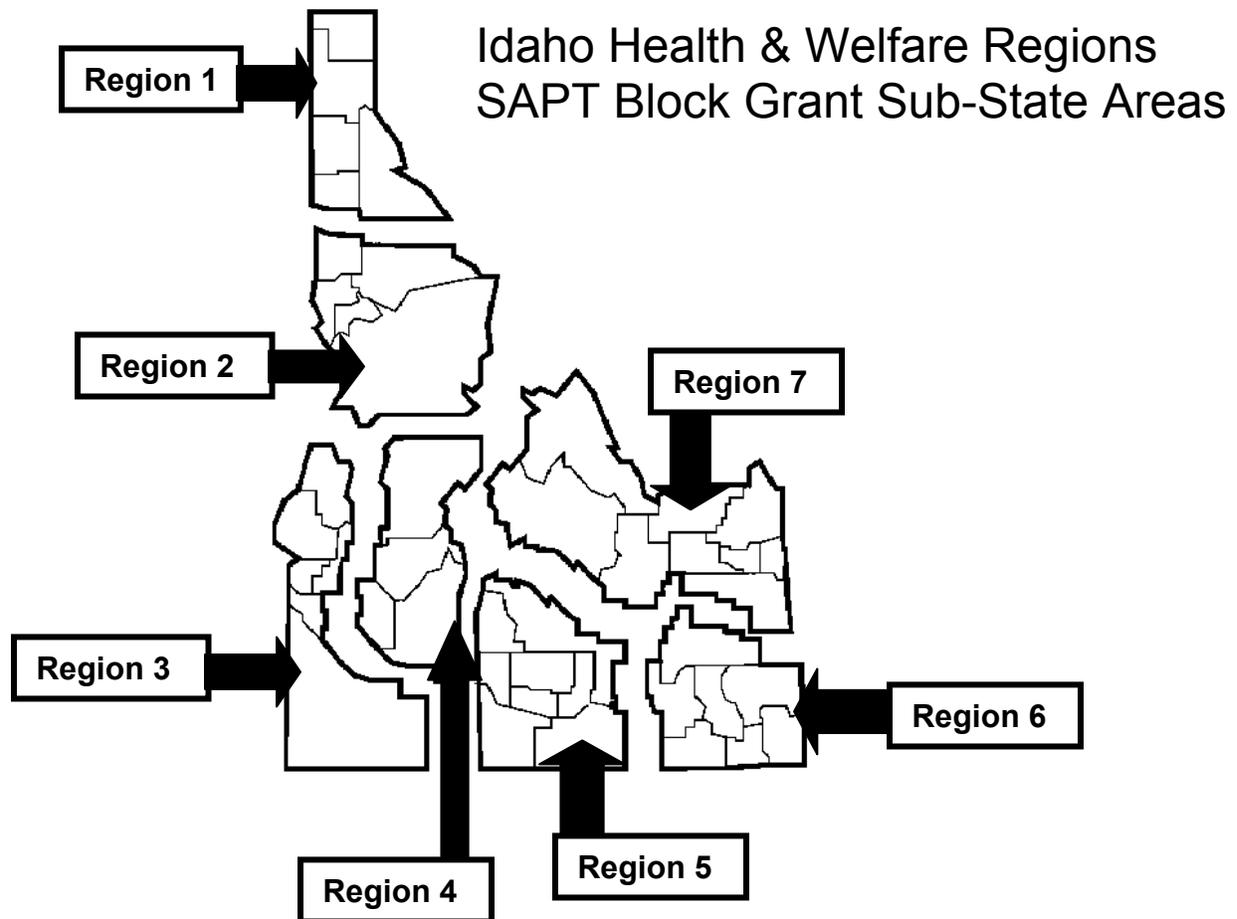
Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient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

Evaluation of Primary Prevention Outcomes

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

Idaho sub-State Areas

Idaho is divided into seven Health and Welfare regions which have been designated the sub-State planning areas for the SAPT Block Grant. These areas are composed of adjoining counties which are similar in geography, business activities and cultural composition. A depiction of the Idaho sub-State areas can be found below.



Currently, the planning processes for treatment and prevention services are conducted separately and with differing data sets. The goal is to more closely align planning processes, as the Idaho Substance Abuse Monitoring System is developed. The Idaho Substance Abuse Monitoring System was initiated by the State Epidemiological Outcomes Workgroup (SEOW). Working with prevention services managers, prevention services providers, coalition members and state staff, the SEOW research staff were able to identify risk factor indicators that would provide state and county level data on the need for prevention services. The criteria for selecting an indicator were that it was consistently collected at least every two years, it was collected at the county level and that all risk factors were included. As the system continues to evolve, data indicators for treatment needs will be added.

In 2007 Idaho legislature established the Office of Drug Policy (ODP) and a governing body, the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA), to provide oversight of planning for SUD treatment and prevention services in Idaho. The administrator of ODP chairs ICSA. The board is made up of the director's of all state agencies providing any type of service that relates to use or abuse of alcohol and other drugs. These include the directors of the Departments of Health and Welfare, State Police, Juvenile Corrections, Adult Corrections, Education and the Courts. It also has voting members representing the boards for Corrections, Juvenile Corrections and Health and Welfare, as well as the board chair for specialty courts, the chairpersons of the Health and Welfare Committees from the Idaho Senate and House of Representatives, the chairpersons of Judiciary and Rules Committees from the Senate and the House of Representatives and a member representing the seven Regional Advisory Committee (RAC) chairs. ICSA also had Ad hoc non-voting members representing the Association of Cities, the Idaho Association of Counties, Idaho Vocational Rehabilitation and community coordinating councils. The members of this committee represent those who live and work throughout the state and each have communication networks providing them with current information in regards to alcohol and other drug use, as well as the ability to assess at a local level what the needs are as they pertain to SUD prevention and treatment. ICSA meetings must be held at least quarterly, but in the last year there were nine ICSA meetings held.

The ability of this committee to assess the treatment needs of the populations they represent is crucial to the work of the committee. All of the departments and the courts operate their systems using the same divisional lines for regionalization of services. The State of Idaho has 44 counties ranging in population from frontier to urban. The counties are divided into seven regions (referred to as districts by the courts) for both service delivery organization and planning. There is significant variation in the population density, economy and social service resources among the regions. The regional approach assures local planning relevant to local needs. The Department uses the same sub-state planning areas as used in the STNAP. A map of the regions can be found above.

The ability of ICSA members to gather regional treatment needs information can be demonstrated by who they track information from. There are courts in each of the 44 counties and all are connected to an information data system maintained by the Idaho Supreme Court. The Department of Corrections and Juvenile Corrections both track court information from adult and juvenile probation workers in the counties as well as their staff working throughout the state. Data comes to DHW from each of the regional offices, as well as local offices throughout the state, but more important, for collecting SUD data, the management services contractor (MSC) Business Psychology Associates (BPA) collects data from all of the 62 private treatment providers at their 96 sites, as well as from 123 RSS providers. Because all client screenings use the GAIN Short Screener and all SUD assessments in Idaho are done using a standard assessment tool, the GAIN I, consistent data is collected on everyone contacting the SUD MSC for services and extensive data is available on those who are assessed, so a very complete picture can be drawn on those asking for SUD treatment in the state and those who proceed to treatment.

The membership of the RACs is diverse, representing state agencies, private treatment providers and public members who include past-client consumers. The legislative members of the committee obviously represent the state as a whole, and chair committees whose memberships

are well aware of the needs of the regions as well as to individual constituents' concerns. Each of the seven RACs submits a treatment report to ICSA for each meeting. It is presented as a standing report by their elected representative to the ICSA board. This report provides a direct link to what RAC members are seeing being provided in their communities for prevention and treatment as well as community need that is unmet.

ICSA makes all decisions regarding client populations to be treated, what level of service will be provided and how funding is allocated. They make these decisions based the input of the membership described above. Every month the committee also receives a budget snapshot showing expenditures, client population served by referral source and level of care provided. They can then make policy decisions regarding the current need being seen as well as make decisions regarding future treatment based on trends they are seeing from the data. They also have access to quarterly reports that show treatment provided at a county and regional level by category of client and level of treatment. All of this information is used to plan how services are provided for the state. By Idaho Code, ODP is required to assess statewide need and develop a statewide plan, which they do based on this data, to address need. Documents regarding this effort can be found at www.odp.idaho.gov.

The Idaho Monitoring System data was used by the Idaho Interagency Committee's Prevention Subcommittee for state level planning. Based on the data, the subcommittee identified underage drinking as the statewide service priority and parents of youth aged 11 to 15 as the priority population. The prevention subcommittee includes representatives from the SSA as well from the department of transportation, juvenile corrections, law enforcement, education, the state liquor dispensary and the office of drug policy. Also included in the membership are community coalition members, prevention providers, college and university representatives, juvenile probation, drug-free work place providers and former legislators.

Communities are defined by the coalitions that serve them. Some Idaho coalitions focus on a specific town, others seek to impact a larger geographic area. There is no standard land area that must be covered in order to qualify as a substance abuse prevention coalition. At the community coalition level, priorities are selected by coalition members, based on the data the SEOW collected as well as other information specific to their community. This data was reported in Regional Needs Assessments which are available on the internet at www.preventionidaho.com. These needs assessments are organized by Health and Welfare Region, to make the information more useful to community groups. The data is reported at the county level because Idaho has very few communities large enough to have sufficient data to complete a community needs assessment. Coalitions funded with block grant funds use this data for community planning and to determine the programs and practices needed to impact the prioritized risk factors. Coalition composition varies by community, but most coalitions include law enforcement, education, faith-base groups, parents, local government representatives, business owners, substance abuse prevention and treatment providers and youth.

Regional needs assessments are also used to identify the need to individual-based services. In general, these services focus on universal and selective populations. The Regional needs assessment data is used to determine identify populations and areas at greatest risk. This data takes a close look at each county within the regional and provides defensible documentation for

delivering evidence-based programs to meet the needs of individuals in high risk communities or those who have specific indicators that cause them to be at greater jeopardy than the general population.

Prevention planning will continue to use Hawkins and Catalano's Risk and Protective Factors to identify populations at risk and their needs. At the state level, the Idaho Substance Abuse Monitoring System will be used for ongoing assessment. At the community and individual level, the Regional Needs Assessments will be used to identify populations and areas at greatest risk.

At the state level, the Idaho's Interagency Committee on Substance Abuse's Prevention Subcommittee uses the Idaho Monitoring System data to identify the population most at risk throughout the state. Their focus is on impacting state population level risks. The subcommittee will use a variety of information dissemination tools to educate the target population or a population that can impact them about the risks their current behavior poses and methods to reduce/eliminate the risk. The plan will include distribution of written materials, multi-agency media campaigns, websites and community meetings.

At the community level, planning will, in part, depend on their funding sources. All coalitions involved in the Idaho Coalition of Coalitions are encouraged to use existing data or the Regional Needs Assessment to identify areas and populations within their community at greatest risk. Coalitions with Drug Free Communities funding will follow the federal requirements. Coalitions requesting Idaho funding will be required to use Regional Needs Assessment data for identifying priorities. In their applications, they will be required to use NREPP to identify evidence-based programs and practices to impact the prioritized risk factors.

Idaho uses a four-part method to ensure areas/populations at highest are appropriately served. The first level focuses on what is the greatest prevention problem shared among all populations in the state. This level of planning uses the SEOW's Idaho Substance Abuse Monitoring System to look at commonalities across the state and focuses on population level change. This level of planning is an interagency partnership within the Interagency Committee on Substance Abuse Prevention and Treatment's Prevention Subcommittee. The next level is based in the Regional Needs Assessment which evaluates each county's risk factor indicators to identify the geographic areas and populations at greatest risk. This data is used at the community level to address specific risks within each coalition's community. This builds what is being done at the state level to tailor services to meet a specific community's needs. The third level of prioritization again uses the Regional Needs Assessments to identify specific populations within all areas of the regions, whether a coalition exists or not, to address individual risk factors. From the state to the individual level, if an entity seeks Prevention Block Grant funding they must use data from the Idaho Substance Abuse Monitoring System or Regional Needs Assessment to document the need for the services. In the fourth level of planning, the SSA reviews and approves all applications for funding evaluating the identified need, the significance of the need and the likelihood that the proposed program(s) or practice(s) will effectively address the need. Priority is given to entities that propose to use evidence-based programs that have been proven effective to address the identified need.

Idaho evaluates prevention outcomes in multiple ways. All individuals over the age of 10 who participated in recurring prevention programs complete a pre-test prior to initiation of the program and a post-test at the completion of the program. This provides the opportunity to evaluate the learning gained, and it also enables us to determine if the program is effectively meeting the need of the Idaho population served. The pre/post tests are also used to evaluate provider effectiveness and identify need to additional support or technical assistance. The pre/post tests are also used to identify providers who need to be replaced. To date we have not had to do that. Technical assistance and additional support has been sufficient to improve the quality of the service. Idaho uses the data system to identify provider staff not meeting the Qualified Prevention Professional Standards and agencies who do not meet the Idaho Prevention Program Standards. These two elements are essential to building a safe, effective and acceptable substance abuse prevention system.

At the state level, the Interagency Committee on Substance Abuse's Prevention Subcommittee will use risk factor indicators from the Idaho Substance Abuse Monitoring System to evaluate the effectiveness of their initiatives. Although the group has identified underage drinking as the major problem in Idaho, they have not yet completed a comprehensive plan to address the problem. When they do, they will be watching the risk factors indicators within the monitoring system to look for improvement in the indicators.

Multiple mountain ranges cover the center of Idaho. Idaho's North/South border runs the full length of the states of Washington and Oregon. The East/West border is shorter, however that does not necessarily make travel easier. Due to these challenges, for the FY 2011 SAPT Block Grant application, Idaho moved from holding public hearings to an internet-based review and comment process. The completed block grant was sent to each of the seven Regional Advisory Committees review and comment as well as posted on the Idaho Department of Health and Welfare's Substance Use Disorders Services website. Legal notice of the posting was placed in all major papers.

Prevention Three Year Plan

Problem Assessment

As stated above, Idaho has used Hawkins and Catalano's Risk and Protective Factor model to identify areas and individuals at greatest risk. Idaho will continue to use this model, annually reviewing the data that is collected to determine the most reliable source of risk indicator data. This process will be used at the state level in the ongoing development of the State Substance Abuse Monitoring System as well as at the local level in the formation of the Regional Needs Assessments.

Prevention System Assessment

All prevention services funded with SAPT Block grant funds must address a prioritized need identified in the Idaho Substance Abuse Monitoring System or the Regional Needs Assessment. The Idaho Substance Abuse Monitoring System is based on risk factor indicator data and all research and reporting is completed by SEOW staff. All documents created by SEOW staff are reviewed and approved by the SEOW workgroup prior to distribution. The Regional Needs Assessments are completed under the supervision of Curt Braun, Ph.D. Dr. Braun was a professor of psychology at the University of Idaho from 1994 to 2007, where he taught courses

in the design of complex systems, research methods, statistics, and ergonomics. Dr. Braun's staff uses strict research methods to create regional needs assessments using existing surveys and law enforcement, transportation, labor, education, welfare and health records. These processes are in place and will continue to be reviewed annually to improve the accuracy and utility of the data.

At the state level, prevention services are managed by Idaho's Interagency Committee on Substance Abuse's Prevention Subcommittee. The prevention subcommittee includes representatives from the SSA as well from the department of transportation, juvenile corrections, law enforcement, education, the state liquor dispensary and the office of drug policy. Also included in the membership are community coalition members, prevention providers, college and university representatives, juvenile probation, drug-free work place providers and former legislators. This committee is responsible for oversight of statewide prevention initiatives. This subcommittee will continue throughout the 3 years of this application. They will use the SEOW Idaho Substance Abuse Monitoring System to identify population-level risk factors. The SEOW monitoring system will also be used to evaluate state-level programs, policies and practices that were implemented to address the population-level risk factors.

At the community and individual level, the Regional Needs Assessment is used to drive needs-based services. All prevention community and individual-based services funded with SAPT Block Grant funds must address a prioritized need identified in the Idaho Substance Abuse Monitoring System or the Regional Needs Assessment. This system has been in place for the past six years and effectively ensures the programs, practices and policies funded with SAPT Block Grant funds are addressing areas and individuals with the greatest need. This process has worked well and will continue to be reviewed annually to improve the accuracy and utility of the data.

When the regional assessment identifies the need for individual-based services, local agencies can apply for funding to serve the targeted population. Agencies are encouraged to use the programs, practices and policies listed in NREPP system to increase the likelihood of positive outcomes. All participants are issued unique identification numbers and their demographic data as well as attendance and pre/post test scores are recorded in the Idaho Prevention Data system. This process allows Idaho to not only evaluate pre/post scores but also review each individual's pre/post test and study engagement patterns. By using local agencies, rather than a centralized service system, cultural issues are addressed in the selection of providers and programs. In communities with large religious groups whose culture is very strong, providers and programs acceptable to the targeted population are selected. In isolated heavy drinking communities with a historical culture of distrust of outsiders, local providers that are respected within the community are recruited to deliver programs to impact the level of use. In areas with high number of non-English-speaking individuals, bilingual individuals fluent in the dominant language are identified and funded. In all areas, agencies are assisted in identifying NREPP programs, policies and practices that are culturally appropriate. This process has worked well and will continue to be reviewed annually to improve the accuracy and utility of the data.

At the community level, community coalitions seeking SAPT Block Grant funding must also use data from the Regional Needs assessment. They can request assistance for coalition development, community planning and creation of tools to evaluate community change. Coalitions can also request funding for implementing environmental programs, policies and practices. Coalitions are encouraged to be inclusive of all populations and cultures within the community. They are educated on the importance of the prioritized population being involved in the planning, selection, implementation and evaluation of targeted services. The SSA only has the ability to impact those coalitions who receive SAPT Block Grant funds through the SSA. These coalitions receive support from regional coordinators in areas where they identify a needs for assistance. It is the SSA's intention to continue working with Idaho coalitions to provide needs assessment data, technical assistance and funding for environmental strategies. This process has worked well and will continue to be reviewed annually to improve the accuracy and utility of the data.

Opportunity for public comment is provided through the DHW and ODP websites as well as at ICSA meetings where members of the public and provider network can both provide written text or ask for agenda time to discuss issues. Obviously much informal comment is gathered through the ICSA membership structure described above as well. In FY 2011, the Idaho Substance Abuse Prevention and Treatment Block Grant Application placed on the Department of Health and Welfare's Substance Use Disorders website. (<http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/tabid/105/Default.aspx>) Public comment was gathered using two methods. Public notice of the opportunity to review and comment on the grant application was placed in all major newspapers. In addition the seven Regional Advisory Committees were informed via email of the placement of the application and opportunity for public comment.

Prevention System Capacity Development

Idaho works at multiple levels to improve system capacity. At the state level the SEOW staff is working with the Interagency Committee on Substance Abuse's Prevention Subcommittee to continue to refine the Idaho Substance Abuse Monitoring system's ability to provide timely and accurate risk factor data. The subcommittee will draw from the expertise within the membership to constantly improve the quality and usefulness of the data produced by the monitoring system. This interagency-public partnership has been productive in providing data sources as well as in identifying data gaps and seeking solutions to address the gaps. This level of work provides support to the regional needs assessment but also keeps the focus at the state level, looking at statewide population issues.

The community coalition work is dependant on two variables. The first variable is having people within a community concerned about alcohol and drug use and the second variable is controlled by the community. It focuses on the community's readiness to make environmental changes to attitudes, norms and laws specific to alcohol and drug use. While most community members can agree the illegal drug use is bad, there is a greater range of opinions on alcohol use, particularly as it relates to underage drinking and binge drinking. The SSA has three major resources to help community coalitions. The first is the availability of technical assistance to facilitate the development of a coalition as well as assist with planning, implementation and evaluation. The second initiative is the support of the Idaho Coalition of Coalitions. The SSA hosts a monthly conference call to facilitate the sharing of information and support the older coalitions mentoring

younger groups. This support has also included developing coalition training tracks in the annual prevention conference, development of a college level coalition/community development course and funding support for coalition members to attend the trainings. The third method of supporting coalitions is to provide funding for coalition meetings, information dissemination activities and environmental programs, policies and practices. Coalitions can complete an annual application to receive funds to impact attitudes, norms and behaviors related to drug and alcohol use in their communities. They can use the Prevention Information System to keep track of their meetings, record attendance and document their activities.

