# Substance Abuse Prevention and Treatment Block Grant Annual Report and Application Guidance

Consolidated Analysis and Response to State Comments Received in Response to the notices in the January 25 Federal Register and March 23 Federal Register Regarding Revisions to the Information Collection Requirements.

## Overall comments

**President's Budget Request fiscal year (FY) 2008**
Oregon (OR), Iowa (IA), New York (NY), Pennsylvania (PA) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) have concerns regarding punitive aspects of the President's budget request i.e., the 5 percent reduction for States not able to report National Outcome Measures (NOMs). Oregon feels that there are no clear and specific definitions for some NOMs and provides specific comments below in the T forms section below. New York feels that the criterion for determining compliance with NOMs reporting have not been specified and therefore the State cannot prepare to address unspecified requirements. Pennsylvania feels that States that are unable to report on performance measures should not be penalized.

*In December 2004, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the States agreed on the goal of having all States reporting the currently defined NOMs by the end of a 3- year implementation period. SAMHSA and the States also recognized that States would require technical assistance in information technology and software purchasing to implement the new NOMs data set and SAMHSA agreed to realign resources to contract for this specialized technical assistance. This technical assistance first became available in September 2006 and the first project was just completed.*

*Thirty-eight States are currently reporting all or some of the NOM measures and 46 States have State or SAMHSA support contracts in place to develop and operationalize the necessary data infrastructure to report all NOMs.*

*So long as States are progressing toward achieving this goal by currently reporting some or all NOM data, or are partnering with SAMHSA to install the necessary infrastructure to report all NOMs, because of the delay securing the necessary information technology technical assistance or the extent to which hardware and software had to be purchased, SAMHSA will continue to accept data submitted as part of the uniform application as meeting the NOMs reporting requirement of the 2008 Presidents Budget.*

*Provisions described in the section "What to do if your State cannot complete all items in Sections I-IV" provide grantees the opportunity to document time-framed plans for collecting and reporting the data. For the FY 2008 revisions, these directions have been extended to cover Section IV of the application. The directions require grantees to address what to do "If your State does not have reliable data to complete an item on the application, or if you cannot get sufficient information to respond fully by the due date..." In addition, a grantee is expected*

*to describe what kind of financial or technical assistance is needed to improve their response in future years.*

**Concerns that FY 2005 is the reporting period addressed in the FY 2008 application for NOMs reporting.** Iowa (IA) feels that FY 2008 reporting should be the preferred starting point. *SAMHSA and the States are committed to begin NOMs reporting at the end of FY 2007. States will be able to report most recently available data.*

**January 23 notice in the Federal Register Retained Some Inappropriate FY References**
Missouri (MO) in their March 9 comments. New York (NY) in their strike and add edits submitted.

*SAMHSA made these corrections.*

**Comparison of Performance Measures Across States**
Louisiana (LA) feels that standardization of data sources, training and examination or reorganization of States with similar resources (fiscal and data capabilities) must be accomplished before State performance measures can be compared across States.

*SAMHSA agrees on general principles here and intends to examine States' performance independently of one another at the outset.*

**Proportion of program funding not addressed by NOMs.**
Iowa expresses concerns regarding issue of some portion of their program activity not being evaluated by NOMs (e.g., call centers do not have measures that would directly address their efficacy).

*SAMHSA and the States have agreed upon a starting set of performance measures and such comments may be useful in future discussions about refinements or enhancements to NOMs.*

**Availability of the FY 2008 Substance Abuse Prevention and Treatment (SAPT) Block Grant Application**
Hawaii (HI) - FY 2008 Application should be available on Web Block Grant Application System (BGAS) by June 1 and is concerned about delays in the availability of the FY 2008 Application on Web BGAS given the need for the Application to undergo the Office of Management and Budget (OMB) review and renewal instructions.

*SAMHSA is aware and concur with Hawaii's concern, however delays and the availability of the 2008 Block Grant by June 1, 2007 is not possible due to the federal approval process. SAMHSA will make available on Web BGAS as soon as possible.*

**Proposed revisions to forms and tables will require modifications to current data systems and training and should increase burden estimate.**
Pennsylvania (PA) feels that this translates to large commitments of time and resources and feels that the burden for collection of information is under reported. Contends that burden to providers and counties is not included in these calculations.

*SAMHSA and the States are committed to begin NOMs reporting at the end of FY 2007. This agreement was reached with the States in December 2004. The revisions have been undertaken to collect the required NOMs data. The burden estimate is provided as an estimate of the time a SAMHSA block grant grantee would require to collect and report the required data.*

**Standard Certifications**
California (CA) suggests that the second certification on OMB form 0920-0428 be changed to reference a 45 CFR 82 as opposed to 45 CFR 76 however the citation is correct and is referencing subpart F "Drug-free Workplace Requirements (Grants)."

**Consistency in State expenditure reporting by Prevention and Treatment**
NASADAD recommends consistency in State expenditure reporting by the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Treatment (CSAT). Currently, the proposed expenditure reporting model for CSAT and CSAP are different.

*SAMHSA does not concur with this comment; currently the proposed expenditure reporting model for CSAT and CSAP are consistent with their particular disciplines and purposes.*

**Coordination of Prevention and Treatment efforts**
Hawaii - While the major focus is on the treatment and prevention NOMs, we urge CSAT and CSAP to coordinate and continue efforts to streamline the other sections of the Block Grant Application in an integrated manner.

*SAMHSA concurs with this point. CSAP and CSAT together are working to streamline all sections of the FY 2008 SAPT Block Grant application.*

**States need for continued technical assistance and sufficient funding**
Hawaii states that treatment and prevention performance measures require different data systems, improvement of data definitions, data collection protocols, and analysis capabilities thus requiring continued technical assistance and sufficient funding.

*SAMHSA concurs with Hawaii and will continue to provide technical assistance through available avenues.*

## Treatment Issues

**Revise Cover Page Reference to "42 U.S.C. 300x-21 through 300x-64"**
NASADAD recommends updating this reference to include 42 U.S.C. 300x-21 through 300x-66.

*SAMHSA proposes to update this reference in response.*

As a component of their single source grant award from CSAT, NASADAD has been funded to provide quality assurance and input on the format and contents of the SAPT Block Grant application. NASADAD recommendations are thorough and comprehensive.

*SAMHSA utilized all technical corrections recommended and thoroughly considered all programmatic recommendations. Wherever practical, within the constraints that such changes would improve consistency, clarity or reduce burden without impacting SAMHSA's ability to collect mandated data elements, NASADAD recommendations where utilized*.

**Forms 4 and 11, Change to row heading for Substance Abuse Prevention and Treatment expenditure row to make category consistent with statute and form 6.**
Hawaii and Illinois objects to changes to Forms 4 and 11 and want CSAT to make Form 6 consistent with prior language on Form 4. Michigan objects to change because treatment expenditures will become "muddled" with prevention expenditures other than primary prevention.

*SAMHSA agrees that there is a need for consistency across forms and will work to ensure that consistency exists across the appropriate forms. SAMHSA made this change to correct Forms 4 and 1 using terminology contained within the statute. Previous terminology employed the term rehabilitation which was not defined or referenced in statute or regulation.*

**Instructions for Form 4b should be clarified**
Hawaii would like to have more clarification in the instructions for Form 4b.

*Prevention strategies may be classified using the IOM Model of Universal, Selective, and Indicated; States must refer back to Form 4 and look at all the entries made on Row 2-Primary Prevention.*

**Replacement of term "methadone" with term "opioid replacement therapy"**
Missouri requests clarification whether methadone references should be changed throughout.

*SAMHSA has made such changes consistently throughout the application.*

**Change to Form 6 column 5 to include prevention other than primary prevention**
Hawaii objects and believes primary prevention column 6 includes forms of prevention other than primary prevention.

*SAMHSA intends that the form be consistent with statute and form is not proposed to be altered.*

**Section II Change to Form 6 instructions to include all State and Federal funded programs Form 6**
Hawaii, California, and New York object to change due to increase in burden. Arizona (AZ) objects because it feels such information release may create expectations within individual providers although such monetary decisions within AZ are made by the individual sub-grantees or intermediaries.

Arizona suggests that Form 6 instructions that were clarified to communicate that "…funding information was sought on all substance abuse prevention and treatment service providers funded through the SSA…" should be modified to define entity as "contractors of the SSA"

because it feels that reporting such funding information for all entities that receive funds through SSA resources would imply a direct relationship where no such relationship exists. Such a situation may create political pressures to adjust or maintain funds for specific providers based on previous funding patterns.

*SAMHSA's intent for this revision was to improve the consistency of the instructions and communicate to States to ensure that they collect the necessary information on all substance abuse prevention and treatment service providers that receive Block Grant funds and/or State funds through the Single State Agency (SSA). SAMHSA will seek approval to collect information on entities funded through the State and the SAPT Block Grant consistent with the intent of 45 C.F.R. Part 96.122(f)(1)(vi).*

**Elimination/deletion of Form 6a**

Hawaii, Illinois, New York - recommends that Form 6a, Prevention Strategy Report, be deleted or would like to minimize the collection of the 6 strategies, in the FY 2008 Block Grant Uniform Application instructions. Hawaii would like to eliminate form 6a all together. This recommendation was also made by NASADAD in the Combined Report--SAPT Block Grant Application FY 2007 and Web BGAS FY 2007; and the SAPT Block Grant Application FY 2008 (Draft 1A) referenced above. Hawaii has concern about frustrating and time-consuming problems involving data entry and edits using Web BGAS to complete form 6a. The elimination of Form 6a would help to reduce the Block Grant Application's reporting burden, especially since States must now focus their time, funding, program planning, implementation, and evaluation efforts, and data collection and reporting systems on the prevention NOMs proposed in Section IV-B.

*SAMHSA concurs with the need to review the form but perceives that the legislative authority requires this form.*

**Budget reporting**

Florida suggests that CSAP ask States to report the portion of budget that supports evidence-based programs and strategies and the overall cost per participant in evidence-based programs.

*SAMHSA supports States commitment to implementing evidence-based programs, and continues to encourage States to move their non-evidenced-based programs, practices and policies to become evidence-based. Additional data States deem important and necessary to report is appreciated and will be accepted.*

**Section II Form 7a, Mean, Median, and Standard Deviation**

South Dakota feels that due to the fact that administrative costs cannot be allocated across the levels of care on a reasonable basis, calculations of mean costs may not be accurate. SAMHSA Technical Advisory Group suggested that inter-quartile range and mean would be more appropriate.

*SAMHSA proposes to revise the Form 7a to collect mean and inter-quartile range for costs data.*

Pennsylvania expresses concerns that the costs of services data form has inadequate instructions, that the stated purpose is inconsistent with the data that would be collected and that providers within that State do not provide data that allocates capital and operating costs across the nine levels of care included in Form 7a. In addition, the State relates that fiscal data is not tracked by individual services, costs for opioid replacement therapy are difficult to calculate when services can be provided across levels of care and treatment goals can differ dramatically.

*SAMHSA intends that the States make reasonable efforts to provide average costs for service based on the level of car. If available, States are expected to provide indicators of cost variation.*

PA expresses concerns that Form 7b does not adequately allow a State to report all individuals served by limiting the main table to collect information on only new admissions during the 12 month period covered by the reporting form.

*SAMHSA has created a separate cell for reporting all other clients served within the 12 month reporting period but admitted in a prior period. SAMHSA believes that it is important to capture the number of new, discrete individuals served with the 12 month reporting period and sees no other practical and effective mechanism of precluding double counting of clients across multiple reporting periods.*

**Section II, Table III HIV**
Hawaii believes the MOE should be calculated on the first year the State became a designated State not on the last time the State cycled back into the category.

*SAMHSA contends that HI's interpretation is inconsistent with SAMHSA policy and regulation*.

**Section II, Table IV Women's Base**
Missouri suggests that it is necessary to specify whether State fiscal year (SFY) or Federal fiscal year (FFY) data is sought because the State interprets the absence of a specification to impute that FFY is required.

*SAMHSA did not specify the nature of the fiscal or calendar year to be utilized by the States as States have expressed a need for flexibility on the reporting period consistent with how they have reported in the past.*

**Section III, Form 8**
Louisiana expresses that technical assistance and a standardized formula would help States submit Form 8 data.

*SAMHSA provides States sub-State needs assessment data from the National Household Survey on Drug Use and Health (NSDUH). SAMHSA will review technical assistance requests for assistance with Form 8 when such are submitted by a State through the TA request process already in place.*

**Section III (Forms 11 a, b, c) Clarification of instructions**
Hawaii would like to have more clarification in the instructions for Forms 11b.

*Prevention activities can be reported according to the six strategies or the State may choose to report activities utilizing the IOM Model of Universal, Selective and Indicated on form 11b.*

**Section IVa General Instruction**
Oregon and NASADAD feel specification suggesting States report most recent fiscal year data may be overly constraining.

*SAMHSA agrees and has revised this requirement to stipulate most recent year for which data are available.*

Pennsylvania has concerns regarding form 7a and Section IVa definitions of treatment episode.

*Treatment Episode Data Set (TEDS) instructions conflict with the definition of an episode as defined in the SAPT Block Grant. SAMHSA will work within its intra-agency workgroup to establish consistent parameters. The episode basis described in the SAPT Block Grant was recommended by the NASADAD Performance Data Workgroup and will be retained. States with differing definitions should report how their specifications vary from those established in the SAPT Block Grant.*

Missouri (MO) desires removal or clarification of continued references to "voluntary treatment measures." Missouri expresses need for clarification whether "Insert Overall Narrative" should be limited to a certain number of pages such as other narratives.

**Section IVa Pre-population Issue**
Hawaii is unclear of when and what will be pre-populated and would like further information. Oregon and Louisiana (LA) feel pre-population will reduce respondent burden. Louisiana expresses concern that pre-populated data would not be comparable to the State's data because the scope of reporting and data elements may differ.

*Pre-population of States' data through the use of already submitted TEDS/SOMMS data is an option for the States available through Web BGAS. A State may elect to submit its own data.*

**Section IVa Form T1**
Pennsylvania feels that clarification should be added to the instructions to clarify that they apply to employment status at admission.

**Section IVa Form T3**
Oregon relates that they have only recently begun implementation of past 30-day arrest history and will not be able to report most recent fiscal year.

**Section IVa Form T4**
South Dakota feels that the State Outcomes Measurement and Management System (SOMMS)/NOMS revision required them to drop alcohol use as a collected element unless it

was reported as a primary, secondary, or tertiary drug of use. South Dakota feels some alcohol use will be missed because of this change.

**Section IVa Form T4 and T5**
Pennsylvania suggests that a new category of State description of "data source" has been added to capture whether a State confirms client self-report of substance or alcohol use with biological tests and must address the costs of such tests.

*SAMHSA responds that this category of "data source" has been in prior applications. SAMHSA is only trying to determine which grantee, if any, collect such data and SAMHSA is not suggesting that such confirmatory testing is required.*

**Section IVa Form T6**
South Dakota observed that the example was incorrect in that it seemed to imply a decrease in social support was a logical consequence of treatment when the reverse is presumed.

*SAMHSA has revised this example.*

Oregon, MI, NY, and PA relate that there has not been a clear definition of social support of recovery.

*SAMHSA convened a Technical Consulting Group that has made recommendations to SAMHSA on changing this measure. This report is being circulated to the field.*

**Section IVa Form T7**
Pennsylvania does not feel the current version off the form collecting average, median and standard deviation is too simplistic to adequately capture the complexities of this specific measure. The instructions ask respondents to report on clients completing care and in Pennsylvania's opinion do not adequately address clients being served at multiple levels of care. SAMHSA utilized recommendations from its Technical Advisory Group report to improve the directions for the length of stay. SAMHSA will examine FY 2008 data and determine if these directions will need to be enhanced or re-examined.

**Other Developmental Measures**
New York relates that perception of care and use of evidence based practices have not been defined.

*Technical Consulting Groups are being formed on these issues and no data will be collected on these measures in the Block Grant application at this time.*

## Section IV-B Prevention NOMs Reporting Section

**Issue: Timing**
A number of States (CA, HI, IA, IL, NY, PA, and Washington (WA)) were concerned about expectations to report FY 2005 data which were collected prior to NOMs requirements and, if collected at all, likely were not necessarily collected in the format required by NOMs. One

State added that SAMHSA does not have the authority to require retroactively. Two States recommended using the latest SFY instead. One recommended no earlier than FY 2008 be the reporting year and another recommended using FY 2007. One State was concerned that the reporting timeframe differed for prevention and treatment and recommended that they be consistent.

**Response**:
*In December 2004, SAMHSA and the States agreed on the goal of having all States reporting the currently defined NOMs by the end of a 3- year implementation period. SAMHSA and the States also recognized that States would require technical assistance in information technology and software purchasing to implement the new NOMs data set and SAMHSA agreed to realign resources to contract for this specialized technical assistance. This technical assistance first became available in September 2006 and the first project was just completed.*

*So long as States are progressing toward achieving this goal by currently reporting some or all NOM data, or are partnering with SAMHSA to install the necessary infrastructure to report all NOMs, because of the delay securing the necessary IT technical assistance or the extent to which hardware and software had to be purchased, SAMHSA will continue to accept data submitted as part of the uniform application as meeting the NOMs reporting requirement of the 2008 Presidents Budget.*

*Provisions described in the section "What to do if your State cannot complete all items in Sections I-IV" provide grantees the opportunity to document time-framed plans for collecting and reporting the data. For the FY 2008 revisions, these directions have been extended to cover Section IV of the application. The directions require grantees to address what to do "If your State does not have reliable data to complete an item on the application, or if you cannot get sufficient information to respond fully by the due date..." In addition, a grantee is expected to describe what kind of financial or technical assistance is needed to improve their response in future years.*

*CSAT and CSAP have agreed that the reporting time frame will be calendar year.*

**Issue: FFY vs. SFY**
Some States (HI, IA, IL, PA) asserted that they would not be able to report by FFY and recommended changing the reporting period to SFY, which would be consistent with the reporting period for treatment. Otherwise, reporting will reflect parts of two State contract years, and possibly different providers. Alternatively, SAMHSA should give States a 2-year grace period to adjust their contracting period, or allow them to choose their own reporting period. Two States specified using the most recent SFY.

**Response**:
*SAMHSA proposed using FFY to assure consistency across States. SFY varies by State so aggregation would be impossible. While the issues raised by States are very real and may result in State merging data across providers and contracts, it is our understanding that State systems typically can generate reports by selecting months or quarters, thus enabling them to*

*aggregate by FFY, SFY, or calendar year even though their budgeting cycle differs. CSAT and CSAP have agreed that the reporting time frame will be calendar year.*

*However, given that the initial NOMs reporting only establishes baseline for comparison with time 2 reports and neither targets nor time frames are yet established, CSAP will work with States in the coming 12 months to define the method and procedure for setting State specific targets, time 2 measurement parameters, and the reporting time frame.*

**Issue: Poor fit for some services**

One State (CA) noted that a number of important terms, while more broadly reflective of actual prevention, sometimes appear ambiguous and/or are used in conjunction with other terms resulting in uncertainty about what exactly to report. The terms in question include program, strategies, practices, procedures, processes, services, and activities. Two other States (IA, PA) reflected that some large group activities, such as information dissemination, training, and evaluation, are not conducive to NOMs measurement and requested modifications to reflect this.

**Response**:

*SAMHSA agrees and has included definitions of the terms in the final 2008 SAPT application in the instructions for Form P13.*

*SAMHSA understands that large group activities, such as those provided as examples, are only conducive to three NOMs domains: Access/capacity; evidence based programs; and cost effectiveness. We do not expect States to collect and report on the other NOMs domains for these types of activities.*

**Issue: NOMs Resources**

Several States (CA, FL, HI, IA, NY, PA, NASADAD) thought that the estimated burden was quite understated, and does not include hours borne by counties and providers at the local level. This would result in significant increases in cost and staff time, especially for cost and demographic data requirements. NASADAD was particularly concerned with the burden incurred by cost data requirements and by the difficulty faced by some populous States who often delegate prevention resources to regional jurisdictions, resulting in the States' inability to track that level of cost data.

They point out that additional costs for technical assistance and training, as well as data system modifications would also be incurred. One State suggested modifying CSAP's Minimum Data Set (MDS) system for NOMs reporting to reduce individual provider burden, particularly for cost, evidence based programs, programs/services and race/ethnicity. A related concern was a perceived inconsistency between Individualized and population based service definitions compared with Universal Direct and Indirect definitions. That State mentioned that MDS captures numbers served, but not numbers impacted. NASADAD recommended that the cost band measure be made voluntary while continued dialogue between NASADAD and SAMHSA refines cost band reporting.