At the individual-based service level, the SSA works community agencies to deliver services within targeted communities. This is a three pronged approach. The first is based in the needs assessment, identifying populations within a community at greatest risk. The second part is identifying agencies with the basic skills, knowledge and attitudes to provide prevention services. The selection process also evaluates how acceptable the agency and proposed staff are to the target population. Every effort is made to create a positive, productive match between the prioritized population and the selected agency. Once an agency is selected, the next step is to review the program or practice that they propose to use to serve the targeted population. Again, if the match is positive and productive, the selected agency staff are provided the training that they need to deliver the services. In addition, their qualifications are matched against the Idaho Qualified Prevention Professional requirements established in the Idaho Prevention Program Standards. (The agency must meet the standards or have a plan to meet the standards within one year in order to be funded) Staff who have completed the required prevention courses, receive credit for the courses they have completed. For any courses that have not been completed, plan must be written to detail how the staff person will access the courses needed to meet the Idaho Prevention Professional Requirements. Staff of SAPT Block Grant funded agencies can access Idaho Prevention Professional courses through Idaho colleges and universities, online within the Idaho Prevention Information System or at the annual Idaho Prevention Institute.

The SSA uses the Prevention Information System to collect information on agencies and staff delivering SAPT Block Grant funded services, community served, participant demographic and attendance data, staff qualification data, evidence-based programs used, pre/post test data and service cost and payment data. The system can generate reports for all required block grant reports, communities/participants served, contract requirements, staff training needs in each region and ad hoc reports on anything it collects. It has been very useful to the state. Its simple design makes it user friendly and able to run efficiently on the slowest of internet lines. The system is 8 years old, so in the next three years some system updates will be made to enable it to continue meeting Idaho's needs.

Implementation of a Data-Driven)Prevention System

As stated previously both at the interagency level as well as the local level, Idaho uses analysis of risk factor data to drive the selection funding of programs practices and services. At the state level, the Interagency Committee on Substance Abuse's Prevention Subcommittee uses the Idaho Substance Abuse Monitoring System to identify the need for population level change. The committee is in the developmental stage of program selection, looking for programs, policies and practices that have been shown to be effective in creating population level change. They have initially focused on information dissemination activities to increase public awareness. Any

activities that SSA Block Grant monies are used to fund will have to have documentation of proven effectiveness.

At the community and individual-levels, priority is given to evidence-based programs, policies and practices listed on NREPP. Idaho has chosen to focus funding on activities that a documented record of effectively address the risk factor within the targeted population. With only \$1.00 per capita for community/individual-based services, Idaho cannot afford to fund the development of new programs nor is it fiscally responsible to fund programs with no documented effect. To that end, Idaho does cover the cost for the purchase of materials to deliver evidence-based programs, as well as any required training. This is a good investment which enables the state to have trained providers for multiple years. Because Idaho prevention providers have accepted the use of evidence-based programs, there have been no monies available at the conclusion of the annual prevention funding application process to support programs other than evidence-based.

Evaluation of Primary Prevention Outcomes

Idaho evaluates prevention outcomes in multiple ways. All individuals over the age of 10 who participated in recurring prevention programs complete a pre-test prior to initiation of the program and a post-test at the completion of the program. This provides the opportunity to evaluate the learning gained, and it also enables us to determine if the program is effectively meeting the need of the Idaho population served. The pre/post tests are also used to evaluate provider effectiveness and identify need to additional support or technical assistance. The pre/post tests are also used to identify providers who need to be replaced. To date we have not had to do that. Technical assistance and additional support has been sufficient to improve the quality of the service. Idaho uses the data system to identify provider staff not meeting the Qualified Prevention Professional Standards and agencies who do not meet the Idaho Prevention Program Standards. These two elements are essential to building a safe, effective and acceptable substance abuse prevention system.

At the state level, the Interagency Committee on Substance Abuse's Prevention Subcommittee will use risk factor indicators from the Idaho Substance Abuse Monitoring System to evaluate the effectiveness of their initiatives. Although the group has identified underage drinking as the major problem in Idaho, they have not yet completed a comprehensive plan to address the problem. When they do, they will be watching the risk factors indicators within the monitoring system to look for improvement in the indicators.

Planning Checklist

Criteria for Allocating Funds

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

Population levels, Specify formula:

- 1 Incidence and prevalence levels
- 1 Problem levels as estimated by alcohol/drug-related crime statistics
- 1 Problem levels as estimated by alcohol/drug-related health statistics
- 1 Problem levels as estimated by social indicator data
- Problem levels as estimated by expert opinion
- Resource levels as determined by (specify method)

Size of gaps between resources (as measured by)

and needs (as estimated by)

- 1 Other (specify method)

Cost to society if not treated

Form 4 (formerly Form 8)

Treatment Needs Assessment Summary Matrix

Form 5 (formerly Form 9)

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	0																		
18 - 24 Years Old	0																		
25 - 44 Years Old	0																		
45 - 64 Years Old	0																		
65 and Over	0																		
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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

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

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

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

Form 6 (formerly Form 11)

INTENDED USE PLAN

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

SOURCE OF FUNDS

Activity	(24 Month Projections)					
	A.SAPT Block Grant FY 2011 Award	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 4,738,773	\$	\$ 257,400	\$ 10,788,800	\$ 2,868,700	\$
Primary Prevention	\$ 1,848,300		\$	\$ 353,200	\$	\$
Tuberculosis Services	\$	\$	\$	\$ 45,000	\$	\$
HIV Early Intervention Services	\$	\$	\$	\$	\$	\$
Administration: (Excluding Program/Provider Lvl)	\$ 344,200		\$ 108,000	\$ 324,900	\$ 364,200	\$
Column Total	\$6,931,273	\$0	\$365,400	\$11,511,900	\$3,232,900	\$0

*Prevention other than Primary Prevention

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 770,525	\$	\$	\$	\$
Education	\$ 880,600	\$	\$	\$	\$
Alternatives	\$ 110,075	\$	\$	\$	\$
Problem Identification & Referral	\$ 98,864	\$	\$	\$	\$
Community Based Process	\$ 110,075	\$	\$	\$	\$
Environmental	\$ 66,045	\$	\$	\$	\$
Other	\$ 165,116	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
Column Total	\$2,201,300	\$0	\$0	\$0	\$0

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$	\$	\$	\$	\$
Universal Indirect	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
Column Total	\$0	\$0	\$0	\$0	\$0

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

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

Yes No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	\$ 0	\$ 16,556	\$	\$ 16,556
Quality Assurance	\$ 0	\$ 12,000	\$	\$ 12,000
Training (post-employment)	\$ 0	\$ 15,000	\$	\$ 15,000
Education (pre-employment)	\$ 0	\$ 35,000	\$	\$ 35,000
Program Development	\$ 0	\$ 36,340	\$	\$ 36,340
Research and Evaluation	\$ 0	\$ 15,000	\$	\$ 15,000
Information Systems	\$ 0	\$ 35,220	\$	\$ 35,220
Column Total	\$0	\$165,116	\$0	\$165,116

Idaho only reports on prevention resource development planned expenditures. We do not plan to expend treatment funds on resource development.

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

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

- | | |
|--|--------------------------|
| <input type="checkbox"/> Competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Competitive contracts | Percent of Expense: 97 % |
| <input type="checkbox"/> Non-competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Non-competitive contracts | Percent of Expense: 3 % |
| <input type="checkbox"/> Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services | Percent of Expense: % |
| <input type="checkbox"/> Other | Percent of Expense: % |

(The total for the above categories should equal 100 percent.)

- | | |
|---|-----------------------|
| <input type="checkbox"/> According to county or regional priorities | Percent of Expense: % |
|---|-----------------------|

Methods for Determining Prices

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

- | | |
|---|------------------------------|
| <input type="checkbox"/> Line item program budget | Percent of Clients Served: % |
| | Percent of Expenditures: % |

- | | |
|---|------------------------------|
| <input type="checkbox"/> Price per slot | Percent of Clients Served: % |
| | Percent of Expenditures: % |

Rate: \$	Type of slot:
Rate: \$	Type of slot:
Rate: \$	Type of slot:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Price per unit of service | Percent of Clients Served: 100 % |
| | Percent of Expenditures: % |

Unit: Residential Day	Rate: \$ 170
Unit: Halfway House Day	Rate: \$ 45
Unit: Outpatient Hour	Rate: \$ 45

- | | |
|--|------------------------------|
| <input type="checkbox"/> Per capita allocation (Formula:) | Percent of Clients Served: % |
| | Percent of Expenditures: % |

- | | |
|--|------------------------------|
| <input type="checkbox"/> Price per episode of care | Percent of Clients Served: % |
| | Percent of Expenditures: % |

Rate: \$	Diagnostic Group:
Rate: \$	Diagnostic Group:
Rate: \$	Diagnostic Group:

Program Performance Monitoring

On-site inspections

Frequency for treatment: ANNUALLY

Frequency for prevention: QUARTERLY

Activity Reports

Frequency for treatment: QUARTERLY

Frequency for prevention: QUARTERLY

Management Information System

Patient/participant data reporting system

Frequency for treatment: OTHER Each Authorization

Frequency for prevention: OTHER Each Billing Cycle

Performance Contracts

Cost reports

Independent Peer Review

Licensure standards - programs and facilities

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NOT APPLICABLE

Licensure standards - personnel

Frequency for treatment: ANNUALLY

Frequency for prevention: ANNUALLY

Other:

Specify:

Form 7

State Priorities

	State Priorities
1	Treatment Goal 1: The Idaho treatment data management system (WITS) will be used for all client management, data collection & billing.
2	Treatment Goal 2: Training & certification on the standard assessment (GAIN) will be available to the provider network through a training protocol at no cost to the Department.
3	Treatment Goal 3: Providers will routinely inform & educate IVDU clients on the health risks of infectious diseases & refer as appropriate.
4	Treatment Goal 4: Reduce duplication of required paperwork for all those working the SUD system.
5	Treatment Goal 5: Increase service accessibility for publically funded non-mandated & non-criminal client population.
6	Treatment Goal 6: Idaho will have licensure for Qualified Substance Use Disorder Professionals.
7	Prevention Goal 1: All recurring substance abuse prevention programs and practices will be needs-based and listed on NREPP.
8	Prevention Goal 2: All staff of DHW-funded substance abuse prevention programs will be Qualified Prevention Professionals.
9	Prevention Goal 3: All Idaho residents will have access to accurate, age-appropriate substance abuse information.
10	Prevention Goal 4: All residents of Idaho will have access to standardized, accurate, current needs assessment data which depicts the impact of substance abuse and addiction sorted by region and county and identifies the need for treatment and prevention services.
11	Prevention Goal 5: The number of Idaho communities with anti alcohol/drug coalitions will be increased.
12	Synar Goal 1: All tobacco retailers will have onsite and online seller training materials which educate them about Idaho and FDA requirements for selling tobacco.

Goal #1: Improving access to Prevention and Treatment Services

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

The Department will use FY 2011 through 2013 SAPT block grant funds to treat adolescents, adults, pregnant women and women with dependent children in each of the 7 sub-state planning areas in the state. Clients will need to be clinically eligible, diagnosed as substance dependent indicating the need for at least outpatient (ASAM PPC 2R Level I) substance use disorders treatment. Treatment services will include assessment, individual and group counseling, education, social setting detoxification and residential and case management in outpatient or residential settings. Recovery support services will also be funded including child care, transportation, drug testing, marriage and family life skills education and safe and sober housing for adults.

To operationalize the delivery of Block Grant funded services, the Department will continue to utilize Business Psychology Associates for statewide management of the substance use disorder treatment and recovery support system of care. Management services will include administration, approved provider network management, client intake and service coordination, data management, fiscal management, reporting and quality assurance.

In FY 2011 the Department anticipates serving 1,200 adolescents, 9,000 adults, 150 pregnant women, 1,000 women with dependent children and 750 involved in the child protection system.

Starting October 1, 2007 the Department used FY 2008 SAPT block grant funds to treat adolescents, adults, pregnant women and women with dependent children in each of the seven adolescents, adults, pregnant women and women with dependent children in each of the seven sub-state planning areas in the state. Clients needed 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 included child care, transportation, drug testing, marriage and family life skills education and safe and sober housing for adults. Business Psychology Associates, the Management Services Contractor (MSC) to deliver treatment and recovery support services through networks of approved providers in all seven sub-state planning areas. As part of the Department's contract, the Care Management unit of the MSC continued to man a statewide 1-800 number to screen clients for financial and clinical eligibility and to make an initial level of care determination according to ASAM PPC 2R and to prior authorize units of service. In 2008, the Department served 919 adolescents, 3864 adults, 157 pregnant women and 864 women with dependent children.

There was no requirement for prevention to be included in this goal in 2008.

The Department used FY 2010 SAPT block grant funds to treat adolescents, adults, pregnant women and women with dependent children in each of the seven (7) sub-state planning areas in the state. Clients needed to be 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.

To operationalize the delivery of Block Grant funded services, the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Department contract with an entity for statewide management of the substance use disorder treatment and recovery support system of care. Business Psychology Associates (BPA) holds this contract. 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.

The Mission of the Idaho Interagency Committee on Substance Abuse Prevention and Treatment is to provide state-wide comprehensive and coordinated funding, programs, and services to Idaho citizens within and outside of the criminal justice system. The System promotes prevention through education, improved quality of life through treatment, prevention of illicit substance use, manufacture and transportation, and correctional intervention and treatment. ICSA is the body that determines State priorities for treatment funding within each State agency including Health and Welfare. An organizational chart is included below that shows the relationship between the SSA and ICSA

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.

Goal #2: Providing Primary Prevention services

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

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

Primary Prevention: Six (6) Strategies

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

Institute of Medicine Classification: Universal, Selective and Indicated:

- o **Universal:** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
- o **Universal Direct. Row 1**—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
- o **Universal Indirect. Row 2**—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- o **Selective:** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- o **Indicated:** Activities targeted to individuals in high-risk environments, identified as having minimal but

detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Because Idaho's Interagency Committee on Substance Abuse Prevention Subcommittee is focusing on statewide population planning and services, the Primary Prevention funds will be used to support community and individual-based services. At the community level, support will be given to coalitions focused on reducing alcohol or drug use. At the individual level there will be three primary populations served by Idaho's SAPT 20% set-aside for primary prevention programs for individuals who do not require treatment for substance abuse. The first target is youth aged 0 – 18. Approximately 11,000 youth will be served in recurring programs. The second focus will be parents. Approximately 500 parents will be served. The third population will be community members working with youth. Approximately 3000 adults will be served. In addition approximately 150,000 youth and adults will receive one-time substance abuse prevention information from the Idaho RADAR center. Services will be offered in all 7 sub-state regions of Idaho. Services will be delivered through a contract with the State's Prime Prevention Contractor.

Idaho will continue to support the goal for all funded programs and practices to be listed on the NREPP site. In FY 2011, Idaho will assess the current process for generating program outcomes for age-appropriateness, accuracy, and utility. In FY 2012 a plan for a prevention evaluation system will be drafted and piloted. The final process for evaluating program outcomes will be established during FY 2013.

Information Dissemination statewide services will be provided by the Idaho RADAR Center who will provide information and educational materials throughout the state to schools, prevention and treatment programs, social service providers, health care providers, other professionals and the general public. The Idaho RADAR Center will also continue supporting the video lending library which will also be available to any resident of the state. At the community level, anti-alcohol/drug coalitions will provide a variety of educational opportunities to increase awareness of alcohol/drug problems within their communities. At the individual level, prevention providers, school counselors, family counselors, etc., will provide materials from RADAR to program participants. These activities will be ongoing from 2011 through 2013.

Education will be provided to Idaho residents through community-based providers. The primary populations for this activity are parents, youth, and community members working with youth. Specific populations to be served will be based on needs assessment data. All recurring education programs will be evidence-based. The majority of the programs will directly serve an identifiable community population, which has not been identified on the basis of individual risk. Examples of programs funded under this strategy are K – 12 school curriculums, parent education courses and community development programs. These activities will be ongoing from 2011 through 2013.

Alternative Activities will include evidence-based education programs partnered with alternative activities such as academic after school programs and mentoring programs. The focus for this strategy will be children and youth. In addition to the education, alternative activities also offer opportunities for children to practice skills learned during the education program and see adults modeling and promoting positive behaviors. All education programs will be evidence-based. These activities will be ongoing from 2011 through 2013.

Problem Identification and Referral services will occur when a child involved in an education program exhibits behaviors associated with multiple risk factors. The primary population to be served with this strategy will be youth aged 10 to 18. The youth will be screened to determine if continuation in the program is appropriate of if

other or additional community resources are indicated. This strategy will be funded as a part of a prevention education system, which enables the facilitator to identify youth at need for additional resources. These activities will be ongoing from 2011 through 2013.

Community-based Process will continue to support the development of community anti-alcohol/drug coalitions throughout Idaho. Coalitions will be provided with resources from Communities that Care. Communities wishing to develop a coalition will receive technical assistance to evaluate community readiness, resources available within the community and assistance in initiating community meetings. At the sub-state level, regional advisory committees will focus on the coordination and prevention planning activities with local governments, public and private entities, including community-based organizations. At the state level, the SSA will partner with the Interagency Committee in Substance Abuse and their Prevention subcommittee, the Department of Juvenile Correction's Enforcing Underage Drinking Laws workgroup, the Tobacco-Free Idaho Alliance, the Idaho Substance Abuse Epidemiology Workgroup, and the Idaho Minor in Prevention to continue the development of a comprehensive state plan to prevention substance abuse and addiction. These activities will be ongoing from 2011 through 2013.

Environmental Strategies will be the focus of coalitions receiving SAPT Block Grant funds. In their annual application, coalitions will be required to outline the environmental programs, policies and practices that they plan to implement for the following year. Top priority will be given to coalitions to propose to implement evidence-based activities. Technical assistance will be available to coalitions from both the SSA as well as from the prevention services management contractor. In addition, at the state level, the SSA as a member of the Interagency Committee on Substance Abuse, Prevention Subcommittee, will be working on state level environmental strategies that promote population level change. These activities will be ongoing from 2011 through 2013.

During FY 2008, Idaho served more than 26,594 individuals with substance abuse prevention in single program and recurring program services funded by the SAPT block grant 20% primary prevention set-aside. There continue to be two major target populations for the Department's primary prevention programs for individuals who do not require treatment for a substance use disorder. The first target population was universal, selective and indicated youth aged 0 – 17 years. In FY 2008, 11,979 youth were served in recurring programs. The second target population was universal and selective, parents and community members working with youth. In FY 2008, 1,234 adults were served in recurring programs. Primary prevention services were provided either through the Department's statewide contracts or under the contract with the statewide Prevention Technical Assistance and Support Contractor (PTASC) (Benchmark Research & Safety) who manages a statewide network of prevention providers to deliver community and individual-based services described below. All activities were ongoing through the grant period. In FY 2008, 100% of funded recurring programs are on the list of Best or Promising Practices managed by the Western Center for the Application of Prevention Technologies (WestCAPT). The process for adult and adolescent programs to report outcome data has been completed using the CSAP Fellow. Standard pre and post-tests are being administered to all participants based on the services being provided. This is enabling the Department to generate data to facilitate the evaluation of the effectiveness of prevention programs on the population served.

Information Dissemination: Information Dissemination statewide services were provided by the Idaho RADAR Network Center through a Department held contract with Boise State University. The RADAR Center provided information and educational materials to schools, prevention, social service providers, health care providers, other professionals and the general public. The RADAR Center also loaned videos to the aforementioned groups. The only cost to the groups is the postage to return the video. The Department estimates 30,000 persons were served by the RADAR Center. At the community level, information dissemination services were provided by community-based programs and coalitions through subcontracts with the PTASC. Community-based providers included information dissemination activities within their recurring programs. All information dissemination services were offered for universal populations. In FY 2008 more than 17,000 youth and adults received these materials as a part of recurring programs. An additional 6,000 Idaho residents received information dissemination services as a part of single programs.

Education: Education services were provided to Idaho residents through community-based providers in all sub-state planning areas due to subcontracts with the PTASC. Examples of community-based providers were 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. Activities made available to youth were targeted to universal, selective and indicated populations. Activities made available to adults were also targeted to universal and selective populations. Types of education programs include, but are not limited to, Project Alert, All Stars, Project Towards No Drug Abuse, Life Skills Training, Meth is My Neighbor, Prevent Alcohol Related Crashes, Parents Who Care, Too Good for Drugs, Positive Action and Strengthening Families. In FY 2008, 18,500 persons were served under this strategy. During this period, 100% of recurring education programs were listed as "Best Practice" on the CASAT (Center for the Application of Substance Abuse Technologies) website.

Alternative Activities: In FY 2008, alternative activities were focused on youth and included skill-building and

academic after school programs, mentoring programs and community service substance use disorder education programs where children see adults modeling and promoting positive behaviors. Activities provided target universal and selective populations. In FY 2008, 600 individuals participated in alternative activities as single programs and 2,200 individuals as a part of recurring programs. All recurring programs were listed as a “Best Practice program” or strategy on the CASAT website. Programs were delivered in all sub-state planning areas of the state through subcontracts with the PTASC.

Problem Identification and Referral: Problem Identification and Referral services were offered to youth with risk factors in multiple domains. The youth were screened for risky behaviors and referred to appropriate community resources. This service was offered in the school or community action agency setting as a part of a student assistance program. In FY 2008, over 600 youth have received problem identification and referral services in single programs and almost 2,400 youth in recurring programs. All activities being provided were targeted to indicated populations. Programs were delivered in all sub-state planning areas of the state through subcontracts with the PTASC.

Community-based Process: In FY 2008, Community-based Process were focused on the development of community anti-AOD (Alcohol and Other Drugs) coalitions throughout Idaho. PTASC regional coordinators provided assistance to community groups or coalitions interested in addressing AOD-related issues in their communities. The specific focus of the coalitions was based on the risk factors, resources and needs identified in the community they sought to serve. The coalitions supported a variety of services including community awareness campaigns, media events, retailer/server education and presentations at community events. These activities were targeted toward universal populations. In FY 2008, 9,200 individuals participated in single event and recurring program community-based processes.

Environmental: Environmental strategies were focused at targets identified by community coalitions as a part of their annual plans. Activities were designed to change community norms, code or law enforcement practices as well as retailer/server practices through funded education programs. All activities being were targeted to universal or selective populations. Examples of environmental strategy activities included community awareness campaigns, media events, retailer/server education and presentations at community events. In FY 2008, over 8,700 persons have been served under this strategy in all sub-state planning areas through the contract with the PTASC.

To date in FY 2010, the Department has served 61,369 individuals with substance abuse prevention single program and recurring program services funded by the SAPT block grant. Another 152,744 individuals were provided with materials from the Idaho RADAR Center and 63,838 viewed videos on loan from the Center. There were three major age groups for Idaho's SAPT 20% set-aside for primary prevention programs for individuals who do not require treatment for substance abuse. The first age group was youth aged 0 – 17 years. To date in FY 2010, 15,720 youth have been served in recurring programs at the universal, selective and indicated levels of care. The age group is young adults aged 18 – 24. To date in FY 2010, 355 young adults were served. The third age group was adult parents and community members who work with youth. To date in FY 2010, 755 adults have been served in recurring programs at the universal and selective levels of care. Primary prevention services were provided either through statewide contracts and the contract with the statewide Prevention Technical Assistance and Support Contractor (i.e., Benchmark Research and Safety) who managed a network of prevention providers statewide to deliver regional services described below. All activities were ongoing through the grant period. To date 100% of funded recurring programs are on the National Registry of Effective Programs and Practices. The process for adult and adolescent programs to report outcome data has been completed using the CSAP Fellow. Standard pre and post-tests are being administered to all participants based on the services being provided. This is enabling the Department to generate data to facilitate the evaluation of the effectiveness of prevention programs on the population served.

Information Dissemination

Information Dissemination statewide services are being provided by the Idaho RADAR Network Center under a contract managed by Boise State University. The RADAR Center is providing information and educational materials to schools, prevention, social service providers, health care providers, other professionals and the general public. The RADAR Center is also loaning videos to the aforementioned groups. The only cost to the groups is the postage to return the video. The Department estimates 216,582 persons are being served by the RADAR Center to date. At the community level, information dissemination services are being offered by community-based programs and coalitions through subcontracts with the Statewide Prevention Contractor. Community-based providers are including information dissemination activities within their recurring programs. All information dissemination services are being offered at the universal level of care. To date, it is estimate that 15,801 youth and adults have received these materials as a part of recurring programs. An additional 4,430 Idaho residents are receiving information dissemination services as a part of single programs

Education

Education services are being provided to Idaho residents through community-based providers in all sub-state planning areas through subcontracts with the Statewide Prevention Contractor. 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 continue to be parents, youth, and community members working with youth. Services are being made available to youth at the universal, selective and indicated levels or care. Services are also being made available to adults at the universal and selective levels of care.

Types of education programs include, but are not limited to, Project Alert, All Stars, Project Toward No Drug Abuse, Life Skills Training, DUI Victims Panel, Meth is My Neighbor, Prevent Alcohol Related Crashes, Parents Who Care, Too Good for Drugs, Positive Action and Strengthening Families. The Department estimates 18,290 persons have been served under this strategy in FY 10. During this period, 100% of recurring education

programs have been listed as “Best Practice” on the CASAT website. To date, approximately 14,822 youth and adults have received education services in recurring programs and 4,401 have participated in one-time education programs.

Alternative Activities

To date, alternative activities have focused on youth and include skill-building and academic after school programs, mentoring programs and community service substance abuse education programs where children see adults modeling and promoting positive behaviors. Services are being provided at the universal and selective levels of care. To date it is estimated that 341 individuals have participated in alternative activities as single programs and 366 individuals are participating in alternative activities as a part of recurring programs. All recurring programs and practices are listed on the NREPP website. Programs are being delivered in all sub-state planning areas of the state through subcontracts with the Statewide Prevention Contractor.

Problem Identification and Referral

Problem Identification and Referral services are being offered to youth with risk factors in multiple domains. The youth are screened for risky behaviors and referred to appropriate community resources. This service is being offered in the school or community action agency setting as a part of a student assistance program. To date in FY 10, 553 youth have received problem identification and referral services in single programs. In addition, almost 1918 youth have received problem identification and referral services in recurring programs. All services are being provided to participants at the indicated level of care. Programs are being delivered in all sub-state planning areas of the state through subcontracts with the Statewide Prevention Contractor.

Community-based Process

To date in FY 10, Community-based Process have been focusing on the development of community anti-AOD coalitions throughout Idaho. Statewide Prevention Contractor regional coordinators continue to provide assistance to community groups or coalitions interested in addressing AOD-related issues in their communities. The specific focus of each coalitions is based on the risk factors, resources and needs identified in the community they seek to serve. The coalitions are supporting a variety of services including, community awareness campaigns, media events, retailer/server education and presentations at community events. These services are being delivered at the universal level of care. To date, 4,437 individuals have participated in single event and recurring program community-based processes.

Environmental

Environmental strategies have been focused at targets identified by community coalitions as a part of their annual plans. Programs, policies and practices were selected to change community norms, code or law enforcement practices as well as to provide retailer/server education. All services are being delivered at the universal or selective levels of care. To date in FY 10, over 15,233 persons have been served under this strategy in all sub-state planning areas through the contract with the Statewide Prevention 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.

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During the fiscal years of 2011 through 2013, the Department will continue to implement the delivery of specialized services according to the CSAT Blending Perspectives model and the Department's guidelines presented in the Pregnant Women and Women with Children Treatment Service Continuum State of Idaho which was completed in FY 2010.

The FY 2011 – 2013 plan will build on our progress.

The Department will work with the three designated PWWC specialized providers and BPA on the continued implementation of Idaho's PWWC protocols. In addition, the Department will work with BPA to revise the PWWC audit tool to evaluate compliance with SAPT Block Grant requirements. The programs that will be delivering services for the next 3 years are Riverside Recovery in sub-state planning area 2, Bell Counseling – Linden House in sub-state planning area three 3, and Road to Recovery – Discovery House 2 in sub-state planning area 6. Our goal is to expand the number of providers as additional funding becomes available.

For the fiscal years 2011 through 2013, the Department anticipates annually serving 150 pregnant women, 1,225 women with dependent children and 965 involved in the child protection system. Significant energy will be put into identifying multiple funding sources to cover the cost for ancillary services for the women as well as the services for children. The Department will be looking to forge state and community level partnerships to provide a comprehensive system of care for the women and their dependent children.

For the fiscal years 2011 through 2013 the Department will provide both Treatment and Recovery Support Services and Care Management statewide through its contract with our Management Services Contractor (MSC) BPA. The Department will continue to have BPA conduct the initial screening and risk assessments of clients and prior authorize eligible clients for assessment and subsequent treatment. The specialized PWWC providers under contract with BPA will conduct full bio-psycho-social assessments of the women needing services and deliver substance use disorders treatment and recovery support services, including child care as needed.

The Department maintained an aggressive approach to the delivery of these services in FY 2008. The applications of the select providers described in the "FY 2007 Progress" were reviewed and providers were selected for specifically delivering the specialized services according to the CSAT Blending Perspectives model and the Department's guidelines presented in the Pregnant Women and Women with Children Treatment Service Continuum State of Idaho (Revised August 2007) in addition to other training and technical assistance provided in FY 2007. The selection of five PWWC designated providers was completed during FY 2008. Four providers were selected statewide in February 2008. These included Riverside Recovery in substate planning area two, Bell Counseling – Linden House in sub-state planning area three, Women and Children's Alliance (WCA) in sub-state planning area four and Road to Recovery – Discovery House 2 in sub-state planning area six. Sitman Family Services, Inc. in sub-state planning area five was selected later in the year. The Department found it necessary to extend its goal of offering this model in each sub-state planning area by the end of FY 2008. It was able to offer it in five of the seven sub-state planning areas. The Department plans to continue to work on implementing the model statewide.

By using specialized providers the Department served fewer clients in FY 2008, which translates to serving 157 pregnant women and 826 women with dependent children in need of substance abuse treatment in all sub-state planning areas of the state during FY 2008. With the aid of CSAT State Systems Technical Assistance Project (SSTAP), the Department hosted a women's best practices training opportunity for designated PWWC providers March 18th and 19th, 2008. The event titled 'Health, Hope, and Healing for Women and Their Children' was well attended and gave attendees resource materials for serving the PWWC population.

During FY 2008 the Department continued to provide both Treatment Services and Care Management statewide through its current contract with Business Psychology Associates (BPA) as the Management Services Contractor (MSC). The Department had the MSC continue to conduct the initial screening and risk assessments of clients and prior authorize eligible clients for assessment and subsequent treatment. Local state approved alcohol/drug abuse treatment providers under contract with the MSC continued to conduct full bio-psycho-social assessments of the women needing services and delivered substance use disorders treatment and recovery support services, which included child care as needed.

In FY 2010 the Department continued to implement the delivery of specialized services according to the CSAT Blending Perspectives model and the Department's guidelines presented in the Pregnant Women and Women with Children Treatment Service Continuum State of Idaho in addition to other training and technical assistance provided in previous fiscal years.

Due to budget cutbacks the Department was forced to reduce the amount of funding allocated for PWCC specialized services. The Department worked with the 3 designated PWCC specialized providers. The three programs are Riverside Recovery in sub-state planning area 2, Bell Counseling – Linden House in sub-state planning area 3 and Road to Recovery – Discovery House 2 in sub-state planning area 6.

Initiated in FY 2008, the Department continued in the process of rewriting the 'Minimum Standards Governing Alcohol and Substance Use Disorders Treatment Facilities and Programs.' Included in this rule rewrite, for the first time, are standards specific to PWCC. The 'Guidance to States: Treatment Standards for Women With Substance Use Disorders' has been referenced during this rewrite. Department 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 FY 2010 the Department provided both Treatment and Recovery Support Services and Care Management statewide through its contract with a Management Services Contractor (MSC). The Department has the MSC conducted the initial screening and risk assessments of clients and prior authorize eligible clients for assessment and subsequent treatment. The specialized PWCC providers under contract with the MSC conduct full bio-psycho-social assessments of the women needing services and deliver substance use disorders treatment and recovery support services, including child care as needed. In addition the MSC created, with the help of the Bureau, a specific audit tool for providers delivering services to the PWCC.

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

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

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

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

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?
3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Pregnant Women/Women with Dependant Children

Only women who were served by agencies providing the specialized services were counted as PWWC clients for the purposes of block grant reporting. Providers who wished to become part of the PWWC specialty provider network signed an addendum to their contract with our MSC stating they would ensure the provision of all the required services and be audited to evaluate their status in meeting the Block Grant requirements and additional State requirements developed. In FY08, 7 sites throughout Idaho provided specialty services for the PWWC clients. These 5 providers are offered as a first choice of treatment options for the PWWC client when they are screened by our MSC.

During the grant period 157 pregnant women and 826 women with dependent children received substance use disorders treatment and ancillary services. Services included within the Idaho model include comprehensive evaluation of pregnant women, women with dependent children and their dependent children, including a risk assessment of immediate needs, gender-specific substance abuse treatment, case management and assistance in accessing other community services including, when appropriate, referral for pre-natal care and parenting classes. In addition to health-related services, the providers were responsible to ensure the women had access to childcare services and transportation. Often funding for childcare came from DHW's Child Care Assistance funds. By far, transportation posed the biggest problem. In a frontier state such as Idaho, the costs for providing transportation can be a huge burden to a provider. There is no public transportation available between small isolated communities, and in larger communities, public transportation is often limited to taxi cabs. Thus, transportation assistance occurred in a variety of ways. Provider employees, family members, community volunteers, including recovering individuals, provided the majority of the transportation assistance.

Although the Department used SAPT block grant funds as payer of last resort, the provider was also responsible to ensure the children received 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 Social Services Block Grant emergency assistance monies and community indigence funding and networking with other community agencies. Clients were required to use a 1-800 number to call the MSC for a screening to determine financial and clinical eligibility. The MSC care management unit also determined if clients were appropriate for PWWC services and prior authorized assessments at the most appropriate ASAM PPC 2R level of care. The provider conducted the biopsychosocial assessment and requested prior approval for indicated initial and ongoing services through the MSC. The MSC used a Department approved form to screen clients and make an initial risk assessment. This collected information to complete the federal Treatment Episode Data Set (TEDS), to make an initial diagnosis using the DSM-IV and to make a determination on each of the six domains of the ASAM patient placement criteria.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children. The selection of five PWWC designated providers was completed during FY 2008.

Program Name	Planning Area	I-SATS Number	Type of Care	Capacity	Funds Available
KC174900 – Business Psychology Associates	Region 2	ID100476	Outpatient Intensive Outpatient	OP – no limit IOP – no limit	No program limit*
KC174900 – Business Psychology Associates	Region 3	ID100476	Outpatient Intensive Outpatient Transitional Housing	OP – no limit IOP – no limit TH - 6 women	No program limit*
KC174900 – Business Psychology Associates	Region 4	ID100476	Outpatient Intensive Outpatient	OP – no limit IOP – no limit	No program limit*
KC174900 – Business Psychology Associates	Region 5	ID100476	Outpatient Intensive Outpatient	OP – no limit IOP – no limit	No program limit*
KC174900 – Business Psychology Associates	Region 6	ID100476	Outpatient Intensive Outpatient	OP – no limit IOP – no limit	No program limit*
				Total	\$1,557,194

*While there is not limit on funds available to a specific program, due to budget constraints, for FY 2008 the total amount available statewide was limited to \$1,557,194..

There is no limit placed on the number of PWWC outpatient and intensive outpatient clients that can be served for FY 2011, but due to budget cuts the amount available to fund PWWC services was limited to \$1,557,194. Pregnant women continued to be admitted and served even after the PWWC limit was exceeded. They received the treatment services that they needed, but not all the services required under the PWWC program were available to them. Per the Idaho program approval standards, for PWWC there was a 1 to 30 staff-to-client ratio. In FY08 the contract with BPA as the MSC for the region continued to require the development of a specialty network of PWWC providers who agreed to follow all Federal Regulations around treatment of this population.

The MSC regional substance abuse professionals conducted regular on-site visits with PWWC treatment providers. The scheduling and depth of the review depended on the provider’s level of implementation of services and need for technical assistance identified in previous site visits. .

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2007 Block Grant and/or State funds?

In FY 2008special substance abuse treatment services were provided for Pregnant Women and Women with Dependent Children (PWWC) through the network of approved specialty providers managed by the Department’s statewide MSC, BPA. Specialty providers, located in the 3 ISA’s, were required, through standards established in their contract with the MSC, to provide specialized services. These

services included comprehensive evaluation of pregnant women, women with dependent children and their dependent children, including a risk assessment of immediate needs, gender-specific substance use disorder treatment, case management and assistance in accessing other community services including, when appropriate, referral for pre-natal care and parenting classes. Although the Department was payer of last resort, the provider was also responsible to ensure the children received 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.

To ensure compliance, a variety of actions were taken by the Department. Initially, the Department identified PWWC populations as high priorities and included the federal requirements in the standards for all services to be provided under the MSC's contract. Performance requirements were incorporated in the contract with the MSC that imposed financial penalties for not meeting the PWWC maintenance of effort (MOE) 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 Department has assigned one of its full time program specialists to focus on development and implementation of specialized services for pregnant women and women with dependent children. This specialist is also designated as Idaho's Women's Services Network Specialist for SAMHSA's Center for Substance Abuse Treatment. The specialist works with the MSC to continually review and implement services identified in the block grant requirements. A specific audit tool has been created to evaluate compliance by providers who are with the PWWC specialty network. Providers within this network are audited quarterly, semi-annually or annually depending on their audit scores. Those providers with low audit scores receive technical assistance and greater oversight by the MSC and the Department to ensure that women and their children are well served. In addition the Department has 4 Performance Requirements in its contract with BPA that pertain to meeting the special needs of pregnant women and women with dependent children and assist in improvements in program development and service delivery.

A. PWWC REQUIREMENTS – The Contractor tracks provider documentation and data and reports Provider performance for: a) compliance with priorities for admission including cross-regional admission for pregnant women needing services; b) PWWC clients' eligibility evaluated using the Department's financial eligibility scale, per policy. Client documentation evidences that Department funds are "funds of last resort" for ancillary services. Clients are assisted in applying for Medicaid; c) Indicators of community network of treatment for the client and the family; and, d) Ancillary services/activities to which a client is referred are monitored for attendance and outcomes of those activities. The Department semiannually conducts random site audits of client records for documentation and assesses BPA a \$100 financial penalty for each audit that does not meet expectations.

B. ANCILLARY SERVICE REFERRALS – PWWC providers facilitate referrals, if applicable, to services that address prevention, developmental issues and issues of sexual and physical abuse/neglect for the dependent child(ren). Referrals are to be made by the end of the second week of services. The Department semi-annually conducts random site audits of client records for documentation and assesses BPA a \$100 financial penalty for each audit that does not meet expectations.

C. USE OF BEST PRACTICE MODELS – Treatment models used in PWWC residential programs are Department approved evidenced-based Best Practices models for the treatment of pregnant and parenting women. The Department semiannually conducts program audits, review of program materials, client records and program improvement plan, if applicable and assesses BPA a penalty of \$500 for each PWWC residential provider who has not created an action plan or implemented a Best Practice or both by June 30, 2006 and maintained thereafter.

D. SUBSTANCE ABUSING PREGNANT WOMEN'S ADMISSION TO TREATMENT – The Contractor shall clear for admission (as evidenced by an authorization and effective date) financially and clinically eligible substance abusing pregnant women in order for them to enter treatment within fourteen (14) calendar days of screening. The Department monitors quarterly care management logs and reports for compliance and assesses BPA a financial penalty of \$100 for each pregnant woman not admitted at the required level of expectation. If a PWWC specialty provider is not able to immediately admit a pregnant woman, a non-PWWC specialty provider is utilized until such time as a PWWC Specialty provider has capacity. If capacity is reached within the entire treatment system, the MSC will make available interim services within 48 hours, including a referral for prenatal care

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

The MSC defines the treatment capacity of providers in their network quarterly through a standard capacity tool that identifies number of beds/slots in the specialty provider network vs. number of PWWC clients requesting treatment. Capacity of the system vs. need is discussed monthly at the BPA/H&W operations meeting. In addition, at these meetings the MOE is discussed to assure compliance with the MOE. As of the writing of this block grant, no issue with capacity vs. need have been identified.

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The Department partnered with the RAC in each sub-state planning area to plan for enhancement of capacity of programs for pregnant women and women with dependent children. Sub-state planning area facilitated the development of a new provider for PWWC specialty services. Sub-state planning area 2 maintained the transitional home for six (6) transitional beds at Linden House for women with their children, coupled with outpatient treatment services in Caldwell. In addition, the MSC in sub-state planning area 2 finalized an agreement with an agency who had purchased a larger facility expanding their capacity to serve thirteen (13) women with their dependent children from the six (6) they had previously. They coupled this with outpatient treatment

services and accepted women from throughout the state. Sub-state planning area 3 maintained 2 PWWC specialty providers, one in Twin Falls and one in Pocatello

Goal #4: Services to intravenous drug abusers

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-13, the Department will continue to have the Management Services Contractor (MSC) triage IVDUs (intravenous drug users) requesting services statewide. Those who do not need emergency care will be scheduled for the first available assessment appointment. Those who need detoxification will be referred to a detoxification center or emergency room depending on the drugs involved, level of intoxication and detoxification history.