**Response**:

*As previously discussed, there are only three domains that are not pre-populated: Access/capacity, Retention/Evidence Based Programs and Cost Effectiveness. The vast majority of States had already been required, under their SIG grants, (and continue to be required under SPF SIG grants) to collect and report on numbers served (access/capacity domain) and evidence based programs, so it was assumed that those State data systems were already configured to collect these data from their local entities, and therefore, burden would be minimized. As mentioned by one State, CSAP's MDS additionally continues to be available to States to collect data on these as well as the cost effectiveness domain. CSAP is aware that certain data elements need to be reconfigured in MDS to be consistent with the NOMs. These have been identified and a number of MDS States have volunteered to assist. They have been sent various materials and we are convening via phone and Webinar on June 4, 2007 to discuss and resolve any inconsistencies. MDS is planned to be reconfigured in early August. Fiscal year 2005 data already collected will have to be downloaded and possibly reformatted by the State. Fiscal year 2006 data will be reformatted by CSAP.*

*We appreciate NASADAD's concern about the cost measure for populous States who allow regional jurisdictions to allocate resources accordingly. However, we must keep in mind the rationale for the NOMs which are performance monitoring. Increasing emphasis is placed on accountability, including accountability for resource allocation. In this context, it does not seem unreasonable to expect States to know how the funds they allocated were spent and how many were served by those funds. We therefore disagree with the recommendation to make the cost band measure voluntary. However, we agree and welcome continued dialogue with NASADAD and the States to refine the cost measure, based on the data that we receive over the next few years.*

*SAMHSA wants to clarify that we are counting the numbers served, not the numbers impacted. Thus, if a public service announcement (PSA) has a "reach" of 10,000 people, those people have been served by the PSA.*

**Issue: Miscellaneous**

California asserts that it developed its data system using information made available "…and presented as final by CSAP in March 2006…", but now find the system would have to be reconfigured to meet the data requirements. Florida perceives a lack of consideration of the SPF in the proposed requirements, and recommends that non-consumption NOMs be removed. New York states that no final agreement was reached on all NOMs data. Pennsylvania mentioned that its data systems do not capture the data as currently proposed. NASADAD recommends SAMHSA work with States on how best to discern trends in use; noting that examining indicators over a three year period may be more meaningful than annually. NASADAD also recommended using the term "form" rather than "table," shading cells where data shouldn't be entered, expanding the introduction to include guidance on data issues/problems and describing the relationship to Web BGAS and pre-population.

**Response**:

*SAMHSA requests that CA be more specific about any discrepancies they have identified since March 2006 that would cause such disruption to their system.*

*We do not see any inconsistencies between the NOMs performance monitoring and the SPF. The inclusion of non-consumption NOMs in the requirements reflects the accepted knowledge in the prevention field, that precursors to use are critical to prevention programming. Reducing these risk factors and intermediary variables reflect a positive outcome of programs attempting to stop drug use before it starts.*

*SAMHSA agrees with NASADAD that longer term trend data can convey more useful information that annual fluctuations in indicators. We also thank NASADAD for its editing and formatting suggestions will address them all in the final SAPT application.*

## Specific Concerns Regarding Proposed Changes Related to Prevention Performance and Outcome Reporting

**Issue: Intervention Type**

Many States (CA, IA, IL, OR, PA, WA and NASADAD) submitted comments and concerns about this topic and reflected divergent positions regarding the use of the IOM model vs. the current six prevention strategies. Among the several States (CA, WA) who were averse to using the IOM model, concern centered on the resource implications and burden for revising their data system and training various staff. One State seemed uncertain whether or not the IOM model would replace the six strategies and was concerned that States would lose a standard descriptive data set. The State requested a data dictionary to define services, implying that otherwise, only population counts would be possible. One State (IA) that supported the use of the IOM model recommended that the six strategies not be used. Another State (OR) noted that it currently requires the six strategies, but provides the IOM categories as an optional data element. The vast majority of these States and NASADAD emphasized the need for clear definitions of the IOM categories, indicating a common concern that the line between indicated prevention and early (treatment) intervention needs to be very clearly delineated.

States (IA, IL, and PA) also commented on issues associated with CSAP's splitting the IOM Universal category further into direct and indirect categories. One concern was that the definitions of direct and indirect terms were not typically in use, so very clear definitions are needed to avoid confusion and training will likely be needed. Another State described difficulty in applying these terms to population based strategies and suggested defining these terms differently; using "direct" to mean involving interpersonal and ongoing/repeated contact (such as coalitions), while "indirect" would apply to programs and policies they implement. Furthermore, prior to this requirement, the Universal category was not broken out, so historical data will not be available in this format. One State noted that MDS has been used for years to collect and report on the six strategies, and recommended that SAMHSA continue to work with States and NASADAD to improve MDS in the context of these new requirements.

**Response:**

*The proposed inclusion of the IOM categories was as a result of a number of discussions between SAMHSA, NASADAD and State representatives. It appeared that the majority of States preferred this model to the six strategies and that it is well known and accepted in the prevention field. Because we cannot currently eliminate the six strategies, we have modified it*

*as an option rather than a requirement so that additional burden is not imposed. We share the States' hope and intention that this change will not result in misappropriation of the 20 percent set-aside to treatment services and will emphasize that in the language.*

*We understand that the Universal subcategories (direct, indirect) are new and have trained our technical assistance and training contractors to meet any needs in this area. The proposed description proposed by one State appears consistent with our intent and does not seem to conflict with the current definitions included in the application. We are currently working with MDS volunteer States to modify the system accordingly, as proposed by one State. The system is due to be modified by August 2007. Any suggestions obtained during the interim, to help clarify the definitions already provided are certainly welcome. Additionally, we do understand that historical data may not be able to be transformed and the tables provided reflect that understanding by including "total" cells for the Universal category which may be used for that purpose.*

**Issue: Pre-populated data**

States who responded on this issue (CA, HI, IA, PA, SD, and NASADAD) raised different types of concerns. One State requested that the pre-populated data for each State be sent to them as soon as possible to allow each State to review in order to identify problems early. Yet another voiced concern that NSDUH data would eventually become benchmarks rather than indicators of need, and emphasized the inappropriateness of using survey estimates as program outcome measures which should be directly linked to each intervention. Also noted were the wide confidence intervals associated with the NSDUH survey and the disparities between the NSDUH and other commonly used State surveys. Another State and NASADAD suggested examining the possibility for future SAPT applications, of using other data sources more representative of small States and inclusive of jurisdictions, one State questioned how NSDUH would be used in completing tables P12-15.

**Response:**

*SAMHSA, in conjunction with NASADAD and State representatives, agreed to use NSDUH as an interim source for many of the NOMs domains during the NOMs development process. While all acknowledged the issues associated with using NSDUH, the benefits (such as reduced burden) were determined to outweigh the limitations. SAMHSA is committed to working with the States over the next 12 months to assess the adequacy of the NSDUH to capture the outcomes of each State's prevention strategies, to determine a reasonable method for setting target outcome levels, and to determine the point for the time 2 measure for assessing change in outcomes.*

*Pre-populated data will be sent to States as early as possible along with the draft SAPT application. NSDUH is not a data source for tables 12-15. These will come from administrative records of the programs, practices and strategies funded by the State with SAPT prevention dollars.*

**Issue: Substitute Data Criteria**

A number of States (HI, IA, IL) were concerned about the proposed criteria that would be used to review substitute data for approval. One State thought the criteria unduly restrictive and

prohibitive. Of most concern was the requirement that the data be collected, analyzed and reported annually. One State thought that, for most States, the resources required to comply with this criteria is unfeasible. Other States have statewide youth surveys in place, but they are conducted bi-annually or tri-annually. One State noted that the NSDUH pre-populated data, while reported annually, is really data pooled over a three year period which limits ability to measure change, and recommended an alternative of reporting survey data every 2 years, but reporting data on populations and programs annually.

**Response:**
*SAMHSA is required by the Government Performance and Results Act (GPRA) and PART to report performance outcomes on an annual basis. There is no exception provided. However, the proposal and rationale by Illinois is provocative and merits further discussion at higher levels with DHHS and OMB. If approved, this could be implemented in future years. However, the proposal, while interesting, does not address outcomes over the lifespan. It only addresses youth outcomes. States would need to identify how outcomes for adults would be measured as well.*

**Issue: Substitute Data Process**
While States (IA, IL, FL, HI, SD, CA, and NASADAD) supported the ability to propose substitute data for the pre-populated data, States generally were quite concerned about the process to obtain approval for substituting data, and deemed it cumbersome and time consuming. One State was concerned about needing additional resources to prepare the data. They recommended streamlining it as much as possible to avoid the possibility of delaying approval of the entire block grant and access to funds. NASADAD also questioned whether the application and appeal forms would be able to be completed on-line and whether each substitute data element would require a separate application and review process. Additionally, NASADAD sought clarification of the language indicating that the application would be submitted to CSAP but cites SAMHSA as the authority, implying a tiered approach.

**Response:**
*SAMHSA shares the States' concern with the lengthy process and modified the timeline as follows:*
*1. States submit their Application to Substitute Data Form due June 15, 2007.*
*2. SAMHSA will provide a decision to the State through the CSAP State Project Officer by July 7, 2007.*
*3. States may appeal the decision by August 1, 2007.*
*4. CSAP will respond to the appeal by August 15, 2007.*

*NOTE: For purposes of the FY 2008 application only, each of the due dates are extended by 45 days.*

*SAMHSA appreciates NASADAD's suggestion about completing the forms on-line and will follow up to see if this can be implemented. There is no tiered approach: CSAP is authorized to make the relevant decisions regarding approval of the substitution. The States may submit one application that includes all the requested substitute data elements.*

**Issue: Supplemental Data**
One State (IL) and NASADAD had several clarification questions about the submission of supplemental data. Illinois wondered whether there were any limitations on the data, if it would be appropriate to submit data that do not meet the criteria for substitute NOMs data and/or to submit their own State performance measures. Illinois requested these clarifications be provided in the FAQs. NASADAD asked where these data would be located: next to relevant P tables or in a generic section other than the appendix.

**Response:**
*SAMHSA appreciates the opportunity to clarify ambiguities surrounding the ability to submit supplemental data. These data should be provided in the appendix section of the application. There are no limitations on the data in any way. That is, they do not need to meet the NOMs criteria for substitution, nor do they need to reflect the NOMs measures. This is an opportunity for States (e.g. States that do not believe pre-populated data reflects their performance) to provide any data that they feel reflects the performance of their use of block grant funds*.