The Department will continue to maintain a protocol for reporting and provision of interim services at the service contractor level. These services include

- ¿ Counseling and education about HIV and tuberculosis (TB),
- ¿ Counseling and education about the risks of needle-sharing,
- ¿ Counseling and education on the risks of transmission to sexual partners and infants, and
- ¿ Counseling and education about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary.

The MSC will be required to notify the Department when their network providers are 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, is so low, that the state anticipates no problems in meeting this federal requirement during FY 2011-13. For the past several years, approximately 8% of clients served identified as IVDU. We anticipate this will continue in FY11-13.

The Department will continue to have language in its contract with the MSC to ensure all providers in the networks for all client groups are capable of treating Injection Drug Users (IVDU's) and that IVDU's 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 will be monitored as part of the overall monitoring of compliance with the terms of the contract and addressed through the annual quality assurance planning process.

During FY 2008, the Department continued its contract with Business Psychology Associates as its Management Services Contractor (MSC) to triage IVDUs (intravenous drug abusers) requesting services through its care management unit. Applying the triage protocols, the MSC scheduled those who did not need emergency care for the first available assessment appointment. The MSC referred those who needed detoxification to a detoxification center or emergency room depending on the drugs involved, level of intoxication and detoxification history. During FY 2008, 1481 IVDUs have been served.

The Department maintained a protocol for reporting and provision of interim services at the service contractor level. The MSC was required to notify the Department 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 meeting this federal requirement during FY 2008. The Department has the following performance requirement in its contract with the MSC to monitor compliance with the requirement to place IVDU's in treatment within fourteen (14) days of request and provide interim services if not.

INJECTION (IV) DRUG USERS ADMISSION TO TREATMENT POLICY - The Contractor shall clear for admission (as evidenced by an authorization and effective date) financially and clinically eligible injection (IV) drug users in order for them to enter treatment within fourteen (14) calendar days of screening.

Required Level of Expectation: 100%

Method of Monitoring: The Department will monitor through review of care management logs and reports.

Monitoring Frequency: Quarterly

Strategy for Correcting Non-Compliance: The Department will deduct \$100 for each IV drug user not admitted at the required level of expectation.

For each quarter of FY 2008 the Department selected a random sample of 75 IVDU's screened during the quarter to see that they were cleared to be placed in treatment within fourteen (14) days of request. A Department staff person and a BPA staff person reviewed the electronic record of each IVDU screened. One (1) IVDU was not cleared within the specified timeframes of the three hundred (300) reviewed. This person was screened within fifteen (15) days. BPA was financially penalized for the non-compliance.

During FY 2010, the Department continued to have the Management Services Contractor (MSC) triage IVDUs (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.

In FY2010, 2206 clients identified themselves as IVDU at intake. All were placed within the appropriate level of care within the 14 day period. BPA was monitored for compliance through randomly selecting 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. As part of BPA's provider audit, referrals and services provided by the private treatment provider were audited against 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 IVDUs in Idaho, particularly HIV positive individuals, was so low, that the state had no problems in meeting this federal requirement during FY 2010. Monitoring of the federal requirements was discussed at BPA/H&W operations meeting. This included discussion of capacity and if any providers had reached 90% capacity. A protocol was in place that BPA would notify the Department within 7 days, through email, if a provider had hit 90% capacity.

The Department maintained language in its contract with the MSC that ensured all providers in the networks for all client groups were capable of treating Injection Drug Users (IVDUs) and that IVDUs in each region of the state were placed in the appropriate treatment level of care within fourteen (14) days of requesting services, and if there was inadequate capacity, interim services were 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 in FY2010. No compliance issues were noted during the 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 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?
2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).
3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).
4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

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

Program Compliance Monitoring (formerly Attachment D)

(See 45 C.F.R. §96.122(f)(3)(vii))

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

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

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

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

1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)
(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)
(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

In FY 2009, treatment of IVDUs was made available within the 14-day period as required by the block grant. The Department did not fund programs serving only IVDUs. The Department required its Management Services Contractor (MSC) to provide both drug and alcohol treatment services. Through the screening process IVDUs were identified as a priority client and given the first available treatment appointment. The number of IVDUs, particularly HIV positive individuals, in Idaho was so low, there was no problem meeting the federal requirements for admission to treatment. The MSC maintained a waiting list on all clients for all providers, all levels of care statewide and reported the waiting list to the Department monthly. This allowed the MSC to know when agencies were at 90% capacity and report same to the Department. The MSC also tracked in their management information system the date an IVDU was screened, the date when services were authorized and the date of the first delivered service. The Department monitored the MSC quarterly by examining the screening records on a sample of seventy-five (75) IVDU clients screened during the quarter being reviewed. The MSC would have been assessed liquidated damages for any occurrence when an IVDU was not cleared to enter treatment within fourteen (14) days of screening and deemed eligible for Department funded treatment services. All 75 of the sample clients were admitted within the 14 day window.

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 FY 2009, the Department continued the services as initiated under the new system of service provision implemented in July 2003 in which multiple entities are required to ensure referral to appropriate services. The Department had the Care Management component of the MSC oversee treatment planning to ensure appropriate, comprehensive services were provided for all treatment needs identified in the comprehensive assessment. In addition, the Department had the MSC have in all sub-state planning areas a substance use disorder professional dedicated to the oversight of services provided to clients. At the program level, counselors were responsible for ensuring that clients receive care for treatment needs identified and to refer clients to ancillary services which were not provided directly by the program.

At the state level, the Department collaborated with DHW's Division of Health to facilitate referrals to services provided by district health clinics. This collaborative effort enabled the state to comply with this requirement without a duplication of effort.

The Department along with the MSC, in cooperation with DHW's Division of Health continued the implementation of infection control procedures established in FY 2004. The procedures were designed to prevent the transmission of tuberculosis, including the following:

1. Screening of patients;
2. Identification of those individuals who are at high risk of becoming infected; and
3. Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2.

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 FY 2009, the Department contracted with the MSC to manage a network of state approved alcohol/drug abuse treatment providers to deliver specialized services to pregnant women and women with dependent children, including women attempting to regain custody of their children.. The MSC managed the treatment services network and performed care management. The MSC conducted the initial client screening and risk assessment and authorized assessment and subsequent treatment for those eligible. Providers in the MSC network conducted full bio-psycho-social assessments of the women needing services. Treatment services were delivered and monitored by the MSC and the Department monitored the MSC for contract term compliance using the following procedures for monitoring performance requirements for services to pregnant women and women with dependent children.

A. **PWWC REQUIREMENTS** – The Contractor tracks provider documentation and data and reports Provider performance for: a) compliance with priorities for admission including cross-regional admission for pregnant women needing services; b) PWWC clients' eligibility evaluated using the Department's financial eligibility scale, per policy. Client documentation evidences that Department funds are "funds of last resort" for ancillary services. Clients are assisted in applying for Medicaid; c) Indicators of community network of treatment for the client and the family; and, d) Ancillary services/activities to which a client is referred are monitored for attendance and outcomes of those activities. The Department semi-annually conducts random site audits of client records for documentation and assesses BPA a \$100 financial penalty for each audit that does not meet expectations.

B. **ANCILLARY SERVICE REFERRALS** – PWWC providers facilitate referrals, if applicable, to services that address prevention, developmental issues and issues of sexual and physical abuse/neglect for the dependent child(ren). Referrals are to be made by the end of the second week of services. The Department semi-annually conducts random site audits of client records for documentation and assesses BPA a \$100 financial penalty for each audit that does not meet expectations.

C. **USE OF BEST PRACTICE MODELS** – Treatment models used in PWWC residential programs are Department approved evidenced-based Best Practices models for the treatment of pregnant and parenting women. The Department semi-annually conducts program audits, review of program materials, client records and program improvement plan, if applicable and assesses BPA a penalty of \$500 for each PWWC residential provider who has not created an action plan or implemented a Best Practice or both by June 30, 2006 and maintained thereafter.

D. **SUBSTANCE ABUSING PREGNANT WOMEN'S ADMISSION TO TREATMENT** – The Contractor shall clear for admission (as evidenced by an authorization and effective date) financially and clinically eligible substance abusing pregnant women in order for them to enter treatment within fourteen (14) calendar days of screening. The Department monitors quarterly care management logs and reports for compliance and assesses BPA a financial penalty of \$100 for each pregnant woman not admitted at the required level of expectation.

The Department continued the Specialized Child Protection Substance Abuse (CP/SA) components of the contract with the MSC to facilitate access to services for women with children involved in the child protection system. A substance use disorders specialist was established in each sub-state planning area to liaison the child protection and substance use disorders treatment systems. The CP/SA liaisons were funded with a combination of SAPT block grant and TANF funds.

DHW's Division of Welfare modified practices in FY 2007 by paying treatment providers directly for services to applicants receiving cash assistance under the TANF funded Idaho Temporary Assistance to Families in Idaho (TAFI) program, rather than running it through the MSC. This continued the delivery of services primarily to women with dependent children.

The MSC through its Regional Coordinators conducted contract monitoring and site visits to assess compliance with the standards set for these specialized services. The visits included file reviews as well as discussions with program managers and counselors. The aforementioned standards were used as the basis of monitoring activities. Quality assurance oversight of the treatment providers was provided by MSC Care Management concurrent reviews and preauthorization for specialized services and by Department staff in monthly meetings with the MSC. Training was provided by Department staff as needed or as requested.

No problems were identified necessitating corrective action.

Goal #5: TB Services

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-13 the Department will continue services similar to those initiated in the contract with a Management Services Contractor (MSC) in July 2009. The provisions of this contract call for multiple avenues or approaches to be required to ensure referral to appropriate services. 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 oversees treatment planning, will ensure appropriate, comprehensive services are provided for all treatment needs identified in Idaho's standard and mandated assessment, the GAINI, including referral to TB screening and treatment. The MSC's regional coordinators will be dedicated to the oversight of services provided to clients including those relating to TB. Counselors at the program level will continue to be 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.

At the state level, the Department will continue to collaborate with the DHW's Division of Health to facilitate referrals to TB services provided by district health clinics (TB related testing, counseling, medications and medical services). This collaborative effort will enable the state to comply with this requirement without a duplication of effort.

The Department does not intend to 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. However, with the implementation of the WITS electronic record system, the Department will be able to collect data during admission regarding whether or not a client has had a TB test in the past.

The Department will continue to annually monitor that MSC providers are discussing TB issues with clients and referring them for testing and services, as indicated through quarterly monitoring. The Department contract monitor will monitor the MSC to ensure that the block grant requirements for TB are being met. In addition, this is contained in the Department's contract with the MSC to include in their quality assurance plan based on chart audit results. All providers will be audited for their compliance at minimum annually through BPA's provider audit.

In FY 2008 the Department continued TB services as initiated in the contract with a Management Services Contractor (MSC). The provisions of that contract called for multiple approaches to ensure referral to appropriate services. These included 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 oversaw treatment planning, was in place to ensure 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 dedicated to the oversight of services provided to clients including those relating to TB. Counselors at the program level were responsible for ensuring that clients received care for identified treatment needs including those relating to TB and to refer clients to ancillary services not provided directly by the program.

At the state level, the SSA collaborated with the Division of Health to facilitate referrals to TB services provided by district health clinics (TB related testing, counseling, medications and medical services). This collaborative effort enabled the state to comply with this requirement without a duplication of effort. The Department did not have a structure in place to track the number of clients referred for TB services.

The Department uses the following procedure to monitor the performance requirement in the MSC's contract pertaining to TB services.

TB:IDENTIFICATION & REFERRAL FOR TUBERCULOSIS (TB) SERVICES – The Contractor assures its Providers adhere to DHW protocols to prevent transmission of TB including identification of those individuals who are at high risk of becoming infected and referral to local TB services, as indicated.

Required Level of Expectation: 100%

Method of Monitoring: Department random audits of client records for documentation of compliance with TB identification and referral protocols. This applies to records from Providers currently in the Contractor's network and to Providers that were in the Contractor's network during the period being reviewed.

Monitoring Frequency: Annually

Strategy for Correcting Non-Compliance: Department will deduct \$100 for each client record that does not pass this review during Provider's audit

In FY 2010 the Department continued services similar to those initiated in the contract with a Management Services Contractor (MSC) in July 2009. The provisions of the contract called for multiple avenues or approaches to be required to ensure referral to appropriate services. These included 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 oversaw treatment planning, was in place to ensure appropriate, comprehensive services were provided for all treatment needs identified in Idaho's standard and mandated assessment, the GAINI, including referral to TB screening and treatment. The MSC's regional coordinators were dedicated to the oversight of services provided to clients, including those relating to TB. Counselors at the program 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.

At the state level, the Department collaborated with the DHW's Division of Health to facilitate referrals to TB services provided by district health clinics (TB related testing, counseling, medications and medical services). This collaborative effort enabled the state to comply with this requirement without a duplication of effort.

As stated in the intended use plan for FY2010, the Department 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 Department monitored that MSC providers are discussing TB issues with clients and referring them for testing and services during each quarterly contract review. In FY2010 the MSC 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 MSC audit 712 charts, representing an 11% sample of overall client files. Of the 712 files reviewed, three 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.

Goal #6: HIV Services

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011-13, the Department will continue 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. The Department will collaborate with community partners to identify and adopt best practices and assist MSC network providers with implementation of services. The Department will continue to provide information to network providers to help in the continuation of integrating education and intervention services for HIV into their programs.

The Department has no plans to continue efforts to have MSC network providers provide Rapid HIV Testing in their programs.

Although Idaho is not designated as a state to fund early intervention services for HIV, in FY 2006 the Department participated in SAMHSA's Rapid HIV Testing Initiative targeting IDU's in all areas of the state served by the MSCs network providers.

The Department designated a program specialist to coordinate with the HIV coordinator in the DHW's Division of Health. The program specialist ensured that all network providers had the opportunity to participate in the initiative, coordinated ongoing training and worked with partners to identify barriers and develop implementation strategies. However, implementation of the testing protocols and tools has not occurred due to funding issues, multiple changes in the Department and a shifting of focus.

Idaho continues to have a low HIV/AIDS rate. Even though Idaho is not a designated HIV Early Intervention State, the Department continued to pursue activities to maintain a low rate of HIV/AIDS among substance abuse receiving treatment.

The Department 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 IACHA, the Department collaborated with 25 different community partners throughout the State of Idaho.

As stated in the intended use plan for FY2009, the Department continued its work on implementing early intervention services for HIV in all sub-state planning areas of the state served by the MSC's network providers. The Department collaborated with the Division of Health and IACHA to provide education and training for treatment programs and counselors on integrating early intervention services for HIV into their programming.

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

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2008 Uniform Application, Section III.4, FY 2008 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

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

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

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

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

Idaho is not a designated state.

Goal #7: Development of Group Homes

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

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Idaho does not participate in this program.

Idaho does not participate in this program

Idaho does not participate in this program

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2008 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

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

Idaho does not participate in this program.

Goal #8: Tobacco Products

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

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

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

Goal #9: Pregnant Women Preferences

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During FY 2011 through FY 2013, the Department will continue to have pregnant women as the highest priority for placement in substance use disordered treatment in all sub-state planning areas of the state. Based on past client counts, the Department anticipates serving at least 200 pregnant women statewide during each fiscal year period.

The Department will continue the system that combines Treatment and Care Management services under one contract. The MSC's Care Management unit will continue to oversee utilization to ensure appropriate, timely and comprehensive services are provided for all treatment and ancillary service needs identified in the comprehensive assessment of each pregnant woman. In addition, the MSC will continue to have, in each sub-state planning area, a substance use disorders professional dedicated to the oversight of services provided to pregnant clients. At the program level, counselors will continue to be responsible for ensuring that pregnant clients receive care for identified treatment needs and refer clients to ancillary services, which are not provided directly by the program. At the state level, the Department will continue to collaborate with the Division of Health to facilitate referrals to services provided by District Health clinics. This collaborative effort will continue to enable the Department to comply with this requirement without a duplication of effort.

The Department will continue the practice of determining pregnancy status when a woman calls 1-800# and is screened and deemed eligible for publicly funded treatment. If they are, then the Department's client prioritization system will be enacted and the client will receive treatment services immediately. The Care Manager will use daily updates information on the capacity available both locally to the client and statewide. MSC will continue to be authorized to place the pregnant client anywhere in the state without first clearing it with the Department. The Care Manager will continue to place pregnant clients in at least an outpatient treatment program within fourteen (14) days of their request for services. The MSC's substance use disorders professionals will continue to work with providers to have them and their counselors ready to deliver services to pregnant clients according to State and Federal requirements, which included referral to prenatal care.

The MSC substance use disorders professionals will continue to provide technical assistance to their pregnant women providers to update them on new/changing programs available through the District Health Departments, such as, prenatal, immunization, WIC, TB and STD/AIDS programs as well as other community services. Annual chart and program audits by the MSC and the Department will include checking that referrals to appropriate services for pregnant clients where made.

The monitoring process for this goal will be included in the overall monitoring by the Department of the MSC and in the MSC's monitoring of treatment providers. The Department will monitor the MSC quarterly through a random selection of PWWC client charts to assure all requirements have been met. The MSC will continue to use their established performance-based system (Provider Report Card) for monitoring provider performance and compliance with MSC contractual obligations. The Clinical Chart, Clinical Supervision and For-Cause Audit processes will continue to be conducted to evaluate quantitative and qualitative data regarding provider performance that assists in developing outcomes to evaluate the provider on an individual as well as, a systems level. This data is used to identify need for technical assistance and may result in the requirement of a corrective action plan. (To date, no provider has been required to complete a corrective action plan.) Those providers needing additional assistance and support will have access to state and contractor staff to assist them in developing an action plan which addresses how identified deficiencies will be corrected and operationalized

within their program.

However, for those providers who continuously who fail meet the minimum performance requirements, the audit process allows BPA to enforce sanctions that would impact the providers' status within the network, which include:

- ¿ Inactivation
- ¿ Termination
- ¿ Claims recoupment

For Fiscal Years 2011 – 2013, the Department will continue to forge alliances with state and community agencies to improve services to pregnant women and women with dependant children. Specific attention will be paid to creating a system of care with braided funding that enables Idaho to expand services while also continuing to improve the quality of care. The Department will pay particular attention to ensuring that children of PWWC clients not only receive the medical and emotional services that they need, but also work on developing systems to ensure the children have the education/ support that they need to succeed in a recovering family.

substance use disordered treatment in all sub-state planning areas of the state. During 2008, 157 pregnant women received treatment services statewide. The Department continued the system wherein Treatment services and Care Management services were combined under one contract with a statewide Management Services Contractor (MSC). The Department had MSC's Care Management unit continue to oversee utilization to ensure appropriate, timely and comprehensive services were provided for all treatment needs identified in the comprehensive assessment for pregnant women. In addition, the MSC continued to have, in each sub-state planning area, a substance use disorders professional dedicated to the oversight of services provided to pregnant clients. At the program level, counselors continued to be 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 SSA continued to collaborate with the Division of Health to facilitate referrals to services provided by District Health clinics. This collaborative effort enabled the Department to comply with this requirement without a duplication of effort.

The Department continued the practice that when a client called the 1-800# and was screened and deemed eligible for publicly funded treatment by the MSC's Care Management Unit, it was clarified at that time if they were pregnant. If they were, then the Department's client prioritization system was enacted. The Care Manager was aware of the capacity available both locally to the client and statewide. The Department had given authority to the MSC to place the pregnant client anywhere in the state without first clearing it with the Department. The Care Manager also has the goal of placing pregnant clients in at least an outpatient treatment program within fourteen days of their request for services, thus negating the need for interim services. The MSC's sub-state planning area substance use disorders professionals worked with providers to have them and their counselors ready to deliver services to pregnant clients according to the requirements, which include referral to prenatal care. The MSC substance use disorders professionals also worked with their pregnant women providers so they were aware of the pertinent programs available through the District Health Departments, such as, prenatal, immunization, WIC, TB and STD/AIDS programs. Annual chart audits by the MSC and the Department included checking that referrals to appropriate services for pregnant clients were made.

In addition the Department monitored quarterly the activity of the MSC to see that pregnant women were cleared for placement in a treatment program within fourteen days of requesting a service. All charts of pregnant women being screened were reviewed in each quarter of the fiscal year. This was typically 40 to 45 women. All women were cleared within fourteen days of request.

In FY 2010 the Department continued to have pregnant women as the highest priority for placement in substance use disorder treatment in all sub-state planning areas of the state. The Department continued the system with Treatment and Care Management services are combined under one contract with a statewide Management Services Contractor (MSC).