**Issue: Duplicate Counts**
One State (IL) found the language about duplicate counts confusing. Illinois recommended that counts be unduplicated within program, but able to be duplicated between programs. Illinois also requested guidance on whether duplicate counts would be appropriate if the same strategy is used with the same population (e.g., weekly radio shows) and suggested that the goal would be to provide annual unduplicated counts (i.e., estimated number reached per market data).

**Response:**
*SAMHSA thanks IL and agrees with the proposed clarifications of duplicate counts. This language will be incorporated into the guidance.*

**Issue: OMB Racial/ethnic categories**
Two States (IL, PA) raised issues in this area. One questioned how to record populations previously categorized as "Latino," noting that Latinos do not typically identify with OMB race classifications and the State wants to be culturally competent. It recommends ensuring that all States report consistently in one way. Another State explained that their current data system does not collect data on ethnicity (Hispanic/Non Hispanic) and would have to be reprogrammed to report separately for race and ethnicity. Providers would also need additional training.

**Response:**
*Per OMB required classifications, Hispanic or Latino is not included in the race classifications. There is now a separate ethnicity classification of Hispanic or Latino-not Hispanic or Latino. Thus, a respondent would e.g., select Hispanic or Latino and also select one or more race categories. More information can be found on the census Web site. The link to the fact sheet is:*
*http://www.census.gov/population/www/socdemo/race/racefactcb.html*.

*These new OMB classifications have been in place since 1997 with compliance required by 2003. Therefore, SAMHSA strongly urges States whose data systems do not meet these requirements to do so as soon as possible.*

**Issue: Evidence Based programs and strategies (EBP)**
Iowa noted that the number of EBPs appears duplicated under two domains. Iowa also questioned the meaningfulness of the total count, when the guidance document gives States the ability to develop their own operation definition and leaves flexibility up to communities.

**Response:**
*While the number of EBP is reflected in two domains, the State only needs to fill out one table (P14). CSAP modified its guidance regarding EBP in response to numerous concerns from the field that the previous criteria were too rigid and heavily weighted on direct service programs. The current version gives States the authority to make their own determinations using broad yet defined parameters. As SAMHSA does not intend to use these data to compare States with each other, but rather to track performance over time for each State, any differences across States should not be a major factor.*

## Specific Concerns Regarding Proposed NOMs Tables P1-15 Related to Prevention Performance and Outcome Reporting

**Issue: Table P1 30 day use**
South Dakota prefers the youth risk behavior survey (YRBS) as a data source for this measure. NASADAD identified the misspelling of heroin.

**Response:**
*SAMHSA proposed NSDUH data source is based on agreements with State representatives and NASADAD in the development of the NOMs approach. We thank NASADAD for identifying the misspelled word and will correct it in the final application.*

**Issue: Table P2 Perceived Risk/Harm**
South Dakota believes that the measure in the application is inconsistent with the measure in NSDUH and also notes that it is not collected by its State surveys.

**Response:**
*SAMHSA, including the office of Applied Studies (OAS), worked collaboratively in identifying the NOMs measures. In fact, we already have the pre-populated data for this measure. Therefore we are confident that the measure is correct, but we will clarify with OAS to alleviate any State concerns.*

**Issue: Table P3 Age of First Use**
Three different comments were received from States (IL, SD and NASADAD). Illinois is concerned about the use of age of first use as an outcome measure for evaluation and the merit of collecting these data for adults. South Dakota notes that the YRBS collects most of the data but differently, and questioned whether, indeed, the NSDUH includes the items. NASADAD

noted that it is also collected in Attachment A item #9 and recommends deletion of that Attachment.

**Response:**
*SAMHSA is using this measure as a performance monitoring (State level surveillance) approach (hence the inclusion of adults) and agrees that it would not be useful as an evaluation outcome measure. SAMHSA, including OAS, worked collaboratively in identifying the NOMs measures. In fact, we already have the pre-populated data for this measure. Therefore we are confident that the measure is correct, but we will clarify with OAS to alleviate any State concerns. We appreciate the opportunity to clarify the last item identified (age of first use of illegal drugs….) as a composite of multiple other item responses obtained via the NSDUH survey. CSAP will produce this composite annually, thus will not further burden the States. If there is redundancy with Attachment A, we will eliminate it.*

**Issue: Table P4 Perception of Disapproval/Attitudes**
South Dakota notes that the State surveys do not collect these data, and questioned whether, indeed, the NSDUH includes the items.

**Response:**
*SAMHSA, including OAS, worked collaboratively in identifying the NOMs measures. In fact, we already have the pre-populated data for this measure. Therefore we are confident that the measure is correct, but we will clarify with OAS to alleviate any State concerns.*

**Table P5 Perception of Workplace Policy**
*No comments received from States or NASADAD.*

**Issue: Table P6 ATOD related suspensions/expulsions**
NASADAD recommends removing all references to this measure from the application as it is in development.

**Response:**
*There is no table included in the application for this measure and it clearly States that it is in development. We will check to assure consistency with the SAMHSA Web site.*

**Issue: Table P7 Average Daily School Attendance Rate**
NASADAD has identified a possible inconsistency in terms used between the application and the SAMHSA Web site and suggests correcting the Web site.

**Response:**
*It is correctly worded in the application. We will check to assure consistency with the SAMHSA Web site.*

**Issue: Table P8 Alcohol Related Traffic Fatalities**
Florida strongly urges the measure for this outcome be changed to Alcohol Related Motor Vehicle Crashes.

**Response:**
*SAMHSA's proposed measure for this outcome is based on agreements with State representatives and NASADAD in the development of the NOMs approach.*

**Issue: Table P9 Alcohol and Drug Related Arrests**
Two comments were received on this topic (FL, NASADAD). Florida believes that this measure is too flawed to be used. NASADAD noted that this measure is redundant yet inconsistent with Form 8 column 6 (A&B) and recommended resolving this dual reporting issue.

**Response:**
*While SAMHSA acknowledges the issues associated with this measure, it appears to be the best alternative compared to weaknesses identified for other measures and data sources at this time. This will be a composite measure of four different drug and alcohol related results in the UCR. We will work together with CSAT to identify and resolve any dual reporting issues and inconsistencies.*

**Forms P10 Family Communications around Drug and Alcohol Use and P11 Youth Seeing, Reading, Watching or Listening to a Prevention Message**

*No comments received from States or NASADAD.*

**Issue: Table P12a and b Persons served by Age, Gender, Race and Ethnicity**
Many comments were received (CA, FL, HI, IA, IL, MI, OR, PA, NASADAD) on the tables to report persons served. Numerous States and NASADAD feel that it is too burdensome to report demographics in the proposed format of age x gender x race/ethnicity and strongly urge reporting in single categories (age, gender, and race/ethnicity). Iowa and PA note that MDS is currently constructed in this way.

California cited language in the October 20, 1997 Federal Register Notice (FRN) on race/ethnicity language for table 12b (population based) and recommends that CSAP apply to OMB for a variance as described in Section 3.b in the FRN. California and FL recommend that instead of estimating populations served/reached, States report on the number of services where there are not identifiable recipients (e.g., compliance checks, zoning ordinances), and only report demographics using single demographic categories (age, gender, race/ethnicity) where there are identifiable recipients (vendor retailer education, technical assistance). Alternatively, IL suggests that activities involving interpersonal and ongoing contact *(similar to identifiable recipients described by CA)* fit better under Universal Direct and implementation of policies/ programs/practices under Universal Indirect. Illinois, MI, OR and HI believes that for table 12b only aggregate numbers served should be reported for all population based programs with no demographic breakdowns at all. California notes the increased relevancy of issue, given that redundant counts may exceed census counts for the area, and the increased use of electronic systems (Internet) which reaches unseen audiences.

Several States (CA, FL, and IA) were concerned that some terms are inadequately defined. California was concerned about the use of the term "program" which, they believed, could

incorporate both individual and population based activities. California is very concerned that categorizing programs as individual or population based was not implemented until November, 2006; after their CALOMS data system went live, thus requiring modifications to their system. CA believes that this categorization is in direct conflict with the single or recurring categories previously used by CSAP and CALOMS. Similarly, PA commented that they only capture data on recurring services and not in the detail format in the tables. Florida is concerned with the term "served" which it believes is inappropriate to use for other than direct contact activities and believes mixing such data for town hall meetings and social marketing campaigns would yield meaningless findings. Iowa would like more guidance on counts for universal/ direct and environmental strategies. Illinois would like clarification on whether individual level data are required for all individually based programs (*unclear comments so assumed to mean gender x age x race/ethnicity*) and asked if exact counts are not collected, should the data report in 12a or 12b. Illinois further wanted clarification whether the pre-post example provided to describe individual-based programs was a requirement.

Hawaii asked for clarification about columns I and J in table 12a regarding the phrase "not required by OMB." NASADAD recommended deleting the term "gender" from the NOMs table on the SAMHSA Web site, and identified a formatting error in tables 12a and b where the age group rows are numbered but the #5 is skipped between age groups 15-17 and 18-20.

**Response:**

*SAMHSA is surprised by the number of comments and extent of the obstacles described in the responses to the FRN on the subject of reporting the demographics of numbers served. SAMHSA appreciates this critical input and in response will modify table 12a and 12b to reflect totals only for gender (two columns for male/female); the OMB racial/ethnic categories and optional columns I and J. Columns will be added for the age groups previously presented on rows 1-10 in which totals only will be reported. In table 12b, the total numbers served column will be retained for those currently unable to report demographic breakouts for population based programs/strategies. While SAMHSA acknowledges the difficulties in providing estimates for some forms of population based programs/strategies, we do not concur that merely counting the services provides sufficient evidence of performance, (e.g., if no one attended). The inclusion of a separate population based table for demographics was made as a result of State input on the November 2006 conference call in which the majority of States participated. MDS, as previously stated, is being modified to be consistent with these NOMs measures and should be ready by August 2007.*

*Additional guidance has been developed and will be used by our technical assistance and training contractors to respond to your requests. As specific questions arise, they will be addressed in the NOMs FAQs which will be updated regularly. We do not agree that "served" only refers to direct services but includes indirect, single and environmental activities as well. The pre-post example of individual based services is not a requirement. Columns I and J (not required by OMB) are provided for States who currently do not collect race data per the new requirements (can select more than one race) and/or for aggregating those that do to reduce duplicate counts. SAMHSA thanks NASADAD for identifying the omission of the term "gender" from the table 12a and 12b titles. This will be added (rather than incorrectly*

*deleting from the Web site). The formatting error correctly identified by NASADAD for the age group rows, will be moot once the tables are revised to show totals only*.

**Issue: Table P13 Persons served by Intervention Type**
Several States (CA, MI, PA, and NASADAD) raised diverse issues regarding this topic. Most are reflected above under "**Specific Issues: Intervention Type**" so only additional comments are noted here to avoid redundancy. California is concerned how it will report programs that incorporate both individual and population based activities. California also does not believe that the definition it provides for Universal can be linked to individual based programs. Pennsylvania asked that the instructions include some explanation that relates to single/recurring services and requests clarification as to the purpose of including population estimates in Column B. NASADAD does not support the inclusion of this table because it believes there is redundancy with other tables (P14 and P15) and because it was not part of the agreements reached under previous discussions.

**Response:**
*Please see the response under "***Specific Issues: Intervention Type***" to avoid redundancy of responses.*

*For those programs that may incorporate activities in multiple categories SAMHSA would like reporting under the category under which the majority of activities fall. We do not believe that our definition of Universal direct conflicts with the definition of Universal provided by CA. We will add the explanation to the instructions as requested by PA. Population estimates will give some indication of those reached by indirect services. We do not believe that the information is redundant with tables P14 and P15. However, we do agree that this specific information was not identified for reporting in discussions with the States and NASADAD. Therefore, this table will be changed from required to optional in the final version.*

**Issue: Table P14 Evidence Based Programs and Strategies**
Several States (CA, FL, IL, and PA) raised diverse issues regarding this topic. Most are reflected above under "**Specific Issues: Evidence Based programs and strategies (EBP)**" so only additional comments are noted here to avoid redundancy.

California believes that the terms are too inadequately defined to be useful and described a negative impact on resources for CA due to the burden placed on States to identify and verify evidence based programs. Illinois similarly believes that this will be difficult to monitor without an EBP list and will be impossible to extract from SFY 2006 and 2007 data. Additionally, CA notes that a program may consist of multiple strategies and vice versa. Both PA and CA cite the absence of such data in their current data systems. California is able to report on EBP based on NREPP listings, but will not categorize by IOM category. Illinois asked for clarification about reporting the number of implementations of the program and recommends using the term "cycles" instead. Florida does not believe it useful to count programs at the provider level because all providers are not equal. IL provides an example where the number of EBP is far fewer than non-EBP, but the number of hours of EBP significantly higher. Both IL and FL recommends that States report the portion of the budget that supports evidence based programs and strategies and the overall cost per participant in

evidence based programs. NASADAD recommends that the redundancy of this measure across two domains be addressed.

**Response:**
Please see the response under **"Specific Issues: Evidence Based programs and strategies (EBP)**" to avoid redundancy of responses.

**Response:**
*While the number of EBP is reflected in two domains, the State only needs to fill out one table (P14). CSAP modified its guidance regarding EBP in response to numerous concerns from the field that the previous criteria were too rigid and heavily weighted on direct service programs. The current version gives States the authority to make their own determinations using broad yet defined parameters. SAMHSA is surprised about any difficulties in data systems as this measure has been required since the SIG program began. Given this history, SAMHSA will continue to request reporting as proposed, although we very much appreciate the idea of reporting percent of funding allocated to EPB, which merits further discussion for future years*.

**Issue: Table P15 Services Provided Within Cost Bands**
A number of States (CA, FL, HI, IA, IL, MI, OR, PA, and NASADAD) provided responses on this topic. NASADAD, CA and MI are concerned that inadequately defined terms such as "program and strategy" will confound the validity of the reporting. California notes that some programs cover an extended period of time that exceeds 1-year. On a related note, CA believes that demographics served by strategies such as policy changes are impossible to report. Additionally, NASADAD, FL, HI, PA and CA are concerned that only using SAPT Block Grant dollars in the calculation of cost per person will result in misleading low unit costs, when most programs having multiple funding sources. California also describes the difficulty for a large State with well over 1,000 programs in reporting these data. Iowa similarly finds burdensome reporting for every program. Oregon and PA say that their data systems are not configured to report this measure, especially for the IOM. NASADAD similarly mentions the IOM categorization as an obstacle. Pennsylvania does not believe that these data will be useful at the national level for management purposes. NASADAD also mentioned that States maintain cost data on a SFY basis and that calculating SAPT costs when they can be expended over a 3-year period poses difficulties. Illinois notes that recurring activities with the same population in a program results in a higher cost per "participant." Illinois also seeks clarification about the statement "… provisional 2005 baseline is that the cost of 50 percent of services provided …" and questions if that means that States will not be required to present a 2005 estimate for what proportion of programs are delivered within the prescribed cost band. Rather, the State would attempt to improve over the 50 percent provisional baseline when reporting the 2006 efficiency measure. Illinois also suggested that it would be useful to examine those which fell below the 75$^{th}$ percentile (e.g., they did not exceed the cost per participant at the 75$^{th}$ percentile. Illinois additionally suggested that CSAP re-consider its timeline for re-calculating cost bands within a 2-year period. Rather, CSAP should develop a new cost bands when it is confident about the quality of information collected.

Florida requests additional guidance in providing these data for Universal direct and indirect categories NASADAD recommends a consistent approach across CSAP and CSAT and

wonders if the worksheets in Attachment D are required. California also correctly notes that the term "participant" should replace the term "client" for prevention.

**Response:**

*SAMHSA appreciates the numerous comments on this OMB required measure which is new to the prevention field. SAMHSA has provided additional clarification of terms and guidance in the materials for our technical assistance and training contractors and will provide responses to specific questions in the regularly updated FAQs. Guidance is included for how to count when programs cross years or have multiple years.*

*Information about cost bands have been disseminated since FY 2005 at the National Prevention Network conference, so it is somewhat surprising that data systems have not been modified in anticipation of this requirement. SAMHSA acknowledges the unique difficulties for States with large numbers of programs and is open to suggestions (i.e., some form of sampling?) It is our understanding that States aggregate their SFY data from monthly data, so it should not be difficult to aggregate by FFY. While SAPT funds can be spread over 3 years, we request only to use the funds for the compliance year (in this case, FY 2005). We agree with IL that recurring service cost per participant would be higher, and that would and should be expected.*

*Illinois also questions whether States should provide FY 2005 results as a baseline is already included. The answer is yes: 50 percent is the expected baseline (based on the Programs and National Significance results). The FY 2005 data provided in the application will yield the actual baseline for SAPT prevention program. While SAMHSA would find it very interesting to know the percentage of programs that fall below and above the cost band, we have limited it to reduce burden.*

*Many States voiced concern about only using SAPT funds in the calculation as programs are often funded by multiple funding streams, resulting in misleading results. We share your concern. This was an extremely difficult decision which was made in the context of the reason for reporting it which is accountability for the SAPT program. This is performance monitoring of the block grant, rather than a true cost study. While the latter would certainly be more useful in program management and identifying specific programs that over- and under spend, we concluded that results that included funding from other sources would not enable us to report on <u>this</u> SAMHSA program, which is our Federal PART requirement.*

*We will correct the term "client" to "participant" and thank CA for identifying it. States are not expected to submit the worksheets: they are provided as a tool that States may use to help obtain the data needed to report the aggregate in the table. We also appreciate IL suggestion to revise the cost band once we feel surer about the data. After 2 years, that may be the conclusion we reach. However, much as we would like to be consistent with CSAT, prevention programs and strategies are very different and more difficult to capture than clients and "slots." We will continue to collaborate with CSAT as much as possible in this area.*

*We look forward to collaborating with NASADAD and the States as we evaluate the methodology proposed the data we receive and its utility in the coming years. We also thank*

*the States for working with us through the piloting and development of this first attempt and experiment in prevention cost reporting. Therefore we hope that States and NASADAD share our view of this as a first step as the measure evolves over time.*

**NASADAD Addendum**

*SAMHSA proposes that the introduction is adequate.*

**NASADAD recommends technical edits to references on page 1**.

*SAMHSA proposes to accept recommendations that are technically accurate i.e., SAMHSA will correct the references to specific statutory and regulatory citation where appropriate.*

**NASADAD recommends that the section on page 3, "Where and when to submit the Application" be adjusted to reflect SAMHSA practice.** The detail as presented asks for *one* signed original of the Assurance and Certifications. There is no reference to submitting an entire application, i.e., using the MS Word version.

*SAMHSA proposes to request and accept one signed original copy and clarify that the grantees may submit a MS Word version of their application in lieu of using the web-based application system.*

**NASADAD recommends adjusting the table titled Overview of the Application; to change references in columns three (3) of the chart, Forms 6A, 7A and 7B to 6*a*, 6*b*, and 7*b*, respectively.**

*SAMHSA* proposes to make *these minor adjustments.*

**NASADAD feels that the Footnotes section provides a dated reference to a MS Word utility.** In the third sentence referring to the *"Insert" pull down menu* appears to be an artifact from an earlier MS Word version.

*Current SAMHSA MS Word software contains this utility under the "Insert" menu item.*

**NASADAD recommends adjusting the section heading "What to do if your State cannot complete all items in Sections I – III" to reference Sections I – IV.**

*SAMHSA proposes to make this adjustment.*

**NASADAD recommends adjusting the section "Getting assistance in completing the application" as the final paragraph references Appendix A (i.e., *See Appendix A*). NASADAD also recommends referencing the BGAS help-desk as a resource for those working on the State's application.**

*SAMHSA perceives that the reference is accurate and clearly is referring to an appendix to the uniform application guidance. A reference to the helpdesk can be provided and SAMHSA proposes to insert text in this section.*

**On page 5 of the Guidance, NASADAD recommends inserting the Text "Identifying Information and Assurances" after Section I and correcting the next year award reference.**

*SAMHSA concurs.*

**NASADAD expresses concerns regarding the configuration of the Web BGAS version of Form 1 in terms of its ability to capture original date of submission and revisions. NASADAD also is concerned that the MS Word version of Form 1 could be improved by a colon after the DUNS Number heading.**

*Web BGAS tracks all dates when a form has been revised. SAMHSA agrees that including a colon after the DUNS Number should clarify that an entry is sought.*

**NASADAD suggests the instructions for Form 2, Table of Contents contains an artifact reference to the Table of Contents being pre-numbered (as) page 2**.