The MSC's Care Management unit continued to oversee utilization to ensure appropriate, timely and comprehensive services were provided for all treatment needs identified in the comprehensive assessment for pregnant women. In addition, the MSC continued to have, in each sub-state planning area, a substance use disorders professional dedicated to the oversight of services provided to pregnant clients. At the program level, counselors continued to be responsible for ensuring that pregnant clients receive care for identified treatment needs and refer clients to ancillary services, which are not provided directly by the program. At the state level, the Department continued to collaborate with the Division of Health to facilitate referrals to District Health clinic services. This collaborative effort enabled the Department to comply with this requirement without a duplication of effort.

The Department continued the practice of asking females calling 1-800# and if they are pregnant as a part of screening and deemed eligibility for publicly funded treatment by the MSC's Care Management Unit. If they were, then the Department's client prioritization system was enacted. The Care Manager was up to date on the capacity available both locally to the client and statewide. The Department gave authority to the MSC to place the pregnant client anywhere in the state. The Care Manager also was responsible to place pregnant clients in at least an outpatient treatment program within fourteen (14) days of their request for services, thus negating the need for interim services. The MSC's sub-state planning area substance use disorders professionals 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.

The MSC sub-state planning area substance use disorders professionals worked with their pregnant women providers so they are aware of the pertinent programs available through the District Health Departments, such as, prenatal, immunization, WIC, TB and STD/AIDS programs. Annual chart audits by the MSC and the Department included checking that referrals to appropriate services for pregnant clients were made. The audit tool and BPA uses to monitor for provider block grant compliance is attached as an optional attachment.

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

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

<

- 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 and Waiting List Systems

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

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In FY2009, the Department continued to function under the structure of a contract with a statewide Management Services Contractor (MSC), Business Psychology Associates (BPA), managing a statewide network of substance use disorder treatment and recovery support services providers, screening new clients via a 1-800 # for financial and clinical eligibility, authorizing placements in ASAM patient placement criteria indicated levels of care for initial assessments and subsequent treatment services and managing client placements based on waiting lists determined by capacity, census and budgeted funds. The MSC reported the status of the waiting list to the Department weekly. They met the requirement to inform the Department whenever a program was at 90% of capacity as required in their contract. The MSC managed clients funded from SAPT block grant, and state sources. The Department expended \$1,376,862 for direct client services on 451 unduplicated PWWC clients in state fiscal year 2009. Separate line item expenditures for the development of capacity management and waiting list systems for IVDU's and pregnant women were not available.

The MSC used a client prioritization system to determine admission to treatment and managed a statewide waiting list centrally. The priority list for adults and adolescents is listed below.

Priority	Target Group	
	Adult	Adolescent
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

The MSC had designated staff assigned in their care management section to work with network providers to serve persons on the waiting list. In the contract with the MSC it is clear that IVDU's and pregnant women are not to be on the wait list unless absolutely necessary. When a pregnant woman or an IVDU called requesting services, the MSC had the ability to connect the client with the program closest to them with space available as well as other programs throughout the state with space available. The care manager could also authorize treatment services at a lower level of care, as well as interim services, if necessary, until space became available in the ASAM PPC 2R indicated level of care.

Interim services provided by network treatment providers included regular phone contact, drop in services and self-pay education groups. The providers also referred clients to a hospital for emergent or urgent care, provided phone numbers for AA/NA and other self help groups, referred clients for HIV/AIDS/TB testing, referred clients to prenatal care, as appropriate, and conveyed instructions to call back on status.

The MSC tracks in their management information system the date an IVDU is screened, the date when services are authorized and the date of first delivered service to verify that IVDU's are cleared and referred for placement within fourteen (14) days of screening. In SFY08 1,890 unduplicated IVDU clients were screened and all entered treatment. Compliance with this requirement is monitored through quarterly contract monitoring site visits by Department staff.

Goal #10: Process for Referring

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FYs 2011-2013 the Department will continue to contract with a Management Services Contractor (MSC), Business Psychology Associates, to manage the statewide substance use disorder treatment system of care to deliver services to adults, adolescents and PWWC (pregnant women and women with dependent children) clients through a network of state approved substance use disorder treatment and recovery support providers and conduct utilization review (i.e., care management).

The initial client screening will continue with an MSC by the care management unit manned with qualified professionals to screen clients from all sub-state planning areas using a 1-800 # to conduct risk and service assessments and prior authorize assessments at the most appropriate ASAM PPC-2R level of care. DHW is moving toward having court-referred mental health initial screenings done by BPA as well, which will allow for co-occurring treatment options to be offered much sooner in the referral process. Because the GAIN Short Screener is used as part of the screening and is recognized as a good screening tool for both mental health and SUD, this is seen as a major step forward. The MSC care managers are to be available from 8 a.m. to 5 p.m. Mountain Time. The care managers will continue to maintain 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.

For the remainder of FY11, the MSC will continue to collect data for the federal treatment episode dataset (TEDS) from the client and enter it in their client information system and transfer it to the Department's data system. It is anticipated that starting in FY12 the State will collect the data through the use of WITS. This Federally approved data system will allow the collection of all intake, admission and discharge data from both treatment providers and our MSC. Idaho is building a system which will allow private providers to use WITS for all client management and data collection. The WITS system will provide a fast and efficient way for clients to be transferred within the provider network to receive appropriate services, while at the same time protecting client records through the use of information authorizations that are built into the system. A module has been built into this system to configure the TEDS data as needed to be able to upload the data to Synectics. The MSC will continue 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.

In state fiscal years 2011-2013 the Department will continue to work with the Courts 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 Department will use the same screening process for these individuals, recognizing they are automatically eligible, and use the ASAM PPC 2R for placement decisions.

During FY 2008, the Department contracted with Business Psychology Associates (BPA) as the Management Services Contractor (MSC) to manage the substance use disorder treatment system of care to deliver services to adults, adolescents and PWWC (pregnant women and women with dependent children) clients through a network of state approved substance use disorder treatment and recovery support providers and conduct client utilization review (i.e., care management).

The initial client screening was conducted by the care management unit manned with qualified professionals to screen clients from all sub-state planning areas via a 1-800 # for clinical eligibility, conduct risk and service assessments and prior authorize assessments at the most appropriate ASAM PPC-2R level of care. The MSC care managers were available from 8 a.m. to 6 p.m. Mountain Time for client and provider calls. The care managers continued to maintain 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. When a potential client called, he/she talked to a person trained in conducting an initial demographic data collection and financial screening activity. They were also trained in confidentiality and supervised by clinical supervisors. One of the first questions they asked is a mandatory question on whether or not the individual consents for BPA sharing the information with a provider. This facilitated the sharing of the screening and risk assessment data and authorization of units with the provider. If they did not consent, the process was terminated. If they consented, the staff collected demographic and federal treatment episode dataset (TEDS) data and financial eligibility information. This typically took 3 to 4 minutes. Once determined financially eligible they were handed off to a trained and clinical supervised Care Manager who asked the potential client questions to make an initial placement decision. The Care Manager faxed the screening and risk assessment findings and the authorization to the selected provider in BPA's closed and secure network of approved providers. If possible, the Care Manager connected the client with the provider through a "warm transfer" so initial appointments were for a more extensive assessment to begin the treatment episode. The MSC continued to collect TEDS data from the client and entered it in their client information system. The MSC conducted concurrent risk factor reviews on data submitted by the provider and assessed the client's progress and adjusted the treatment level of care as indicated.

In FY 2010 the Department continued to contract with a Management Services Contractor (MSC), Business Psychology Associates (BPA), to manage the statewide substance use disorder treatment system of care to deliver services to adults, adolescents and PWWC (pregnant women and women with dependent children) clients through a network of state approved substance use disorder treatment and recovery support providers and conduct utilization review (i.e., care management).

The initial client screening continued with the MSC by the care management unit manned with qualified professionals to screen clients from all sub-state planning areas via a 1-800 # for financial (up to 175% of federal poverty guidelines) and clinical eligibility, conduct risk and service assessments and prior authorize assessments at the most appropriate ASAM PPC-2R level of care. The MSC care managers are available from 8 a.m. to 5 p.m. Mountain Time. The care managers continued to maintain 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.

BPA continued to collect data for the federal treatment episode dataset (TEDS) from the client and entered it in their client information system and transferred it to the Department's data system. They 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.

In state fiscal year 2010 the Department continued to work with the Courts 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 Department used the same screening process for these individuals, recognizing they are automatically eligible, and used the ASAM PPC 2R for placement decisions. In FY10 2,061 19-2524 clients were screened with 1,350 of those screening clinically eligible based on ASAM criteria. Additionally in FY10, 518 20-520I clients were screened with 400 of those screening clinically eligible based on ASAM.

Because of time-span issues that are sometimes occurring from the time a judge orders a SUD assessment for sentencing purposes and when a GAIN I assessment report is being returned to the judge, a study was done to evaluate where process breakdowns are occurring. A plan is being put in place to elevate the issue. Because the GAIN Short Screener (SS) has a very high reliability rate as compared to the GAIN I assessment, the plan is for BPA to create a report based on screening information including the SS which will be used for sentencing purposes by the judge. If the client is screened appropriate for treatment, they will then be ordered for assessment and treatment as indicated.

Goal #11: Continuing Education

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL # 11c An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2011-FY 2013 (Intended use plan)

TREATMENT

As we look forward for FY 2011-FY 2013, we will be re-evaluating the continuing education of pre and post employment clinical staff of Substance Use Disorders treatment facilities. Re-evaluation appears to be an ongoing necessity when taking into consideration both the recent, and expected system changes, which have and will continue to affect staffing requirements and fiscal resources.

Idaho Administrative Code relative to SUD Treatment and RSS Facilities and programs was updated and implemented on May 1, 2010. Reduction in fiscal resources, in addition to changes in priority populations receiving those funds continues to be an ongoing challenge.

A major change is reflected in Idaho's stated Goal of requiring Professional Licensure for SUD Treatment Clinicians by the end of fiscal year 2013. The current Idaho Administrative Code, requires SUD certification by entities that not only have accepted standards of professional qualifications and performance, but also have an ability to take decisive action in regard to any potential ethical violations that a certified clinician may exercise. In the absence of SUD specific certification, the current code requires, a Professional Licensure, issued by the Idaho Board of Occupational Licenses plus 1040 hours of clinically supervised SUD specific direct client services and related training and mentoring per the NFATTC model of clinical supervision.

The SSA plans to continue to provide continuing education to the following three groups, however, those individuals described in bullet #1, are a priority as we move forward. We will continue to invite those individuals described in bullets #2 and #3, to participate, however, will expect them to contribute to or assist in sharing the costs of providing continuing education.

1. Substance use disorders treatment clinicians and apprentices in the Management Services Contractor's (MSC) network whose services were partly or wholly funded with SAPT block grant SUD Treatment funds;
2. Substance use disorders treatment clinicians and apprentices from identified partner agencies, e.g., Department of Correction, Department of Juvenile Corrections, Idaho Supreme Court Drug Court System; and,
3. Substance use disorders treatment clinicians and apprentices from non-network and non-identified partner agencies.

Idaho Conference on Alcohol and Drug Dependence (ICADD) –corporation. is an annual conference, supported through the collaborative efforts of private and community based partners, who have formed a non-profit corporation, addressing addiction issues among Idaho Citizens. The conference provides skills based workshops and break out sessions on a variety of topics. It

is held at Boise State University in Boise, Idaho. The SSA plans to continue to serve on board of directors, and the annual conference planning committee as an advocate for providing skills based workshops that train clinicians in best SUD clinical and recovery support services approaches to meet the challenges of serving the varied needs of an at times difficult and multi-problematic client base. As funds become available there may be opportunities for the SSA to partner with ICADD to provide additional training opportunities to clinicians in more remote areas of the state.

GAIN Training:

GAIN Site Interviewer and GAIN GRRS Editing and Interpretation training sponsored by the SSA is to be scheduled in October through December 2010. The trainings will be offered in various locations around the state to meet the needs based on findings of a recent survey of contract providers.

The SSA plans to provide for ongoing GAIN training for direct services clinicians during the life of this Block Grant. However, by the end of FY 2013, the SSA intends to move the logistical responsibilities for GAIN Training to the IDEAS Schools and the Management Services contractor.

Business Psychologist Associates (BPA)

The Management Services Contractor, will continue to provide best practices training events throughout the state, to meet identified training needs. On the current list of best practices being trained to are the following: Case Management, ASAM and Clinical Supervision. This list is subject to expansions as need and resources allow.

IDEAS

A major part of the re-evaluation of meeting continuing education needs will be the relationship between the SSA and IDEAS contracted schools. Historically, colleges and universities were reluctant to provide addiction studies courses as required by an independent certifying body such as the IBADCC or ICRC. They however, expressed that if professional licensure through the IBOL were available they could find a basis on which to fund courses to meet the licensure requirements without subsidy of the SSA. With this in mind, it appears important to move toward increasing an emphasis on a minor in SUD Treatment to accompany Professional Clinical Degree programs at the Masters Level. It also calls attention to likely need for a tiered licensing system that utilizes the collective knowledge, skills and attitudes of member of the IBADCC relative to developing such a system.

We will continue to work with the IDEAS Schools to enhance and expand their ability to grow their GAIN Training and Certification Programs which were formally implemented in January 2010.

PREVENTION

(1) Who will be served;

1. Staff of Community-based Prevention Programs providing youth education
2. Staff of Community-based Prevention Programs providing parenting education
3. Staff of Community-based Prevention Programs offering after school programs

4. Staff or members of Community Substance Abuse Prevention Coalitions

(2) *What activities/services will be provided/expanded or enhanced;*

Training to be offered during FY 2011

1. Public Colleges & Universities providing Introduction to Prevention course
2. Substance Abuse Prevention Conference providing short sessions on a variety of topics
3. Public Colleges & Universities providing Addiction and the Family course
4. Public Colleges & Universities providing Coalition Development course
5. Public Colleges & Universities providing and regional workshops offering Prevention Ethics course
6. Regional Workshops providing Human Development Theory and Its Impact on Prevention
Public Colleges & Universities providing Drugs and Society course

(3) *When will the activities services be implemented(date);*

1. Intro to Prevention – Course available at public colleges and universities and available online to staff of currently-funded prevention providers
2. Substance Abuse Prevention Conference – May 2011
3. Addiction and the Family - Course accessible from public colleges and universities for pre/post-professionals
4. Coalition Development - Course accessible from public colleges and universities for pre/post-professionals
Prevention
5. Ethics - August 3, 2006 - Course accessible from public colleges and universities each for pre/post-professionals
6. Human Development Theory Course accessible from public colleges and universities for pre/post-professionals
7. Drugs and Society- Course accessible from public colleges and universities each semester for pre-professionals and available online to staff of currently-funded prevention providers

(4) *Where in the STATE (geographic area) will the activities/services be undertaken;*

Training opportunities are open to all staff whose positions are partly or wholly funded with SAPT prevention funds. Those living outside of regular commuting area - the distance people in that area regularly travel to work - are offered travel, per diem and when needed, housing or registration fee assistance.

1. Intro to Prevention - Course available at public colleges and universities in Moscow, Lewiston, Boise and Twin Falls, Idaho and available online to staff of currently-funded prevention providers.
2. Substance Abuse Prevention Conference - Sun Valley, ID
3. Addiction and the Family - Course available at public colleges and universities in Moscow, Lewiston, Boise and Twin Falls, Idaho
4. Coalition Development - Course available at public colleges and universities in Moscow, Lewiston, Boise and Twin Falls, Idaho
5. Prevention Ethics - Course available at public colleges and universities in Moscow, Lewiston, Boise and Twin Falls, Idaho
6. Human Development Theory - Course available at public colleges and universities in Moscow, Lewiston, Boise and Twin Falls, Idaho
7. Drugs and Society- Course available at public colleges and universities in Moscow, Lewiston, Boise and Twin Falls, Idaho and available online to staff of currently-funded prevention providers

(5) *How will the activities/services be operationalized;*

Some trainings are for information only, others will result in the development of specific skills as noted below.

1. Intro to Prevention - Skill Developed - Completion of the Idaho Logic Model; Ability to determine most appropriate theory to apply for the activity to be undertaken
2. Substance Abuse Prevention Conference - Information Only
3. Addiction and the Family - Skill Developed - Ability to identify impact of substance abuse on youth or adult participating in recurring prevention programs
4. Coalition Development - Skill Developed - Ability to apply principles of effective coalition development and management
5. Prevention Ethics - Skill Developed - Ability to identify ethical issues and take most appropriate action
6. Human Development Theory - Skill Developed - Ability to use human development theory to select most appropriate prevention program for target population
7. Skill Developed - Drugs and Society - Information Only

Prevention

In FY 2008 continuing education of employees of prevention facilities were provided to:

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

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 the regular commuting area for the training location were offered travel, per diem and when needed, housing or registration fee assistance. Continuing education offered in FY 2008 included:

1. The 15th Annual Idaho Prevention Conference held in Sun Valley, Idaho, April, 2008. The Department assisted 67 Department-funded prevention providers with attending the conference.
2. The Substance Abuse Prevention Institute held in Boise, Idaho in the summer of 2008. Courses offered were Prevention Ethics, Addiction and the Family, Prevention Group Facilitation, Introduction to Drugs and Society and Human Development for the Prevention Professional. A total of 81 individuals participated.
3. The Department offered one (1) course on the www.PreventionIdaho.net website. The course, Prevention Theory, was available only to staff whose salary was funded wholly or in part by the SAPT block grant. The course covered the history of substance abuse prevention, the four major substance abuse prevention theories, the CSAP strategies and Institute of Medicine (IOM) levels of care, the National Registry of Effective Programs and Practices (NREPP), and developing an effective prevention system. Sixty individuals took the course.

Prevention continuing education was operationalized using different methods. Master or Doctorate level instructors with experience teaching the topic at the college level taught all training. The Department produced the Prevention Institute in Boise and either delivered the sessions with Department staff or private presenters. The Department participated in the planning of the Idaho Prevention Conference and covered the registration, lodging and travel costs for prevention providers receiving SAPT Block Grant fund to attend. The development and maintenance of the online courses were included in the PTASC contract.

Treatment

In FY 2008 continuing education of employees of treatment facilities was provided to:

1. Substance use disorders treatment clinicians and apprentices in the Management Services Contractor's (MSC) network;
2. Substance use disorders treatment clinicians and apprentices from identified partner agencies, e.g., Department of Correction, Department of Juvenile Corrections, Idaho Supreme Court Drug Court System; and,
3. Substance use disorders treatment clinicians and apprentices from non-network and nonidentified partner agencies.

Treatment continuing education conducted in FY 2008 included:

1. American Society of Addiction Medicine Patient Placement Criteria 2 Revised (ASAM PPC 2R) conducted in all sub-state planning areas in the state between February 5 and 20, 2008 with 124 participants;
2. Clinical Documentation and Treatment Planning incorporated into the ASAM training schedule;

3. Clinical Supervision I NFATTC model training and Clinical Supervision Training-of-Trainer (TOT) training conducted in Boise (sub-state planning area 4) in March 2008 with 11 participants;
4. The Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Office of Drug Policy and the Department continued to implement the GAIN (Global Appraisal of Individual Need) Family of Assessments throughout the state. In FY 2008 training was supplied to establish 52 local trainers (46 certified and 6 pending certification) and 168 site interviewers (140 certified and 28 pending certification);
5. The 24th Annual ICADD statewide conference held in Boise in May 2008 including the following skill development courses: a) CBT (Cognitive Behavioral Therapy) in Adolescents, 28 participants; b) Relationship Addiction, 37 participants; c) Essentials of Case Management, 35 participants; d) DBT (Dialectical Behavioral Therapy) in Adolescents, 19 participants; and, e) Clinical Supervision II with 16 participants.

The location of continuing education of treatment services were based on survey results of contract provider clinicians desiring and/or needing a particular training because of contract requirements or partnership agreements. Continuing education events were located in or adjacent to population centers in the seven sub-state planning areas.

The continuing education of treatment services events were operationalized differently.

1. ASAM PPC-2R, Clinical Documentation and Treatment Planning was procured as part of the MSC contract.
2. Clinical Supervision I was provided as part of an agreement with and by the Mountain West ATTC and a cadre of Mountain West ATTC trained trainers from among contracted providers.
3. The Department contracted with a statewide entity, Meetings, Etc., to cover the costs of registration, housing and travel for employees of treatment facilities to attend ICADD.

The Department continued the interdepartmental and MSC/network providers Statewide Training Planning Team to determine how to more effectively and efficiently deliver continuing education to addiction professionals and stakeholders using various modalities.

GOAL # 11b An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2010 (Progress)

TREATMENT

In FY 2010 continuing education of employees of treatment facilities was provided to:

1. Substance use disorders treatment clinicians and apprentices in the Management Services Contractor's (MSC) network whose services were partly or wholly funded with SAPT block grant SUD Treatment funds;
2. Substance use disorders treatment clinicians and apprentices from identified partner agencies, e.g., Department of Correction, Department of Juvenile Corrections, Idaho Supreme Court Drug Court System; and,
3. Substance use disorders treatment clinicians and apprentices from non-network and non-identified partner agencies.

Training events were scheduled in locations throughout the state in an effort to reduce participant travel costs and time away from work.

Continuing Education opportunities included:

Idaho Conference on Alcohol and Drug Dependence (ICADD) - providing workshops and short sessions on a variety of topics held at BSU in Boise, Idaho, May 17-20 2010. Skills based workshops presented at the specific request of SUD were: NFATTC Model Clinical Supervision I - 28 participants. ASAM PPC 2R – 16 Participants, and; Ethics – 67 Participants.

GAIN Training:

Since July 1, 2009, a total of 31 GAIN Site Interviewers have been trained and certified by Local Trainers within their own treatment agencies, or in partnership between treatment agencies where one of the treatment agencies did not have a certified GAIN Local Trainer on staff. The decision to discontinue the practice of allowing a Certified GAIN Local Trainer to provide GAIN Site Interviewer Training outside his/her own agency has been discontinued due to labor intensive nature of the certification process and ongoing mentoring required of a GAIN Local Trainer.

On June 1-4, 2009, 18 Clinicians including 9 adjunct faculty members at Idaho Educators in Addiction Studies Programs were trained as GAIN Local Trainers. Their certification process was scheduled to be completed by December 31, 2009. As part of their Certification Process they each were required to train one GAIN Site Interviewer through to certification.

Nine 1 day GAIN GRRS Editing and Clinical Interpretation training events were provided in all sub state planning areas between February 6, 2010 and April 9, 2010. 130

Clinicians completed the training, including 13 from the MSC Care Management team, which has responsibility for treatment authorization for clients referred from the network treatment providers.

Business Psychologist Associates (BPA) - contracted to provide the following best practices trainings which are offered each year, as part of their management services contract: Case Management, ASAM, NFATTC Model of Clinical Supervision. Training events are scheduled to meet needs as determined by surveys and ongoing communication between BPA and contracted treatment providers relative to clinical staff turn over and at times, requests for refresher training:

- Case Management Training

Case Management Training was offered in one location during the fiscal year. A total of 26 clinicians participated in the training. An additional Case

Management training event is scheduled for September 15, 2010.

- ASAM Training

ASAM Training was presented in four geographical regions of the state over the course of the fiscal year. A total of 107 clinicians participated in the training. An

Additional ASAM training event is planned for August 24 & 25, 2010.

- NFATTC Model Clinical Supervision Training:

Clinical Supervision was presented in 4 geographical regions of the state, including the ICADD Conference, over the course of the fiscal year. A total of 67 clinicians participated in the training, 32 of which participated in the training event at ICADD.

IDEAS – Idaho Educators in Addiction Studies

The SSA continues to contract with five land grant colleges and universities in Idaho to provide the following competency-based addiction studies courses. Each school is required to present no less than five unduplicated core function courses per academic year with no less than 10 students in each course. All 9 semester courses must be within a two year period.

4. Introduction to Drugs and Society
5. Pharmacology of Psychoactive drugs
6. Counseling Skills I
7. Screening and Assessment
8. Case Management
9. Ethics
10. HIV/AIDS and other Infectious Diseases
11. Alcohol/Drugs and the Family
12. Group Counseling Skills: to be added to Course Manual by January 1, 2007

Students represent both pre-employment and post employment participants. An estimated 458 students were served of which 372 were degree seeking and 264 were seeking Idaho Board of Alcohol and Drug Counselor Certification (ICRC State affiliate) as either an Idaho Student of Addiction Studies (trainee that may provide services under intensive clinical supervision) - 70, or as a CADC - 194.

In addition to the above contracted addiction studies coursework, the decision was made to infuse GAIN Training into the IDEAS Contracts. See GAIN Training above in this narrative. Only students scheduled to complete their addiction studies programs during the current academic year were allowed to participate in GAIN Training. As a result, an additional 14 GAIN Site Interviewers were trained and certified through the Idaho Educators in Addiction Studies Programs.

MWATTC

The Mountain West Addictions Technology Transfer Center provided the following training events in a variety of geographical area for Idaho Clinicians, at no cost to Idaho: Essentials of Case Management – 3 events serving 155 Participants; Buprenorphine and Buprenorphine for Young Adults – 3 events around the state serving 47 participants, and PAMI – two events serving 33 participants. In addition, MWATTC sponsored 9 clinicians to attend national conferences and training events.

PREVENTION

Prevention – Idaho only reports on prevention for this goal

In FY 2010 continuing education of employees of prevention facilities were provided to:

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.

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 FY 2010 focused on the use of online courses. Staff of prevention programs funded wholly or in part with Block Grant Funds could access three courses online - Prevention Theory, Addiction and the Family and Prevention Business Ethics. 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 also offered as was the Substance Abuse Prevention Institute held in Boise, Idaho in the summer of 2010. Courses offered at the institute were Prevention Ethics, Human Development for the Prevention Professional, Addiction and the Family, Prevention Group Facilitation, and Coalition Development. A one day course on adolescent brain development was also offered. Prevention continuing education was operationalized using a variety of methods. Master or Doctorate level instructors who have experience teaching the topic at the college level taught all training. The Department produced the Prevention Institute in Boise and either

delivered the sessions with Department staff, contracted with presenters or covered the presenter under the contract with the statewide Prevention Technical Assistance and Support Contractor (PTASC).

The Department participated in the planning of the Idaho Prevention Conference and provided registration scholarships prevention providers in their network to attend. The development and maintenance of the online courses were included in the PTASC contract.

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 polices for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In Fiscal years 2011 through 2013 the Department will continue to develop and support the RAC's to meet the intent of Idaho Code to provide for the coordination of, and exchange of information on, all programs relating to alcoholism and drug addiction, and act as liaison among the Departments engaged in activities affecting alcoholics and intoxicated persons and supply the local input to the state level Interagency Committee on Substance Abuse Prevention and Treatment (ICSA). Idaho statute Title 39 CHAPTER 3 defines the Regional Advisory Committees. This statute section reads

39-303A.REGIONAL ADVISORY COMMITTEES. "(1) Regional advisory committees that address substance abuse issues shall be established by the department of health and welfare. The regional advisory committees shall be composed of regional directors of the department or their designees, regional substance abuse program staff and representatives of other appropriate public and private agencies. Members shall be appointed by the respective regional directors for terms determined by the regional director. The committees shall meet at least quarterly at the call of the chair, who shall also be appointed by the regional director. The committees shall provide for the coordination of, and exchange of information on, all programs relating to alcoholism and drug addiction, and shall act as liaison among the departments engaged in activities affecting alcoholics and intoxicated persons.

(2) The chairpersons of each regional advisory committee shall collectively meet at least annually and elect one (1) of its members to serve as the regional advisory committees' representative on the interagency committee. Each regional advisory committee shall provide to the regional advisory committees' representative, before each regular meeting of the interagency committee, a report addressing local substance abuse program needs and other information as it pertains to the treatment and prevention of alcoholism and other drug addiction or as required by the chairperson of the interagency committee. The regional advisory committees' representative shall be responsible for communicating information from these reports at each regular meeting of the interagency committee."

The Department will annually monitor through discussions with the Regional Director and Community Resource Development Specialists to see that the RACs have a member participate on the Regional Mental Health Advisory Boards as required by Idaho Code. This is monitored by the Regional Director who appoints members to both the RAC and the Regional Mental Health Advisory Boards.

The Department will continue to have at least one representative on the advisory board for the Enforcement of Underage Drinking Laws program of the Department of Juvenile Corrections and the Juvenile Justice Children's Mental Health workgroup. Department staff will also participate on the planning committees for the annual Idaho Conference on Alcohol and Drug Dependency. In FY 2011 the conference will be expanded to include prevention and community coalition tracks in an effort to expand the knowledge of prevention services within the treatment provide network and treatment services within the prevention professional and community coalition communities.

The Department will continue the collaborative effort with DHW's Child Welfare Services Program for on-site substance use disorder screening and case management services in all seven sub-state planning areas. The program will join 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 Department will maintain 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 will also assist in coordinating the drug court and mental health court system with the overall substance use disorder treatment system.

The Department will maintain an active participation on the Interagency Committee on Substance Abuse (ICSAA) which will facilitate the coordination of prevention and treatment services within the SSA with treatment, prevention and ancillary services supported by other state agencies. ICSA participation will also enable interaction with Native American tribes to address substance abuse prevention and treatment issues within Indian Country in Idaho. In addition, participation on the ICSA will allow for coordination of efforts with Idaho State Police, Idaho Department of Juvenile Corrections, Idaho Department of Correction, Idaho Department of Education, Idaho Department of Transportation and the Supreme Court system.

The Department will continue to work with DHW's Self Reliance Program on the implementation of the Temporary Assistance for Families in Idaho (TAFI) applicant substance abuse screening and treatment program.

The Department will also continue its support of the Community Coalitions of Idaho. Members of this group represent community anti-AOD coalitions. In addition to supporting their monthly conference call, the Department will be working with the coalitions to identify needs of coalition development, community education and sustainability materials. The goal is to partner with concerned individuals within each community to develop coalitions focused on impacting the community environment.

During FY 2008 to coordinate prevention activities and treatment services, the Department continued to develop and support the RAC's as they met the intent of Idaho Code to provide for the coordination of, and exchange of information on, all programs relating to alcoholism and drug addiction, and act as liaison among the Departments engaged in activities affecting alcoholics and intoxicated persons and supply the local input to the state level Interagency Committee on Substance Abuse Prevention and Treatment (ICSA).

The Department annually monitored through discussions with the Regional Director to see that the RACs had a member participate on the Regional Mental Health Advisory Boards as required by Idaho Code. The Department continued to have at least one 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 and the Juvenile Justice Children's Mental Health workgroup. Representatives also participated on the planning committees for the annual Idaho Prevention Conference and the annual Idaho Conference on Alcohol and Drug Dependency.

The Department continued the collaborative effort with DHW's Child Welfare Services Program for on-site substance use disorder screening and case management services in all seven sub-state planning areas. 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 Department 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.

The Department maintained active participation on the ICSA, which among other areas allowed its interaction with Native American tribes to address substance use disorder prevention and treatment issues within Indian Country in Idaho. In addition the Department participated in quarterly meetings with the Northwest Portland Area Indian Health Board which included all the tribes with reservations in Idaho to update them on substance use disorder prevention activities and treatment services.

The Department continued to work with DHW's Self Reliance Program on the implementation of the Temporary Assistance for Families in Idaho (TAFI) applicant substance abuse screening and treatment program. The Department also continued to participate on the Idaho Care and Prevention Council (ICPC) dealing with HIV/AIDS and gave updates on prevention activities and treatment services. The Department issued contracts in FY 2008 in which prevention activities and treatment services continue collaborative services for individuals who are dually diagnosed, provide support to communities wishing to develop anti-alcohol/drug coalitions and continue 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.

In FY 2010 the Department continued to develop and support the RACs as they met the intent of Idaho Code to provide for the coordination of, and exchange of information on, all programs relating to alcoholism and drug addiction, and act as liaison among the Departments engaged in activities affecting alcoholics and intoxicated persons and supply the local input to the state level Interagency Committee on Substance Abuse Prevention and Treatment (ICSA).

The Department monitored, through discussions with the Regional Director, to see that the RACs had a member participate on the Regional Mental Health Advisory Boards as required by Idaho Code. This is monitored by the Regional Director who appointed members to both the RAC and the Regional Mental Health Advisory Boards.

The Department continued to have at least one 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 and the Juvenile Justice Children's Mental Health workgroup. Representatives also participated on the planning committees for the annual Idaho Prevention Conference and the annual Idaho Conference on Alcohol and Drug Dependency.

The Department continued the collaborative effort with DHW's Child Welfare Services Program for on-site substance use disorder screening and case management services in all seven sub-state planning areas. 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 Department 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.

The Department maintained an active participation on the Interagency Committee Substance Abuse, whose focus is to coordinate services among state agencies. The membership of ICSA includes state agency directors, legislators, the Office of Drug Policy and community members. The Department staff were key in developing and continuing to provide support to the ICSA Prevention Subcommittee which is working on the development of a state level substance abuse prevention plan. The goal is that the statewide plan will result in population level change.

ICSA also included representatives of Idaho's Native American Tribes of which enable the group to address substance abuse prevention and treatment issues within Indian Country in Idaho. In addition the Department 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 Department continued to work with DHW's Self Reliance Program on the implementation of the Temporary Assistance for Families in Idaho (TAFI) applicant substance abuse screening and treatment program.

The Department issued contracts in FY 2010 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.

Goal #13: Assessment of Need

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FY 2011-2013 the Department plans to make state and local needs assessment data available via the Department website. This new website will contain substance abuse prevention and treatment reports and data that has been collected and produced by the Idaho State Epidemiological Outcomes Workgroup (SEOW).

In addition the Department will continue to build on the data sources available to the statewide Prevention Technical Assistance and Support Contractor (PTASC) for community based needs assessments. The RACs will have access to these resources to inform the Department where services are needed and to give input to the PTASC on the programs to fund. Current needs assessments for each sub-state planning area will continue to be available at <http://preventionidaho.net/NeedsAssessments.htm>.

The Department will continue to deliver the Idaho Substance Abuse Prevention Institute to make the information and skill development available to prevention professionals throughout the state.

The Department will continue to work closely with the Division of Health and their work on the Youth Behavior Risk Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS) to assist in substance use disorder needs assessments and planning.

In addition, the Department will continue to use data from the National Survey on Drug Use and Health (NSDUH) to provide a reference point for the number of persons dependent on either alcohol or drugs and in need of treatment.

The Department will continue to work with and support the efforts of the Office of Drug Policy (ODP) in the Governor's Office, and the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA).

In FY 2008 the Department continued to contract with the University of Idaho to: 1) maintain and refine the statewide database to facilitate the use of needs assessment data in planning on both the state and local level; and, 2) continue to add validated risk and protective factor data sources to the data set to enable communities to identify needs. This resource was available on the internet and accessible to all Idaho community coalitions.

In addition the Department continued to build on the data sources available to the statewide Prevention Technical Assistance and Support Contractor (PTASC) for community based needs assessments. The RACs had access to these resources to inform the Department on where services were needed and to give input to the PTASC on the programs to fund. These documents were available on the internet throughout FY 2008. The Department continued to deliver the Idaho Substance Abuse Prevention Institute to make the information and skill development available to prevention professionals throughout the state. See discussions in Goal 11: Continuing Education for more details.

The Department continued to work closely with the Division of Health and their work on the Youth Behavior Risk Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS) to assist in substance use disorder needs assessments and planning. In addition, the Department used some data from the National Survey on Drug Use and Health (NSDUH) to provide a statewide assessment number of persons dependent on either alcohol or drugs and in need of treatment.

Lastly, the Department worked with and supported the efforts of the Office of Drug Policy (ODP) in the Governor's Office to produce a more credible tool for assessing need locally based on their work to implement the Idaho Meth Project. These findings continued to assist the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Department to better understand the need for both prevention and treatment services. The Department through the State Epidemiological Outcomes Workgroup (SEOW) completed work on state profiles to assist in assessing need. Three profile documents – "Substance Use: Idaho Epidemiological Profile 2006," Substance Use Epidemiological Treasure Valley Profile 2007" and "Substance Use Disorders Annual Profile SFY2009" – were completed.

In FY 2010 the Department transitioned the contract with the University of Idaho that refined a statewide database to facilitate the use of needs assessment data in planning on both the state and local level. Unfortunately, due to budget considerations, the Department was unable to create a website containing substance use prevention and treatment reports as indicated in the FY2010 intended use portion of the grant. However, the Idaho State Epidemiological Outcomes Workgroup (SEOW) continued to collect prevention and treatment data and deliver reports to key stakeholders.

The Department continued to build on the data sources available to the statewide Prevention Technical Assistance and Support Contractor (PTASC) for community based needs assessments. The RACs continued to have access to these resources to inform the Department on where services are needed and to give input to the PTASC on the programs to fund. Current needs assessments for each sub-state planning area will continue to be available at <http://preventionidaho.net/NeedsAssessments.htm>.

The Department delivered the Idaho Substance Abuse Prevention Institute in an effort to make information and skill development available to prevention professionals throughout the state.

The Department continued to work closely with the Division of Health and their work on the Youth Behavior Risk Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS) to assist in substance use disorder needs assessments and planning.

In addition, the Department continued to use data from the National Survey on Drug Use and Health (NSDUH) to provide a reference point for the number of persons dependent on either alcohol or drugs and in need of treatment.

The Department supported the efforts of the Office of Drug Policy (ODP) in the Governor's Office to produce a credible local needs assessment tool based on their work to implement the Idaho Meth Project. These findings assisted the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA), and the Department, in efforts to gain a greater understanding of the need for prevention and treatment services.

Goal #14: Hypodermic Needle Program

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

No SAPT Block Grant or State funds will be used to purchase needles during the period of FY 2011 - 2013. The Department will only reimburse for abstinence-based services. In the years 2011 - 2013, the Department will continue paying established fees for approved services. Approved services are clearly specified and no costs associated with need purchase or distribution will be reimbursable activities under the treatment contract.

No SAPT Block Grant or State funds were used to purchase needles during the FY 2008 grant period. The Department only reimbursed for abstinence-based services. During the grant period, the Department only paid established fees for approved services. Approved services were clearly specified and no costs associated with need purchase or distribution was reimbursable activities under the treatment contract.

No SAPT Block Grant or State funds were used to purchase needles with the FY 2010 SAPT grant. The Department only reimbursed for abstinence-based services. With 2010 SAPT grant funds, the Department only paid established fees for approved services. Approved services were clearly specified and no costs associated with need purchase or distribution was reimbursable activities under the treatment contract.

Goal #15: Independent Peer Review

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

peer reviews on 5% of all Department approved substance use disorder treatment entities that receive SAPT Block Grant funds and count the number of entities in all seven sub-state planning areas, not the total number of sites in those areas. Because the process that Idaho has used for the past 5 years is well accepted and valued by treatment providers as well as reviewers. Idaho plans to continue the process. In FY2011, Idaho will review 5% of the adult outpatient providers. In FY2012, Idaho plans to review adolescent outpatient providers. In 2013, Idaho plans to review adult residential providers.

The review process will be the same as in previous years in that Department staff will coordinate the selection of programs and reviewers and facilitate the review events. Reviewers' travel, lodging and per diem expenses will be covered. The review forms will be reviewed to assure they align with the current system.

The Department anticipates this continue to be a worthwhile experience for both programs being reviewed and reviewers.

In FY 2008 the Department continued the practice of conducting independent peer reviews on 5% of all Department approved substance use disorder treatment entities that receive SAPT Block Grant funds and count the number of entities in all seven sub-state planning areas, not the total number of sites in those areas. Using that approach, the Department had 50 programs, so reviewed at least 3 programs to comply with the requirement.

The target group of programs to be reviewed was adolescent residential treatment programs statewide to complete the review of adolescent treatment programs initiated in FY 2007. As it turned out the Department reviewed all 5 of the adolescent residential programs serving the state during the grant period. Harmony House in sub-state planning area three was reviewed on September 4, 2008, Patriot Center also in sub-state planning area three was reviewed on September 5, Daybreak in Spokane, Washington serving youth from all of Idaho was reviewed on September 12, Harbor House in sub-state planning area seven was reviewed on September 16 and MK Place in sub-state planning area six was reviewed on September 17, 2008.

Eight qualified clinicians participated in the review, allowing two (2) reviewers for each program being reviewed. Two reviewers reviewed 2 programs. The review process was the same as in previous years in that Department staff coordinated the selection of programs and reviewers and facilitated the review events. Reviewers' travel, lodging and per diem expenses were covered. The review forms were reviewed to assure they align with the current system.

In FY 2010 the Department continued the practice of conducting independent peer reviews on 5% of all Department approved substance use disorder treatment entities that receive SAPT Block Grant funds. The number of entities in all 3 sub-state planning areas was tallied at 64. Five percent of 64 totaled at least 3 programs to receive an Independent Peer Review to comply with the requirement.

The target group of programs to be reviewed in FY10 was adult residential providers. The Department currently has 5 adult residential providers in the Management Service Contractor's (MSC's) network and all 5 providers had an Independent Peer Review this cycle. The reviews were completed between March 23 and May 7, 2010. The goal was to complete the FY10 reviews prior to September 30, 2010 and that goal was accomplished. The providers included Port of Hope in sub-state planning areas 1 and 2, Walker Center, Road to Recovery and Addiction Rehabilitation Associates in sub-state planning area 3.