*SAMHSA concurs and has removed the reference and clarified that the Table of Contents should be used as a checklist.*

**NASADAD suggests various improvements to Form 2**

The term *Form 2* does not appear in the Heading on the Table of Contents form.

*SAMHSA concurs that this should be added and has done so.*

The following *items* are not included on Form 2: Item number 1: FY 2005 SAPT Block Grant

*SAMHSA concurs and has added that to Form 2.*

Add an item to distinguish between Attachment J Waivers and Attachment J: Waivers (Narrative)

*SAMHSA does not concur.*

Add an item at the end of the application, after section IVb, Appendix A, Additional Supporting Documents

*SAMHSA concurs and has added that to Form 2.*

Introduction, item #1, NASADAD does not believe a number is needed.

*SAMHSA does not concur.*

Form 7B should have its own item number

*SAMHSA concurs and has added that to Form 2.*

The Funding Agreements/Certifications format on page 9 should be utilized for item 35 (I – IV.) for the listing of the 4 MOE Tables.

*SAMHSA does not concur.*

Item #4, Section III, "How Your State Determined the Estimates for Form 8 and Form 9," should be re-designated as Item #5 and appear after Form 9.

*SAMHSA concurs and has altered Form 2.*

Treatment Capacity – item #10 – no item number is needed.

*SAMHSA concurs and has altered Form 2.*

Purchasing Services – item #12 – no item number is needed.

*SAMHSA concurs and has altered Form 2.*

IVb – item #1 – the *measure* for Form P1, we believe, should be changed to *30-day use.*

*SAMHSA concurs and has made the appropriate changes in the table of contents.*

IVb – item #6 – this item is not included in FY 2008, and should not appear in the Table of Contents.

*SAMHSA does not concur that this item should be deleted, but will amend the Table of Contents to reflect its developmental status.*

IVb – item #12 – this item contains Form P12 and P12 b, which should be itemized separately.

*SAMHSA has already constructed Forms P12a and 12B to count separately individual vs population estimates. SAMHSA does not concur that other measures should be itemized separately.*

**Funding Agreements/Certifications**

The introductory paragraph references that an authorized designee could sign the application and that if so, authorizing documentation must be attached as an "*Appendix.*" NASADAD believes it would be helpful to provide guidance on the format, content and scope of the delegation of authority (D/A) letter signed by the Governor, including its currency, given the official due date requirement (October 1) for a valid D/A. NASADAD also believes that the guidance should also indicate whether the D/A could be a copy and whether it could be provided in the Web BGAS Appendix A (e.g., the instructions for "*Form 3*" do not reference Web BGAS).

*SAMHSA does not concur as no States have expressed confusion on this matter.*

**Form 3, Assurance XIII (Section 1941) is missing the close quote after the final period is missing (hard copy only).**

*SAMHSA concurs and has added that to Form 3.*

**Section II: Annual Report, Progress Report and Plan Actual Use of 2005, Progress Report on 2006 and Plan for FY 2008 Program Activities**

The Section II heading in the 2nd line (above) should reference …Progress Report on *FY 2007* (not FY 2006). This heading does not match the Table of Contents heading for Section II on page 8. There seems to be an artifact "4" at the end of the Heading. This "Heading" Table of Contents inconsistency is also true of Section III (page 72), which Heading does not match.

*SAMHSA concurs and has revised the Table of Contents heading for Section II.*

The first narrative paragraph should reference *its FY 2007* (not FY 2006) award at the end of line 2.

*SAMHSA concurs and has revised this reference.*

The chart at the bottom of the page does not reference the narrative *Description* of *Calculations* for the 3 MOE tables, i.e., item #34 on Table of Contents Page 10.

*SAMHSA does not concur that this revision is necessary.*

We would like to highlight that the statutory reference cited in the 1st paragraph as requiring the reporting for 2005 and 2007 (42USC 300x-52) is only applicable to FY 2007 (i.e., the prior year). We suggest that the last two sentences in paragraph one be deleted; the ensuing sentence/paragraph citing 42 USC 300x–21 et. seq serves to establish the authority in a more generic way.

*SAMHSA concurs and has revised this reference.*

Paragraph four (4) starts with "This section has five (5) *items."* The term "*subsection*" would be more appropriate since *item*, as now used, (e.g., in the Table of Contents (Form 2) refers to an actual categorical data entry format). Therefore, under this construction, *subsection 2* would contain 21 (or more) items; *subsection 3* would contain 2 items (Form 6 and Form 6a), etc.

*SAMHSA does not concur that this revision is necessary.*

**Section II, FY 2005 SAPT Block Grant**

The actual instruction should specify that States using the MS Word version must "fill-in" the FY 2005 SAPT BG Award amount.

*SAMHSA does not concur that this revision is necessary.*

**Section II, How substance abuse funds were used and intended [narrative])**

This heading seems awkwardly worded in that *intended* is not followed by the word *use;* and the final word in parenthesis (*narrative*) implies that this subsection is "*narrative*" only. Given the content of the next subheading in *bold caps* (the only such use of this convention in the document) adding the word *use,* and deleting (*narrative*) because subsection 2, also contains Form 4, etc. would make the subsection 2 heading more accurate.

*SAMHSA does not concur that this revision is necessary.*

The first narrative paragraph identifies Goal #8 and Goal #7 as the only exceptions to the "three" narratives per goal requirement. As currently formatted Goal #17 (page 37) is listed as "*Not Applicable"* regarding FY 2005; this "Not Applicable" is probably a carryover artifact, however.

*SAMHSA concurs and has removed the "Not Applicable" reference.*

**Section II, Federal Goal Narratives**
While brief instructions for completing the (up to) 16 goal narratives theses instructions are provided they are not sufficiently clear to determine their applicability by year. There are various strategies for improving them, but only a few minimalist ones will be presented here in the next three paragraphs. In general, the generic instructions on pages 25/26, which address development of required narratives for three (3) non-consecutive FFYs (FY 2005, 2007, 2008) do not specify enough to guide States' responses.

*SAMHSA has added an instruction to clarify the desired format of these narratives.*

**Section II, Goal 2, Primary Prevention**

The Goal #2 agreement statement contains an artifact legislative reference. Effective beginning in FY 2001, that reference was re-codified at 42 USC 300x-22(a)(1) not (b)(1).

**Section II, Goal 3: Pregnant Women and Women with Dependent Children (PW/WDC) and Attachment B**

All of the items relating to the PW/WDC *State* expenditure requirement reporting should be consistently clarified to reduce duplicative/fragmented reporting and to effect and reflect policy resolution of the "FFY vs. SFY" policy issue accruing from the evolving interpretation(s) of 42 USC 300x–22(b)(1)(C) and 45CFR 96.124(c)(3).

Goal #3 should be rewritten to focus on the *maintenance* expenditure requirements for FY 2008 (i.e., FY 1995 and beyond) as specified in 45CFR 96.124(c)(3), instead of the cited requirements to establish *new or expanded capacity* programs applicable to FY 1993, as specified in 45CFR 96.124(c)(1), and to 1994 as specified in 45CFR96.124(c)(2). See the last sentence of the 2nd instructional paragraph on page 29, which is a more accurate overall description regarding service availability for *FY 1995 and beyond.*

Attachment B is now located ahead of Form 6. Therefore, the term *refer back* in the first paragraph is inaccurate, and the word *back* (an artifact) should be deleted. Further, given the possible variance, by State, in the designated State expenditure period, some State funded PW/WDC projects funded during the applicable period may not be included on Form 6 (i.e., Column 4).

Question #1 (in the section referred to in Web BGAS as *Attachment* B *continued*) is potentially redundant with the Fiscal reporting by entity on Form 6. Both formats may be insufficient; we believe SAMHSA should "fix" one and delete the other.

*SAMHSA does not concur that such revisions are necessary at this point in time*.

**Section II, Goal 7: Group Homes and Attachment F: Group Home Entities and Programs**

Reference to 45 CFR 96.129 which is included in Goal #7 and attachment F are inappropriate, since 45CFR 96.129 was <u>not</u> revised to match 42USC 300x–25; it is therefore not accurate, because it does not cite the requirement as *optional*.

*SAMHSA concurs and has deleted that reference.*

**Section II, Goal 8: Tobacco Products**

Reference to 45 CFR 96.122 (d) should be relocated from the end of the agreement statement to after the N*ote* at the bottom of the page, since it only applies to the "statutory" due date for the Annual SYNAR Report; the term statutory should probably be changed to *regulatory*, since the due date was established by a rule change effective on September 4, 2001.

**Section II, Goal 17 and Attachment I**

The narrative content in the agreement for Goal #17 "Charitable Choice" consists largely of statutory and regulatory references. We believe that in itself the content does not provide sufficient guidance. The regulatory citation was not readily available through a hypertext link to the T.I.E. Web site. Page 38 contains a description of the Charitable Choice requirements, which are apparently applicable to Attachment I. The statement addresses the rights of service recipients but not the nongovernmental (e.g., religious) organizations. As a result, it seems to be incomplete guidance for Goal #17. The agreement might be made more accurate by rewording the goal statement: "An agreement to ensure that access to services provided by nongovernmental organizations, including the provision of such services, is implemented in compliance with 42USC 300x-65, and 42C.F.R. part 54…."

*FY 2005 (Compliance)*: for Goal #17 reporting is identified as *Not Applicable*, and is probably an artifact. We recommend deleting the *Not Applicable* if reporting is necessary.

The paragraph immediately after the *Attachment I*: *Charitable Choice* heading implies, through use of the wording "*provide a description,*" that a *narrative* regarding Charitable Choice procedures and activities is sought; it does not appear to be. Alternative wording is suggested such as "*complete* the following checklist items…."

The final checklist item asking for number of referrals to be entered seems poorly constructed and worded. We recommend the following: "*Enter in the box provided the total number* of referrals to other substance abuse providers (alternate providers) necessitated by clients' *religious* objections to Faith-based providers … No information on specific referrals *is* required."

*With the exception of removing the text "Not Applicable," SAMHSA does not concur that such revisions are necessary at this point in time.*

**Section II, How to complete Form 4**
There is no reference to completion of Form 4 through Web BGAS. The revised heading for *Row 1: Block Grant Funds* for Substance Abuse Prevention (other than primary *prevention*) does not match the Column 1 (Treatment and Column 2 (Prevention)) on related Form 4b page 48. Using the term Substance *Abuse* Treatment and Rehabilitation to refer to Treatment and Primary Prevention is arguably more appropriate since specifically referencing "prevention" in the fundamental treatment definition has been inordinately confusing. However, we recommend that the headings and terms used throughout Forms 4, 4a and 4b (and 11, 11a and 11b) remain consistent.