The review teams were composed of professional staff from substance use disorder treatment providers in the MSC's network of providers. There were a minimum of 2 reviewers who were Qualified Professionals who participated in each review. 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. This was highlighted when discussing reviews with program administrators.

The role of the Department staff was to coordinate the program review schedule and make arrangements to accommodate the reviewers. A Department staff member accompanied the review team to the site to support the reviewers. The staff member provided the standardized forms used to ensure the information gathered at the review was consistent with the guidelines. Department staff did not participate in any of the review sessions or focus groups.

Once a schedule was established and the peer reviewers were identified, a letter explaining the Independent Peer Review guidelines was sent to all parties involved. The information packet contained tips for the providers to promote preparation and a positive experience for all. It also contained an agenda for the visit and explained how to access travel and lodging arrangements.

Once onsite, the peer review began with an entrance conference and introductions. The Department staff member conducted the conference and 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. During the conference the goals for the day and any scheduling issues were discussed. The entrance conference was followed by a tour of the facility. The reviewers determined how to structure their day depending on the program activities and availability of staff for interviews and clients for focus groups. They were provided with standardized forms for client record reviews and questions for interviews. Interviews with clients were conducted without staff of the reviewed program present and staff interviews were private. Upon completion, the team united to discuss how and what they would cover for the exit conference. The Program Managers were encouraged to have as many staff as possible present throughout the day of the visit. This was an opportune time to foster collaboration and participate in a professional exchange between the parties. The written information was given to the Department staff member at the end of the review.

It is noteworthy to report that this process was embraced by the programs being reviewed and the review team

members. The value of the process was affirmed by all through out the practice. With the number of budget constraints and hardships that our providers have endured due to these tough economic times; the enthusiasm displayed through the course of the reviews was refreshing. There was a genuine exchange that was demonstrated by all parties at each review. While a meaningful exchange is the desired result of the peer review, the camaraderie appeared to be at a deeper level.

Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2009 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

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

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

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

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

In FY 2009 the Department continued the practice of conducting independent peer reviews on five percent (5%) of all approved SAPT block grant funded entities. Five percent of entities calculated to reviewing three 3 programs in FY 2009. The target group of programs to be reviewed in FY 09 was adult residential providers statewide. The Department had six (6) adult residential providers in the MSC's network and intended to review all programs prior to September 30, 2009 with at least two (2) qualified professionals reviewing each program. Unfortunately, due to a change in Department staff to include a retirement and two layoffs due to budget constraints, the reviews were not completed by the September 30th deadline. It is anticipated that the reviews will be complete within FY2010. With six reviews projected in FY2010, Idaho should have met our requirement for both FY 2009 and FY 2010. However, only 5 reviews were completed: Port of Hope in sub-state planning areas one and two, Walker Center in sub-state planning area three, Road to Recovery in sub-state planning area three and Addiction Rehabilitation Associates in sub-state planning area three.

:

March 23, 2010 - Walker Center, Gooding, ISA 3

March 25, 2010 - Port of Hope, Nampa, ISA 2

March 30, 2010 - Road to Recovery, Pocatello, ISA 3

April 23, 2010 – Addiction Rehabilitation Associates, Idaho Falls, ISA 3

April 28, 2010 – Port of Hope, Coeur d'Alene, ISA 1

The review teams were composed of professional staff from substance use disorder treatment providers in the Management Service Contractor's (MSC's) network of providers. 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. This was highlighted when discussing reviews with program administrators.

The role of the Department staff was to coordinate the program review schedule and make arrangements to accommodate the reviewers. A Department staff member accompanied the review team to the site to support the reviewers. The staff member provided the standardized forms used to ensure the information gathered at the review was consistent with the guidelines. Department staff did not participate in any of the review sessions or focus groups.

Once a schedule was established and the peer reviewers were identified, a letter explaining the Independent Peer Review guidelines was sent to all parties involved. The information packet contained tips for the providers to promote preparation and a positive experience for all. It also contained an agenda for the visit and explained how to access travel and lodging arrangements.

Once onsite, the peer review began with an entrance conference and introductions. The Department staff member conducted the conference and 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. During the conference the goals for the day and any scheduling issues were discussed. The entrance conference was followed by a tour of the facility. The reviewers determined how to structure their day depending on the program activities and availability of staff for interviews and clients for focus groups. They were provided with standardized forms for client record reviews and questions for interviews. Interviews with clients were conducted without staff of the reviewed program present and staff interviews were private. Upon completion, the team united to discuss how and what they would cover for the exit conference. The Program Managers were

encouraged to have as many staff as possible present throughout the day of the visit. This was an opportune time to foster collaboration and participate in a professional exchange between the parties. The written information was given to the Department staff member at the end of the review. Client chart review documents were left with the program administrator for further study.

After all the reviews were completed a survey was sent to the reviewers asking them to evaluate the process and give comments for improvements.

Goal #16: Disclosure of Patient Records

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

During the fiscal years 2011 through 2013, the Department will continue to maintain the policies and procedures established in previous years. At the MSC and provider level, compliance with this requirement will be checked during contract monitoring visits and facility approval site reviews. At the state level, the Department will continue 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.

During the fiscal years 2011 through 2013, the Department will continue working with our MSC and with MWATTC to provide Confidentiality and Ethics trainings regionally. Department staff will also participate on the annual Idaho Conference on Alcohol / Drug Dependency (ICADD) planning committee and promote having Confidentiality and Ethics training included conference.

In addition courses in Ethics, Confidentiality and HIPAA compliance will continue to be included as standing courses offered through the Idaho Educators in Addiction Studies program at five Idaho public colleges and universities.

In FY 2008, the Department continued to maintain the activities as in previous years. At the MSC and provider level, compliance with this requirement was checked during contract monitoring visits and facility approval site reviews. At the state level, the Department continued to maintain a firewall around the state's automated Treatment Client Information System and keep historical data, which might identify clients, in a locked storage cabinet. The Department offered no Confidentiality and Ethics trainings in FY 2008. The Department participated on the annual Idaho Conference on Alcohol / Drug Dependency (ICADD) planning committee and promoted having a "Disclosure of Patient Records" at the May 2008 conference to meet the needs of the MSC and treatment providers. In addition courses in Ethics, Confidentiality and HIPAA were included as standing courses offered through the IDEAS! program at five of Idaho public colleges and universities.

The Department conducted an annual chart audit for the period October 1, 2007 to October 31, 2007 to determine if providers in the MSC's network were seeking proper releases of information to protect the disclosure of client information. BPA collected a statistically significant sample of client charts from providers around the state to use to audit clinical charts. The Department generated a random sample of 75 charts from those held by BPA during their audit. Fifty-four (54) of the charts passed the audit. BPA was assessed \$500 for the providers who had charts that did not pass. Thirteen (13) charts from one provider did not pass. BPA was instructed to address this.

level, compliance with this requirement is checked during contract monitoring visits and facility approval site reviews. At the state level, the Department 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 Department held a Confidentiality and Ethics training in FY 2010 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 Idaho Educators in Addiction Studies program at five of Idaho's public colleges and universities.

Goal #17: Charitable Choice

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

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

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

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FY 2011-2013, the Department will continue to work with the MSC to oversee that any contracted religious organizations give notice to all potential beneficiaries. The MSC will be required to continue to maintain a record of referrals made by religious organizations that are providers. The Department will continue to monitor compliance with the MSC as referrals are made. Compliance with the Charitable Choice requirements will continue to be part of the ongoing compliance review process that is conducted quarterly.

In addition, the Department will continue to provide charitable choice information to potential faith-based providers who express an interest in providing substance abuse services during 2011-2013. A formal letter describing the charitable choice provisions and regulations will be sent to any faith-based organization that contacts the Department regarding interest in providing services governed by the Department including substance abuse prevention or treatment.

The Department expects the MSC to orient their providers about Charitable Choice requirements and have that orientation continue 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 Department monitors the MSC through receiving information at least yearly on meetings held by the MSC for the purpose of orienting providers on Charitable Choice provisions.

In FY 2008, the Department worked with the MSC and PTASC to oversee that any contracted religious organizations gave notice to all potential beneficiaries. The Department required the MSC and PTASC to maintain a record of referrals made by religious organizations that were providers. The Department continued monitoring compliance by the MSC and the PTASC as referrals were made. The Department expected the MSC and the PTASC to orient their providers about Charitable Choice requirements and have that orientation include a thorough explanation of the Charitable Choice rule to include why charitable choice partners are important, how charitable choice protects participants and recipients and what charitable choice is and is not.

During FY 2008 three treatment service providers were contracted with the MSC that met the criteria for Charitable Choice. They were located in sub-state planning areas 4 and 6 and served 50 clients during the period. During FY 2008 there were thirteen (13) recovery support providers contracted with the MSC that met the criteria for Charitable Choice. They were located in all seven sub-state planning areas and served 658 clients.

During the same period six prevention programs contracted with the PTASC defined themselves as faith-based and met at least one of the following criteria:

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

These programs were located in sub-state planning areas 1, 3 and 4, and served 979 recurring participants with evidence-based programs found on the WestCAPT Best/Promising Practices list or the NREPP list. The Department included Charitable Choice provisions and regulations in the RFP that was released in FY 2008 for the Management Services Contractor.

In FY 2010, the Department worked with the MSC to oversee that any contracted religious organizations give notice to all potential beneficiaries. The MSC is required to maintain a record of referrals made by religious organizations that are providers. The Department continued to monitor compliance with the MSC as referrals are made. Compliance with the Charitable Choice requirements is part of the ongoing Department and MSC compliance review process.

In addition, the Department provided charitable choice information to potential faith-based providers who expressed an interest in providing substance abuse services during 2010. A formal letter describing the charitable choice provisions and regulations was sent to any faith-based organization that contacted the Department regarding interest in providing services governed by the Department including substance abuse prevention or treatment.

The Department 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 Department monitors the MSC through receiving information at least yearly on meetings held by the MSC for the purpose of orienting providers on Charitable Choice provisions.

During FY 2010, one treatment service provider (i.e., Change Point – Turnaround) located in substate planning Region 2 was contracted with the MSC that met the criteria for Charitable Choice. During FY 2010, 7 Recovery Support service providers (21 individual sites), located in substate planning regions 1, 2, 3, 4, and 7, met the criteria for Charitable Choice and contracted with the MSC.

During FY 2010 58 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.

These programs were located in sub-state planning areas 1, 3 and 4, and served 968 recurring participants as of June 30, 2010.

Charitable Choice (formerly Attachment I)

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

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

For the fiscal year prior (FY 2010) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

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

Referrals to Alternative Services -Check all that Apply

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

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

The Department has the MSC include in their orientation of new providers to their

network information about Charitable Choice requirements. The MSC has typically four (4) or five (5) new providers enter the network each year. FY2010

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.

Idaho has no waiver requests for the FY 2011 Application.

Form 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

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

Activity	Source of Funds					
	A.SAPT Block Grant FY 2008 Award (Spent)	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 4,892,900	\$ 642,400	\$ 299,000	\$ 13,365,200		\$ 3,232,400
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	\$	\$
Column Total	\$6,907,500	\$642,400	\$615,700	\$14,663,000	\$0	\$3,263,500

*Prevention other than Primary Prevention

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 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	\$	\$	\$	\$
Section 1926 - Tobacco	\$ 0	\$	\$	\$	\$
Column Total	\$1,671,100	\$0	\$145,000	\$0	\$0

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$	\$	\$	\$	\$
Universal Indirect	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
Column Total	\$0	\$0	\$0	\$0	\$0

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

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

Yes No

Expenditures on Resource Development Activities are:				
<input type="radio"/> Actual <input checked="" type="radio"/> Estimated				
Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
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
Column Total	\$279,153	\$276,464	\$0	\$555,617

Departmental Budget (by Agency)

Fiscal Year	Agency ID	Region	2008	FISCAL YEAR 2008			
				Original Budget	Revised Budget	Actual Expenditure	Balance
7C0787	ID100631	Region 7	\$0	\$0	\$0	\$0	\$0
BC0005	ID100778	Statewide (optional)	\$0	\$0	\$0	\$0	\$0
DC0127	ID100779	Statewide (optional)	\$8,500	\$0	\$0	\$0	\$0
DHW0	ID100472	Statewide (optional)	\$0	\$0	\$0	\$0	\$0
IDPV-1-1	X	Region 1		\$18,710	\$0	\$0	\$0
IDPV-1-10	X	Region 1		\$0	\$0	\$31,446	\$0
IDPV-1-2	X	Region 1		\$0	\$0	\$35,300	\$0
IDPV-1-3	X	Region 1		\$0	\$0	\$4,493	\$0
IDPV-1-4	X	Region 1		\$0	\$0	\$25,447	\$0
IDPV-1-5	X	Region 1		\$0	\$0	\$5,098	\$0
IDPV-1-6	X	Region 1		\$0	\$0	\$41,250	\$0
IDPV-1-7	X	Region 1		\$0	\$0	\$15,512	\$0
IDPV-1-8	X	Region 1		\$3,305	\$0	\$0	\$0
IDPV-1-9	X	Region 1		\$0	\$0	\$19,561	\$0

IDPV-2-1	X	Region 2		\$0	\$0	\$19,926	\$0
IDPV-2-2	X	Region 2		\$23,600	\$0	\$0	\$0
IDPV-2-3	X	Region 2		\$0	\$0	\$26,965	\$0
IDPV-2-4	X	Region 2		\$4,990	\$0	\$0	\$0
IDPV-2-5	X	Region 2		\$0	\$0	\$17,014	\$0
IDPV-2-6	X	Region 2		\$0	\$0	\$8,208	\$0
IDPV-3-1	X	Region 3		\$0	\$0	\$26,899	\$0
IDPV-3-2	X	Region 3		\$0	\$0	\$5,000	\$0
IDPV-3-3	X	Region 3		\$0	\$0	\$33,439	\$0
IDPV-3-4	X	Region 3		\$0	\$0	\$74,771	\$0
IDPV-3-5	X	Region 3		\$0	\$0	\$2,781	\$0
IDPV-3-6	X	Region 3		\$0	\$0	\$74,096	\$0
IDPV-3-7	X	Region 3		\$0	\$0	\$6,760	\$0
IDPV-4-1	X	Region 4		\$0	\$0	\$15,044	\$0
IDPV-4-10	X	Region 4		\$0	\$0	\$45,336	\$0
IDPV-4-11	X	Region 4		\$0	\$0	\$11,112	\$0
IDPV-4-12	X	Region 4		\$0	\$0	\$13,856	\$0
IDPV-4-13	X	Region 4		\$0	\$0	\$31,865	\$0
IDPV-4-14	X	Region 4		\$0	\$0	\$23,052	\$0
IDPV-4-2	X	Region 4		\$6,498	\$0	\$0	\$0
IDPV-4-3	X	Region 4		\$4,594	\$0	\$0	\$0
IDPV-4-4	X	Region 4		\$0	\$0	\$18,999	\$0
IDPV-4-5	X	Region 4		\$0	\$0	\$1,576	\$0

IDPV-4-6	X	Region 4		\$0	\$0	\$21,864	\$0
IDPV-4-7	X	Region 4		\$0	\$0	\$25,176	\$0
IDPV-4-8	X	Region 4		\$0	\$0	\$9,339	\$0
IDPV-4-9	X	Region 4		\$0	\$0	\$22,310	\$0
IDPV-5-1	X	Region 5		\$0	\$0	\$27,507	\$0
IDPV-5-2	X	Region 5		\$0	\$0	\$7,194	\$0
IDPV-5-3	X	Region 5		\$0	\$0	\$31,473	\$0
IDPV-5-4	X	Region 5		\$5,908	\$0	\$0	\$0
IDPV-5-5	X	Region 5		\$0	\$0	\$27,292	\$0
IDPV-5-6	X	Region 5		\$0	\$0	\$14,036	\$0
IDPV-5-7	X	Region 5		\$0	\$0	\$68,765	\$0
IDPV-6-1	X	Region 6		\$0	\$0	\$17,156	\$0
IDPV-6-2	X	Region 6		\$0	\$0	\$104,926	\$0
IDPV-6-3	X	Region 6		\$0	\$0	\$9,929	\$0
IDPV-6-4	X	Region 6			\$0	\$0	\$0
IDPV-6-5	X	Region 6		\$0	\$0	\$11,234	\$0
IDPV-6-6	X	Region 6		\$0	\$0	\$19,536	\$0
IDPV-7-1	X	Region 7		\$0	\$0	\$5,006	\$0
IDPV-7-2	X	Region 7		\$0	\$0	\$15,099	\$0
IDPV-7-3	X	Region 7		\$0	\$0	\$35,314	\$0
IDPV-7-4	X	Region 7		\$0	\$0	\$62,604	\$0
IDPV-7-5	X	Region 7		\$0	\$0	\$15,999	\$0
IDPV-7-6	X	Region 7		\$0	\$0	\$17,915	\$0

IDPV-7-7	X	Region 7		\$0	\$0	\$5,958	\$0
IDPV-7-8	X	Region 7		\$0	\$0	\$42,864	\$0
KC1638	ID100475	Statewide (optional)	\$240,200	\$0	\$0	\$0	\$0
KC1749	ID100476	Statewide (optional)	\$13,365,200	\$4,892,900	\$877,300	\$0	\$0
KC1798	ID100477	Statewide (optional)	\$0	\$0	\$0	\$0	\$0
KC1802	ID100478	Statewide (optional)	\$5,900	\$0	\$0	\$0	\$0
KC1814	ID100473	Statewide (optional)	\$222,800	\$0	\$0	\$1,671,000	\$0
KC1950	ID100479	Statewide (optional)	\$0	\$0	\$0	\$0	\$0
KC1951	ID100632	Statewide (optional)	\$1,300	\$0	\$0	\$0	\$0
KC2098	ID100633	Region 5	\$43,500	\$0	\$0	\$0	\$0
KC2099	ID100634	Region 6	\$43,800	\$0	\$0	\$0	\$0
KC2100	ID100477	Statewide (optional)	\$55,700				
KC2101	ID100635	Region 2	\$41,500	\$0	\$0	\$0	\$0
hr 2 e) q u q	q nt	S	u nuq S u	

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
BC0005	Meetings Etc.	POB 1311 Meridian, ID 83680 208-466-2519
DC0127	CRI Advantage Inc.	12754 W.Lasalle Boise, ID 83713 208-287-4161
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-1-2	Coeur d' Alene School District #271	311 N 10TH ST 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	BOX 1114 OROFINO, ID 83544

	Workgroup	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-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-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 R4	4802 West Kootenai BOISE, ID 83705 208-336-2308
IDPV-4-14	Women's and Children's Alliance	720 W WASHINGTON ST BOISE, ID 83702 208-343-3688
IDPV-4-2	Boise County Community Justice Coalition	PO BOX 486 IDAHO CITY, ID 83631 208-392-4431
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-6-2	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-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

Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Parenting and family management [11]	0
	Student Assistance Programs [32]	0
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	0
	Information lines/Hot lines [8]	0
	Posters in Liquor Stores [9]	0
	Parenting and family management [11]	0
Drop-Outs [3]	Clearinghouse/information resources centers [1]	0
	Education programs for youth groups [14]	0
	Student Assistance Programs [32]	0
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	0
	Ongoing classroom and/or small group sessions [12]	0
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	0
	Parenting and family management [11]	0
	Student Assistance Programs [32]	0
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Academic Afterschool Programs [27]	0
Abuse Victims [8]	Clearinghouse/information resources centers [1]	0

	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
Already Using Substances [9]	Clearinghouse/information resources centers [1]	0
	Parenting and family management [11]	0
	Student Assistance Programs [32]	0
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	0
	Parenting and family management [11]	0
	Education programs for youth groups [14]	0
Communities with Norms Favorable to ATOD Use [11]	Clearinghouse/information resources centers [1]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Community team-building [44]	0
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	0
Youth at Risk of Academic Failure [12]	Education programs for youth groups [14]	0
	Mentors [15]	0
	Student Assistance Programs [32]	0
	After school academic assistance skillbuilding programs [71]	0
Children Under Age of First Use [13]	Clearinghouse/information resources centers [1]	0
	Brochures [4]	0
	Ongoing classroom and/or small	0

	group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Academic Afterschool Programs [27]	0

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

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

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services	D.Median Cost of Services	E.Standard Deviation of Cost
Detoxification (24-Hour Care)					
Hospital Inpatient			\$	\$	\$
Free-standing Residential			\$	\$	\$
Rehabilitation / Residential					
Hospital Inpatient			\$	\$	\$
Short-term (up to 30 days)			\$	\$	\$
Long-term (over 30 days)			\$	\$	\$
Ambulatory (Outpatient)					
Outpatient			\$	\$	\$
Intensive Outpatient			\$	\$	\$
Detoxification			\$	\$	\$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy			\$	\$	\$

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																			
2. 18-24																			
3. 25-44																			
4. 45-64																			
5. 65 and over																			
6. Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Pregnant Women																			

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)).

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

SSA (MOE TABLE I)

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

PERIOD	EXPENDITURES	B1(2007) + B2(2008)
(A)	(B)	----- 2 (C)
SFY 2008 (1)	\$9,917,000	\$14,938,485
SFY 2009 (2)	\$19,959,970	
SFY 2010 (3)	\$ 18,369,300	

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

FY 2008 Yes No

FY 2009 Yes No

FY 2010 Yes No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA 9/1/2011
(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2010 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

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

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

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

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

Yes No

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

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)	\$ 26,773	3.51 %	\$ 940	\$ 941
SFY 1992 (2)	\$ 23,012	4.09 %	\$ 941	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)
SFY 2010 (3)	\$ 49,032	%	\$

At this point with current data available we are not able to answer "% of TB Expenditures Spent on Clients who are Substance Abusers in Treatment". Our state TB program indicates that this information will be available by March 1, 2011.

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 2010 (3)	\$

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

Womens (MOE TABLE IV)

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

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	\$634,045	
2008		\$1,557,194
2009		\$875,896
2010		\$ 877,312

Enter the amount the State plans to expend in FY 2011 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$ 635,000

Form T1

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

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	46	39
Total number of clients with non-missing values on employment\student status [denominator]	159	159
Percent of clients employed (full-time and part-time) or student	28.9%	24.5%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	359
Number of CY 2009 discharges submitted:	335
Number of CY 2009 discharges linked to an admission:	265
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	247
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	159
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	2	6
Total number of clients with non-missing values on employment\student status [denominator]	10	10
Percent of clients employed (full-time and part-time) or student	20.0%	60.0%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	21
Number of CY 2009 discharges submitted:	16
Number of CY 2009 discharges linked to an admission:	15
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	10
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	448	560
Total number of clients with non-missing values on employment\student status [denominator]	1,180	1,180
Percent of clients employed (full-time and part-time) or student	38.0%	47.5%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,060
Number of CY 2009 discharges submitted:	2,645
Number of CY 2009 discharges linked to an admission:	2,331
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	2,110
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,180
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	737	942
Total number of clients with non-missing values on employment\student status [denominator]	1,688	1,688
Percent of clients employed (full-time and part-time) or student	43.7%	55.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,699
Number of CY 2009 discharges submitted:	2,812
Number of CY 2009 discharges linked to an admission:	2,581
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	2,363
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,688
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T2

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

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	132	143
Total number of clients with non-missing values on living arrangements [denominator]	153	153
Percent of clients with stable housing	86.3%	93.5%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	359
Number of CY 2009 discharges submitted:	335
Number of CY 2009 discharges linked to an admission:	265
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	247
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	153
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	10	9
Total number of clients with non-missing values on living arrangements [denominator]	10	10
Percent of clients with stable housing	100.0%	90.0%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	21
Number of CY 2009 discharges submitted:	16
Number of CY 2009 discharges linked to an admission:	15
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	10
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	1,024	1,054
Total number of clients with non-missing values on living arrangements [denominator]	1,093	1,093
Percent of clients with stable housing	93.7%	96.4%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,060
Number of CY 2009 discharges submitted:	2,645
Number of CY 2009 discharges linked to an admission:	2,331
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	2,110
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,093
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	1,553	1,579
Total number of clients with non-missing values on living arrangements [denominator]	1,599	1,599
Percent of clients with stable housing	97.1%	98.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,699
Number of CY 2009 discharges submitted:	2,812
Number of CY 2009 discharges linked to an admission:	2,581
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	2,363
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,599
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T3

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

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

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	121	165
Total number of clients with non-missing values on arrests [denominator]	174	174
Percent of clients with no arrests	69.5%	94.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	359
Number of CY 2009 discharges submitted:	335
Number of CY 2009 discharges linked to an admission:	265
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	259
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	174
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	10	10
Total number of clients with non-missing values on arrests [denominator]	11	11
Percent of clients with no arrests	90.9%	90.9%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	21
Number of CY 2009 discharges submitted:	16
Number of CY 2009 discharges linked to an admission:	15
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	14
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	11
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	1,144	1,261
Total number of clients with non-missing values on arrests [denominator]	1,371	1,371
Percent of clients with no arrests	83.4%	92.0%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,060
Number of CY 2009 discharges submitted:	2,645
Number of CY 2009 discharges linked to an admission:	2,331
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,290
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,371
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	1,753	1,780
Total number of clients with non-missing values on arrests [denominator]	1,887	1,887
Percent of clients with no arrests	92.9%	94.3%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,699
Number of CY 2009 discharges submitted:	2,812
Number of CY 2009 discharges linked to an admission:	2,581
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,551
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,887
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T4

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

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	94	151
All clients with non-missing values on at least one substance/frequency of use [denominator]	171	171
Percent of clients abstinent from alcohol	55.0%	88.3%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		66
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	77	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		85.7%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		85
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	94	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		90.4%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	359
Number of CY 2009 discharges submitted:	335
Number of CY 2009 discharges linked to an admission:	265
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	259
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	171

Long-term Residential(LR)		
A ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	9	9
All clients with non-missing values on at least one substance/frequency of use [denominator]	11	11
Percent of clients abstinent from alcohol	81.8%	81.8%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		50.0%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		8
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	9	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		88.9%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	21
Number of CY 2009 discharges submitted:	16
Number of CY 2009 discharges linked to an admission:	15
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	14
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	11
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	

Intensive Outpatient (IO)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	824	1,179
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,360	1,360
Percent of clients abstinent from alcohol	60.6%	86.7%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		415
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	536	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		77.4%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		764
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	824	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		92.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,060
Number of CY 2009 discharges submitted:	2,645
Number of CY 2009 discharges linked to an admission:	2,331
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,290
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,360
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	

Outpatient (OP)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	1,485	1,753
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,876	1,876
Percent of clients abstinent from alcohol	79.2%	93.4%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		337
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	391	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		86.2%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		1,416
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,485	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		95.4%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,699
Number of CY 2009 discharges submitted:	2,812
Number of CY 2009 discharges linked to an admission:	2,581
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,551
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,876
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	
[Records received through 5/6/0010]	

Form T5

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

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	82	147
All clients with non-missing values on at least one substance/frequency of use [denominator]	171	171
Percent of clients abstinent from drugs	48.0%	86.0%
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		70
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	89	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		78.7%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		77
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	82	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		93.9%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	359
Number of CY 2009 discharges submitted:	335
Number of CY 2009 discharges linked to an admission:	265
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	259

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file
 [Records received through 5/6/0010]

Long-term Residential(LR)

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

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	6	9
All clients with non-missing values on at least one substance/frequency of use [denominator]	11	11
Percent of clients abstinent from drugs	54.5%	81.8%

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

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		80.0%

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

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		5
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		83.3%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	21
Number of CY 2009 discharges submitted:	16
Number of CY 2009 discharges linked to an admission:	15
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	14

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file
 [Records received through 5/6/0010]

Intensive Outpatient (IO)

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

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	761	1,152
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,360	1,360
Percent of clients abstinent from drugs	56.0%	84.7%

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

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		460
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	599	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		76.8%

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

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		692
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	761	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		90.9%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	2,060
Number of CY 2009 discharges submitted:	2,645
Number of CY 2009 discharges linked to an admission:	2,331
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,290

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,360
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs [numerator]	1,419	1,765
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,876	1,876
Percent of clients abstinent from drugs	75.6%	94.1%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		395
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	457	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		86.4%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,370
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,419	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		96.5%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	2,699
Number of CY 2009 discharges submitted:	2,812
Number of CY 2009 discharges linked to an admission:	2,581
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,551

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	1,876
---	-------

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]

Form T6

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

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

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

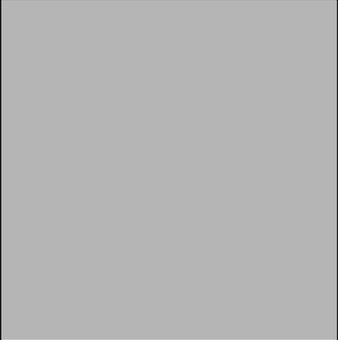
STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <input type="text"/>
---------------------------------------	--

DATA SOURCE	<p>What is the source of data for table T6? (Select all that apply)</p> <p><input type="checkbox"/> Client Self Report</p> <p>Client self-report confirmed by another source:</p> <p><input type="checkbox"/> Collateral source</p> <p><input type="checkbox"/> Administrative data source</p> <p><input type="checkbox"/> Other: Specify</p> <input type="text"/>
-------------	---

EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T6? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p> <input type="text"/>
-----------------	--

DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T6? (Select all that apply)</p> <p><input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge</p> <p>Specify:</p> <p><input type="radio"/> In-Treatment data <input type="text"/> days post admission</p> <p><input type="radio"/> Follow-up data <input type="text"/> months post <input type="text"/> admission</p> <p><input type="radio"/> Other, Specify:</p> <input type="text"/>
	<p><input type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are not collected for approximately <input type="text"/> % of clients who were admitted for treatment</p>

RECORD LINKING	<p>Was the admission and discharge data linked for table T6? (Select all that apply)</p> <p><input type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)</p>
----------------	--



- Select type of UCID:
- Master Client Index or Master Patient Index, centrally assigned
 - Social Security Number (SSN)
 - Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
 - Some other Statewide unique ID
 - Provider-entity-specific unique ID

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

IF DATA IS UNAVAILABLE

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

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

DATA PLANS IF DATA IS NOT AVAILABLE

State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

The Department currently uses an intermediary to collect TEDS/NOMS data and new data elements for social consecutiveness have been incorporated into the data set. The intermediary collects the data directly from the client during intake and from provider reports at discharge. The intermediary reports data to DHW/BSUD electronically; providers report data to the intermediary electronically and by the submission of paper forms. The intermediary is required to ensure timelines, completeness, and accuracy of data prior to submitting the data to DHW. DHW staff run error checks on data submitted by the intermediary. Data is linked back to the client through a unique client identifier. DHW is transitioning to an Electronic Health Record system and is implementing the WITS system. Initial modifications to modules within WITS for collecting TEDS/NOMS and other data specific to Idaho are complete and include the new TEDS elements. DHW has initiated a WITS User Testing program and will fully implement the system once testing is complete.

Form T7

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

Length of Stay (in Days) of All Discharges

Level of Care	Length of Stay (in Days)			
	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
Detoxification (24-Hour Care)				
1. Hospital Inpatient				
2. Free-standing Residential	94	3	13	69
Rehabilitation / Residential				
3. Hospital Inpatient				
4. Short-term (up to 30 days)	102	29	60	122
5. Long-term (over 30 days)	160	17	133	262
Ambulatory (Outpatient)				
6. Outpatient	133	46	98	186
7. Intensive Outpatient	161	47	104	212
8. Detoxification				
Opioid Replacement Therapy (ORT)				
9. Opioid Replacement therapy	12	2	3	32
10. ORT Outpatient	94	35	80	113

Notes:		
Level of Care	2008 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Total count, all levels of care	5,936	5,293
1. Hospital Inpatient-Detoxification (24-Hour Care)		
2. Free-standing Residential-Detoxification (24-Hour Care)	128	98
3. Hospital Inpatient-Rehabilitation / Residential		
4. Short-term (up to 30 days)-Rehabilitation / Residential	335	265
5. Long-term (over 30 days)-Rehabilitation / Residential	16	15
6. Outpatient-Ambulatory (Outpatient)	2,812	2,554
7. Intensive Outpatient-Ambulatory (Outpatient)	2,645	2,331
8. Detoxification-Ambulatory (Outpatient)		
9. Opioid Replacement therapy-Opioid Replacement Therapy (ORT)		3

10. ORT Outpatient-Opioid Replacement
Therapy (ORT)

27

Source: **SAMHSA/OAS TEDS CY 2009 linked discharge file**
[Records received through **05/06/2010**]

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

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

State Performance Management and Leadership

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

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

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

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

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

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

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

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

Treatment Corrective Action Plan (submit upon request)

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

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

Form P1

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

Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	<p>Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used alcohol during the past 30 days.</p>	Ages 18+ - FFY 2008 43.50	
		Ages 12-17 - FFY 2008 11.60	
2. 30-day Cigarette Use	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.</p>	Ages 12-17 - FFY 2008 8.50	
		Ages 18+ - FFY 2008 22.30	
3. 30-day Use of Other Tobacco Products	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).</p>	Ages 18+ - FFY 2008 8.20	
		Ages 12-17 - FFY 2008 3.90	
4. 30-day Use of Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.</p>	Ages 12-17 - FFY 2008 6.90	
		Ages 18+ - FFY 2008 5.40	
5. 30-day Use of Illegal Drugs Other Than Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?"</p> <p>Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).</p>	Ages 12-17 - FFY 2008 5.30	
		Ages 18+ - FFY 2008 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	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 18+ - FFY 2008 84.20	
		Ages 12-17 - FFY 2008 79.20	
2. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 12-17 - FFY 2008 95.10	
		Ages 18+ - FFY 2008 94.90	
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 18+ - FFY 2008 77.70	
		Ages 12-17 - FFY 2008 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	Source Survey Item: NSDUH Questionnaire: “Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of alcohol.	Ages 12–17 - FFY 2008 13.10	
		Ages 18+ - FFY 2008 16.60	
2. Age at First Use of Cigarettes	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you smoked part or all of a cigarette?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of cigarettes.	Ages 18+ - FFY 2008 15.40	
		Ages 12–17 - FFY 2008 12.10	
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you used [any other tobacco product] † ?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.	Ages 18+ - FFY 2008 18.70	
		Ages 12–17 - FFY 2008 13.50	
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you used marijuana or hashish?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2008 13.90	
		Ages 18+ - FFY 2008 17.50	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: “How old were you the first time you used [other illegal drugs] ‡ ?” [Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.	Ages 18+ - FFY 2008 19.10	
		Ages 12–17 - FFY 2008 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>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 93.10	
2. Perception of Peer Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: “How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>	Ages 12–17 - FFY 2008 92.60	
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age trying marijuana or hashish once or twice?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 85.90	
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age using marijuana once a month or more?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 87.20	
5. Disapproval of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - FFY 2008 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>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference]</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>	Ages 18+ - FFY 2008 40.90	
		Ages 15-17 - FFY 2008 28.30	

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

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

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
In Development	In Progress	In Progress	((s))	

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

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

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	<p>Source:National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>		FFY 2008	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>Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p>Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>	FFY 2008	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	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2008	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>Source Survey Item: NSDUH Questionnaire: “Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.” [Response options: Yes, No]</p> <p>Outcome Reported: Percent reporting having talked with a parent.</p>	Ages 12–17 - FFY 2008 63.80	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	<p>Source Survey Item: NSDUH Questionnaire: “During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?” † [Response options: 0 times, 1 to 2 times, a few times, many times]</p> <p>Outcome Reported: Percent of parents reporting that they have talked to their child.</p>	Ages 18+ - FFY 2008 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>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] †?"</p> <p>Outcome Reported: Percent reporting having been exposed to prevention message.</p>	Ages 12–17 - FFY 2008	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

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2007	6/30/2008
Form P12b Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2007	6/30/2008
Form P13 (Optional) Number of Persons Served by Type of Intervention	7/1/2007	6/30/2008
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	7/1/2007	6/30/2008
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	7/1/2007	6/30/2008

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

Idaho's prevention data collection system, 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	165
	2. 5-11	5856
	3. 12-14	4104
	4. 15-17	1854
	5. 18-20	304
	6. 21-24	68
	7.25-44	573
	8. 45-64	275
	9. 65 And Over	14
	10. Age Not Known	0
B. Gender	Male	6714
	Female	6500
	Gender Unknown	0
C. Race	White	10796
	Black or African American	116
	Native Hawaiian/Other Pacific Islander	29
	Asian	61
	American indian/Alaska Native	187
	More Than One Race (not OMB required)	76
	Race Not Known or Other (not OMB required)	64
D. Ethnicity	Hispanic or Latino	1885
	Not Hispanic or Latino	11329
	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	66421
	2. 5-11	85853
	3. 12-14	35851
	4. 15-17	37000
	5. 18-20	34002
	6. 21-24	46527
	7. 25-44	221636
	8. 45-64	204683
	9. 65 And Over	99376
	10. Age Not Known	0
B. Gender	Male	417599
	Female	413750
	Gender Unknown	0
C. Race	White	768386
	Black or African American	5119
	Native Hawaiian/Other Pacific Islander	1182
	Asian	9469
	American indian/Alaska Native	9689
	More Than One Race (not OMB required)	19481
	Race Not Known or Other (not OMB required)	18022
D. Ethnicity	Hispanic or Latino	82194
	Not Hispanic or Latino	749155
	Ethnicity Unknown	0

NB - In 2008, several Idaho coalitions began using a social marketing approach to community change and began a series of monthly local newspaper, radio and billboard campaigns. This accounts for the large increase in the universal indirect population over the prior year for Idaho.

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 the exposed counties. For Idaho, that is the 2008 US Census estimates.

This method works well for Sex, Race and Hispanic Ethnicity but not for Age. The US Census uses a different age categorization than SAMHSA that prevents use of US Census data for the SAMHSA Age table. For the 2008 reporting period, Idaho used 2008 CDC age data, which is available for each age-year (e.g., 5, 6, 7...). The CDC age-years data were combined into SAMHSA categories and the resultant population proportions were used to estimate the number of people potentially exposed to Universal Indirect prevention in 2008 in Idaho

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

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	11871	N/A
2. Universal Indirect	N/A	831349
3. Selective	1313	N/A
4. Indicated	30	N/A
5. Total	13314	831349

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 P13, 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 P13.
- 2) Of the remaining programs, programs that listed Selected alone or in combination with Indicated were counted as Selected for Form P13.
- 3) Of the remaining programs, programs that listed Indicated alone were counted as Indicated for Form P13.

The following shows the various combinations of intervention types that were used to report on Form P13.

Of 13,214 participants in recurring direct service programs:

11,871 participated in a program listed as Universal
U 8,215
U-S 422
U-S-I 3,234

Of the remaining 1,343 participants, 1,313 participated in a program listed as Selected but not Universal
S 699
S-I 614

There were 30 participants in programs listed as solely Indicated.
I 30

Grand Total 13,314

Form P14

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

NOMs Domain: Retention

NOMs Domain: Evidence-Based Programs and Strategies

Measure: Number of Evidence-Based Programs and Strategies

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

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
 - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
 - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). “Informed experts” may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition. In 2008, Idaho used the NREPP substance abuse prevention list (<http://www.nrepp.samhsa.gov/AdvancedSearch.aspx>) to select evidence-based SAP programs. Idaho encouraged adoption of evidence-based programs by prioritizing them for funding and by removing the financial barriers to participating in formal training by the evidence-based program vendors.

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

In 2008, Idaho collected all information regarding evidence-based program status and categorization through the PreventionIdaho.Net data system. Individual evidence-based programs were selected from a list by the state prevention contractor staff in conjunction with each community based provider based on identified risk factors, target population, delivery mode & location and community acceptance. The final choices were reviewed by the prevention contractor director.

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

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded						
2. Total number of Programs and Strategies Funded						
3. Percent of Evidence-Based Programs and Strategies	NaN	NaN	NaN	NaN	NaN	NaN

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

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant \$Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct		\$
2. Universal Indirect		\$
3. Selective		\$
4. Indicated		\$
5. Totals	0	\$0.00

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

Prevention Corrective Action Plan (submit upon request)

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

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

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet .
Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note:The Sub-totals for each IOM category and the Total FFY 2008 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

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

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

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

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

Description of Supplemental Data

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

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

Attachment A, Goal 2: Prevention

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

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

Yes No Unknown

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

Yes No Unknown

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

SAPT
Block
Grant

Yes
 No
 Unknown

Other
State
Funds

Yes
 No
 Unknown

Drug Free
Schools

Yes
 No
 Unknown

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

Yes No Unknown

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

Education Bureau? Yes No Unknown

Dissemination of materials? Yes No Unknown

Media campaigns? Yes No Unknown

Product pricing strategies? Yes No Unknown

Policy to limit access? Yes No Unknown

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

Yes No Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to

alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:

Yes No Unknown

New product pricing:

Yes No Unknown

New taxes on alcoholic beverages:

Yes No Unknown

New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:

Yes No Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages:

Yes No Unknown

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

Yes No Unknown

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

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

Cigarettes

Alcohol

Marijuana

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

Motor vehicle drivers age 21 and older? 0.08

Motor vehicle drivers under age 21? 0.02

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

Communities: 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.