*SAMHSA made this change to correct Form 4 using terminology contained within the statute. Previous terminology employed the term rehabilitation which was not defined or referenced in statute or regulation.*

The instruction for Row 2: *Primary Prevention* contains an artifact reference to FY 2004 instead of FY 2005. While the instruction indicates that early intervention activities should not be included as part of primary prevention, it neither defines the term (which is used for the first time in the guidance) nor specifically States where to classify these costs, i.e., Treatment and Rehabilitation. The 20% minimum expenditure requirement should be referenced here, as well as citing the direct connection to the fiscal data provided on Form 4a.

*SAMHSA believes the term primary prevention is understood and no change is necessary other to revise reference to FY 2004.*

**Section II, Form 4, Column A: Expenditures of SAPT Block Grant**
In the first line the word *award*s should be singular**.**

*SAMHSA concurs and has made the revision*.

**Section II Column D: State Funds**
The statement regarding *Column D; State Funds* that says this column provides an *estimate* of annual State Funding is inaccurate in that Column B (Medicaid) may contain State funding as well.

*SAMHSA does not concur that revision is necessary at this point in time.*

**Section II, Form 4, Row 1**
The activity heading for Row 1 should be consistent with both its own instructions and with Form 6 and its instructions; preferably using the heading listed here, i.e., Substance Abuse Treatment and Rehabilitation.

*SAMHSA made this change to correct Form 4 using terminology contained within the statute. Previous terminology employed the term rehabilitation which was not defined or referenced in statute or regulation.*

**Section II, Form 4a, Detailing expenditures on primary prevention (Row 2)**

The title at the top Page 45 should reference both *Form 4a* and (*Row 2 on Form 4*) especially since neither is mentioned in the specific instruction. (In Web BGAS ascertaining the reference to *Row 2* would require more of a search.) The current reference to (*Row 2*) does not specify (*Row 2*) *on Form 4*. An alternate Heading might be, *Form 4a: detailing expenditures on primary prevention (see Row 2 on Form 4).*

The heading for *Costs Associated with….Tobacco Inspections* does not match Form 4a; use of Section 1926 – Tobacco is an incomplete identifier for the requirements specified in 42 USC 300x–26 (b)(2)(A). We believe the heading should match. We suggest using *Tobacco Inspections* as an alternative. Finally, there is nothing to suggest that this form should be referred to as a "checklist," given its design to capture fiscal data. The chart's asterisks are unintelligible in relation to the request for revenue sources; there is no instruction for how or where to report the information, and, this convention repeated on Form 11a is probably an artifact.

*SAMHSA is considering these suggested revisions*.

**Section II, Form 4c: How to report expenditures on substance abuse resource development activities**

The heading should reference both *Form 4b* and *RD Expenditure Checklist* similar to the comment above, concerning Form 4a.

*SAMHSA concurs.*

**Form 4b Resource Development Expenditure Checklist)**

The first narrative paragraph references *line 1 on Form 4* as: *(1) Substance Abuse Treatment and Rehabilitation*, further evidence of the need to use a consistent descriptor for all the fiscal reporting forms throughout the Forms 4 through 6 series. This is the preferred term. *SAMHSA made this change to Form 4c consistent with the correction to Form 4 using terminology contained within the statute. Previous terminology employed the term rehabilitation which was not defined or referenced in statute or regulation.*

**Section II, Form 6: Substance Abuse Entity Inventory**

By deleting the last sentence at the end of the second paragraph, SAMHSA has made it clear and consistent for the first time that States must itemize expenditures, by State expenditure period (SEP), for "all direct providers of treatment and prevention…activities." For an SSA that receives a State appropriation that approximates its annual SAPT Block grant award, the burden for retroactively reporting such information (e.g., for SFY 2005 or SFY 2006) could approximate a doubling of the size of the workload burden (e.g., one large State has itemized 112 sub-recipient entities within the SAPT BG expenditure column). While some States have voluntarily provided this information in the past, many have not; these have never been an identified resultant problem. In previous application years the instructions have addressed the need for fiscal information for State funded entities that do <u>not</u> expend compliance year Block Grant funds in an inconsistent manner, in effect leaving States to decide. Moreover, none of the performance measures relating to sub-recipient performance request information regarding non-Block Grant funded providers. Finally, reference to the Federal Managers Integrity Act does not cite the need in the instructions for States only expenditures at the sub-recipient level. NASADAD recommends that SAMHSA limit the data collection in Form 6 to entities that receive only block grant funds, or that States be allowed to continue to report on those entities receiving only State appropriated funds, voluntarily.

*SAMHSA does not concur that revision is necessary at this point in time. The grantees must demonstrate an ability to track and report all sub-State recipients as: 1) the distinction between SAPT Block Grant and State funds is indistinguishable at sub-State levels in many States and States treat SAPT block grant funds as their own merging them with State revenues; and 2) States' maintenance of effort require States to be able to track and report aggregate State resource expenditures and can only be demonstrated as being valid by documenting that individual sub-recipients and amounts can be reported.*

In paragraph three, on page 49 FY *2005* should replace FY 2004 block grant funds.

*SAMHSA concurs and has made this revision.*

**Section II, Form 6: Stage one: Entering entity information (Columns 1 through 3)**
In the middle of the page, *Column 3: Area served* reference to Web BGAS indicates that a code of 99 must be entered for Statewide Programs. In fact, a code of 95 will also be accepted.

*SAMHSA does not concur that revision is necessary at this point in time.*

*Column 5*: NASADAD believe the sentence starting with "*Early intervention activities*" is written in a confusing manner and recommends the following: "Early intervention activities should be included as part of *Column 5.*" NASADAD also recommend adding the following: "Do not include funds for administration cost *or* for primary prevention in this column."

*SAMHSA does not concur that revision is necessary at this point in time.*

*Column* 5a: The reference to tuberculosis (TB) services not being included with pregnant women is confusing in that there is no apparent link between these subpopulations; and, there is no instruction as to whether or not to include grantee expenditures related to TB anywhere else on Form 6.

*SAMHSA does not concur that revision is necessary at this point in time.*

*Column 6*: The instruction says to include "funds for education and counseling, *and* for activities designed to reduce the risk of substance abuse. Because the wording strongly implies that the *counseling* is mutually exclusive from reducing the risk, e.g., a form of early intervention inserting the word *other* before the word *activities* would probably resolve the issue. We believe the instructions should be consistent with the definition on page 41 for primary prevention. It might also be beneficial to add: "*Do not include funds for early intervention in this Column.*"

*SAMHSA does not concur that revision is necessary at this point in time.*

**Provider List to be attached to Form 6**
NASADAD believes the last sentence under this heading is an artifact sentence that predates the Web BGAS format, and should be deleted.

*SAMHSA concurs.*

**Form 6: Substance Abuse Entity Inventory**

The inclusion of the box "Page___of___pages" in the upper right hand corner is an inconsistent use of the convention in the MS Word version, only. It is probably an artifact. As such, it is inconsistent with the pagination instruction contained in the first sentence in the first full paragraph on page 4. Finally, there is no instruction on pages 49-51 that addresses whether or not the columns are to be totaled, and there is no total row on Form 6. (Web BGAS calculates Column totals.)

*SAMHSA has provided the page__of page___ format for those States copying form 6 and completing it as opposed to completing it in MS Word. For those not using Web BGAS, totals will be calculated after the States' data are entered into the Web BGAS database.*

**Prevention Strategy Report Form 6a and, Form 6a Prevention Strategy Report Risk-Strategies**

The issues regarding Form 6a (page 56) and its set of hardcopy instructions have been previously addressed. If retained, (NASADAD recommended its deletion) we believe that the instructions and form need a complete rewrite. Issues to consider include: reporting time period; the (15-year) temporary nature of the form as reflected in the opening note on page 52; and, the instructions that require completion of only Column B, although Form 6A as presented on page 55 contains a "completed" Column A; the statutory citation which refers to Section 1929, i.e., Planning (Assessment of Need) while in the same sentence linking the Form 6A to Form 6, i.e., a grant list from 3 prior years. Finally, because Column A is filled-in, there is no convenient way to provide more than one example of an "*other*" strategy; although the instruction says to begin with Code 71, it is unclear how this would differ for codes 09, 17, 27, 34, 46 and 55, respectively. In sum, we believe the directions do not differentiate between a strategy and an activity.

The revised opening note under the heading suggests that the form would be optional for a further three (3) years except for Column B, which will be required until the phase-in year 2010. It is unclear what "phase-in year 2010" means, however by 2010 CSAP will have maintained this largely optional form without the promised "refinements to finalize the form" also promised in the notice.

*SAMHSA does not concur that this form should be removed as such information collection is required by statute.*

**Instructions on How to complete Forms 7A and 7B**

In the first line, Forms 7a should be singular. In effect, there are two (2) sets of instructions for Forms 7a and 7b: the first describes them together (page 57, top half); and, the second, pages 57-59 (for 7a), and page 61 (for 7b) which addresses them separately. Specifically, the second paragraph on page 56 says: "These forms are intended to capture the unduplicated count of persons with initial admissions to an episode of care"… However, the instruction for Column A on Form 7a on page 58 indicates that "each readmission of a client….would be counted." This is an apparent inconsistency between the generic (page 57) and the specific (i.e., page 58) sets of instructions.

*SAMHSA believes the instructions should remain unchanged at this point in time as it seems that most grantees understand that initial and subsequent admissions in a certain period are counted for each client served as a new client (i.e., no services have been received within the last thirty days) admitted within that time period.*

The definition for *Row 9: Opioid Replacement Therapy* does not define the term. We believe it should given that the term is used for the first time this year to replace methadone. It needs to be updated to reflect Opioid Replacement Therapy, the term that appears on Form 7a and Form T7.

*SAMHSA does not concur.*

**Reporting on Form 7b**

The instruction in the final paragraph describes a (one item) second section of Form B. This second section is an "add-on" that constitutes an exception to the description in the second paragraph. Therefore, paragraph 2 on page 61 should probably start with: Section one on Form 7B covers.

*SAMHSA concurs that a revision would clarify this paragraph and has added language to clarify this section.*

**Maintenance of Effort (MOE) Tables: Simple State Agency (SSA) MOE, TB MOE, HIV MOE, and Women's Base and Expenditures**

There is no formatted question for a State to indicate that it intends to submit a request to SAMHSA to exclude funds from the SSA MOE calculation (e.g., for FY 2007). For Table 1, this could be formatted on page 64. Page 63 cites *CSAT* as the approval entity, whereas page 63 specifies that such a request is to be submitted to the *SAMHSA Administrator*. We believe reference to both the statutory (42 USC 300x-30) and regulatory (45 CFR 96.134) citations would be useful to include on page 63 after the Table I heading and above the two (2) bullet instructions.

*SAMHSA concurs and has revised the inappropriate reference to "CSAT approving" exclusion requests and has inserted the statutory and regulatory reference.*

**Table III**

The instruction for Table III references that "Web BGAS will provide an appropriately configured table." This reference is not specifically repeated for Table I (page 63), Table II (page 66) or Table IV (page 70). We believe, for consistency, they should be addressed uniformly. Reference to SFY 2006 in the final paragraph should instead reference *SFY 2007*.

*Table III is the only table that changes contingent on when a State most recently became a designated State. Web BGAS only provides differing versions of Table III and therefore the comment above is not appropriate.*

**Table III [Base and Maintenance])**

The data entry line at the top of page 69 does not exist in Web BGAS. We believe it should be a pre-populated item. This line uses a "FFY" convention that is not used elsewhere. The instruction #2 on page 68, however, does not specify that State funds are to be reported by SFY, although it is implicit.

*Web BGAS contains information about when States last became designated States and therefore it is unnecessary for States to enter this in BGAS.*

**Table IV**

We believe that Table IV is probably not an MOE table in the "statutory authority" sense as provided at 42 USC 300x–22(b) - *Allocations* Regarding Women. Given its link to expenditures, it probably should be relocated, perhaps as a "Form 4c". As indicated, guidance

for completion of this table needs to be clarified in the context of addressing the fiscal year reporting issue for all PW/WDC reporting formats. Similarly, the single item entry at the bottom of Table IV regarding FY 2008 expenditure plans could be relocated as a "Form 11c" within Application Section III.

*SAMHSA does not concur that revision is necessary at this point in time.*

## Section III: State Plan – Intended Use of 2008 SAPT Block Grant Funds

**Page 71**
The word *use* should be inserted after *intended* near the top of the Chart margin.

*SAMHSA does not concur that revision is necessary at this point in time.*

**1. Planning**
There is no checklist item for using NOMs or performance measures as a criterion for allocating FY 2008 SAPT Block Grant funds. We recommend including one.

*SAMHSA does not concur that revision is necessary at this point in time.*

**How to complete the Treatment Needs Assessment Summary**

There is no instruction regarding a State Total row for Form 8, applicable e.g., to Columns 2-5, nor is there such a row displayed on Form 8.

*For those States not using Web BGAS, totals will be calculated after the States' data are entered into the Web BGAS database.*

After page 74 the pagination is out of synchronization, i.e., it returns to page 72 (e.g., Form 8); there are two page 72's, 73's, and 74's.

*Pagination problem should be fixed at this time.*

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

The end of the last sentence of the first paragraph should specify…Column 6 and 7 *on Form 8.*

*SAMHSA concurs.*

**4. Intended Use Plan [*Form* 11]**

In general, the entire heading encompasses the content on pages 78 through 85. However, the heading incorporates many items *in addition to Form 11*. As a result, we believe "(*Form 11*)" should be deleted from the heading.

*SAMHSA does not concur.*

The reference back to Form 4 for the row (1-6) definitions in the opening paragraph is probably inappropriate given that the next paragraph then lists the row 1 definition from page 40 almost verbatim.

*SAMHSA does not concur.*

The final sentence on page 79 refers the user back to Form *04* for funding source definitions. The term Form *04* (i.e., Form 4) is an artifact. This instruction should precede the itemized *Column* B-F instructions, in a separate paragraph preceding "Column B: *Medicaid*", not at the end of the *Column F* paragraph.

*SAMHSA moved the instruction and revised the form 4 reference.*

**Primary Prevention Planned Expenditure Checklist**

There is no description on the form designating it as Form 11a. There is no specific reference to provide 24-month budget estimates either in the instructions (pages 81-83) or on Form 11a. Further, the Form 11a version is in an earlier "checklist format" than Form 4a which is a later formatted chart version used in recent years. The asterisk reference at the bottom of the chart (as with Form 4a) is an apparent artifact with no clear instruction as to how to provide the data.

*Refer to SAMHSA consolidated analysis and response.*

**5. Treatment Capacity Matrix (Form 12)**

The opening statement that Form 7a is identical to Form 12…except…*the 24-month period during which your principal agency of the State is permitted to spend the FY 2008 BG award*, may be misleading in that readmissions within 24 months are much more likely than within 12 months; this would affect the Column B totals.

*SAMHSA does not concur that revision is necessary at this point in time.*

We believe the Row 9 Definition for *Methadone* should be rewritten for *Opioid Replacement Therapy*. As written, the definition is in the wrong tense (i.e., received instead of will receive). On page 86 in the next to the last line the term should be level *of* care, not level *or* care.

**Methods for Purchasing**

The sub-item regarding county/regional priorities should probably reference SPA, either instead of, or in addition to, the listed priorities. Presently, there is no guidance provided for completion of this final checklist item on this page.

*SAMHSA does not concur that revision is necessary at this point in time.*

**Methods for Determining Prices**

There is no specific reference to applicable fiscal year for the data regarding Methods for Determining Prices. FY 2008 is implicitly intended, although use of the term percent of clients served (i.e., past tense) makes this unclear.

*SAMHSA does not concur that revision is necessary at this point in time.*

**7. Program performance monitoring**

There is no actual fiscal year reference to *7. Program Performance Monitoring*; present ("uses") and future ("will") tenses are used in the instructions.

*SAMHSA does not concur that revision is necessary at this point in time.*

**Section IV-A: Treatment Performance Measures**

General Comment: We recommend a 1-2 page overview of NOMs. We believe it would be helpful if this 1-2 page summary provided an integrated perspective concerning performance management for treatment and *primary* prevention, not dissimilar from the integrated perspective taken regarding the planning requirements described briefly on application page 70. Ultimately, integrating Section IV A and IV B into, e.g., Section IV would be a worthwhile objective for FY 2009 to avoid the appearance that these are separate, unlinked efforts.

*SAMHSA does not concur that revision is necessary at this point in time.*

**General Instructions for Treatment Performance Measure Forms T1 – T7**

The hyphen between IV and A should be deleted in the Section title. The same change should be made for Section "IV *B"* on page 134 for consistency; no hyphen is used on the Overview (page 3) or on the Table of Contents (page 11).

*SAMHSA concurs.*

The word Measures in the above title should be plural.

*SAMHSA does not concur that revision is necessary at this point in time.*

Detailed comments on this expanded set of general instructions are presented in a yellow highlight and red bold format on the subsequent six (6) pages. Additional comments are located on the specific T Forms below.

NASADAD believes that SAMHSA should provide a basic introductory overview on NOMs and Performance Measurement, perhaps a section *titled IV. Performance Measures.* That creates an integrated context between IV A and IV B.

*SAMHSA does not concur that revision is necessary at this point in time.*

We believe the phrase Treatment Performance Measures should be added to this heading. We recommend additional detail provided about how and when States may elect to use pre-populated data, including notification to the States for which this is not an option. There is no reference anywhere to the fact that Form T7 will not be pre-populated.

*Information about pre-population of data via Web BGAS has been added. If possible and if a State so chooses, Form T7 will be pre-populated.*

Moreover, the general instructions indicate that the "most *recent* SFY" for which data are available…is applicable to Forms T1 – T7; however, the separate instructions for T7 (page 130) cites use of the State Expenditure Period (SEP) designated on Form 1 as applicable. The references to SEP may be an artifact; however, given the historical link between Form T7 and Forms 7a/7b in terms of the reporting time period, clients and revenue source (current instructions indicate that all "T" forms address…only clients (Entities) receiving services from BG funded agencies (#1on page 94), whereas Form 7a/7b requires reporting on <u>all</u> care purchasers by the Single State Authority (SSA) during the SEP. Finally, T1 – T7 addresses and asks for reporting on <u>all</u> discharged clients with treatment periods ending in "the most recent SFY", whereas 7a and 7b (for the most part) provide information for all clients admitted <u>and</u> discharged (otherwise determining an episode would not be possible) within the SEP, but would exclude prior admissions and those admitted but not yet discharged.

*SAMHSA has revised the treatment performance measure forms to allow reporting on the most recent year for which data are available to facilitate States' NOMs reporting.*

Guidance is not provided regarding detoxification only clients or clients receiving opioid replacement therapy.

*SAMHSA does not concur and feels that such guidance is supplied in the General Instructions.*

Unlike the separate instructions for IV B, the instructions #4 repeats that programs not reporting must provide a detailed plan to collect and report.

*This is accurate.*

A mechanism is provided for each Form from T1 – T6, to address data plans – a mechanism for T7 is not specified.

*This is accurate.*

Of the five (5) information request/questions posed in this seven (7) paragraph subsection, #4, #6 and #7, as phrased, will simply generate yes/no answers. Question 3 (located in paragraph at the top of page 96) contains a typo (i.e., reports not repots). *SAMHSA has corrected this typographical error.* In sum, these questions should provide some guidance regarding response timeframe even if its "recent past" or "near future", and provide additional instructional guidance (e.g., what is meant in the yes/no question #7 by the term "intensity").

*SAMHSA does not concur that revision is necessary at this point in time.*

**State Description of Employment Data Collection (Form T1); Data Source**

Inclusion of a check-off box for urinalysis, blood test, or other biological assay seems inappropriate for measuring change in employment, living status (p 106), arrests (p 112), and social support (p 128).

*SAMHSA concurs and has revised these references.*

**Interim Standard – Change of Persons Arrested (Form T3)**

The advice to "see *ATR* RFA" in the 2nd and 3rd boxes of the 1st Column should include instructional detail regarding how to access the applicable document or a summary of the relevant information.

*SAMHSA concurs, revised to reference current TEDS manual.*

**Form T7: Retention**

Row 9 in the Level of Care Column should be changed from "Methadone" to Opioid Replacement Therapy. As referenced previously the line for filling in the "Most Recent State Fiscal Year for which data are available needs to be consistent with the instruction on page 130 (i.e., State Expenditure Period).

*SAMHSA has revised the treatment performance measure forms to allow reporting on the most recent year for which data are available to facilitate States' NOMs reporting.*