

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

The Maine Office of Substance Abuse has a public library and 1-800 number for access to information on prevention, treatment providers and community partners and information throughout the state. There is a plan underway with the office's agency monitoring team to update the treatment directory should a provider obtain less than adequate re-licensure from the Division of Licensing and Regulatory Services so that an individual can make an informed choice about accessing a particular provider. There is also a link to the Maine 211 number so that any individual accessing information via that line has a direct link to the treatment provider directory for information should the Information and Resource Center be closed. Annually the Maine Office of Substance Abuse conducts a Client Satisfaction Survey to access client's perspectives of the service system as it relates to Substance Abuse. Feedback is regularly solicited from prevention providers about support needed and materials created for their local audiences.

Providers that have contracts with the Maine Office of Substance Abuse are required to use ASAM – PPC2 to assess for level of need for services, within that the clients "readiness for change is assessed" and they are offered a menu of available services and are allowed to make informed choices about the services they receive. Additionally, the expectation for the individualized treatment planning process is client-directed and reviewed each time there is contact. Currently individuals do not have direct control of the financial (budgeting) aspect of services in Maine

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E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Maine's Treatment Data System collects unique client level encounter data. Also, within the Maine Department of Health and Human Service we have a link created that allows client data from Substance Abuse, Adult Mental Health and Medicaid clients to match up.

If not, respond to the following as to how it plans to do this, the process to do this, the resources needed to do it, and a timeline for developing such capacity:

Our data system and data extract process is very adaptable and can be updated/enhanced to provide any data that are needed to support the grant as long as the needs are identified and defined by SAMHSA. Maine's data system within the SSA provides other outcome and performance information outside of the National Outcome Measures. We have an oracle based Treatment Data System (TDS) which captures client and agency level data from agencies who receive funding from the State; some of this data is uploaded from this system into the Federal TEDS system. We also have a Prescription Monitoring Program system (PMP) which pulls data from pharmacies who dispense drugs in Maine. The data is collected by an out of state vendor (Health Information Designs), cleaned and is then provided to the State of Maine which houses it in an Oracle database. Both the TDS and PMP data systems are maintained by the State's Office of Information Technology.

TDS includes information on the Provider, the level of care, type of service they provide, and cost per unit. The TDS also includes the following information on clients: Dates of contact and treatment; age, race, ethnicity, gender, and county of residence; insurance; veteran status, education, marital and dependent status; pregnancy status; living arrangements; employment; income; source of income; prior treatments in SA and MH; violence and incarceration information; primary presenting problem; drug use and route of administration; age at first use; MAT status; OUI offense; Global Assessment Functioning Scale score; self-help group attendance; and gambling.

PMP collects data on the prescription dispenser, the prescriber regarding location. It also collects information on patients on the date dispensed and prescribed, address, gender, age, schedule II-IV drugs that were dispensed including days supply, quantity dispensed, and strength.

MACWIS (Maine Automated Child Welfare Information System) MACWIS is a secure database (login credentials are necessary) that is used by many Agencies within the Department of Health and Human Services. The database contains highly confidential information regarding clients and children throughout the State; however, MACWIS is only used by OSA to verify License Status of agencies.

KIT Prevention collects data on contracted prevention providers and measures outcomes and collects reach and counts. For prevention services targeted to specific individuals, a variety of demographics and session counts are also collected.

The Prevention Services uses the KIT Prevention System through a contract with KIT Solutions, Inc, of Pittsburg, PA. Prevention providers are not required to have a national provider identifier. KIT Prevention does create a unique identifier for providers that can be used to aggregate services and other information. KIT Prevention also has unique participant identifiers that allows for unduplicated counts of participants and the ability to aggregate services by participants, but only for selected, indicated and universal direct prevention programs.

In the PMP system, providers and dispensers each have unique DEA numbers, which are included, and searches may be performed by this unique identifier. The State also requires the provider to edit this if the DEA number changes, and the State receives information on DEA numbers which have been cancelled or lapsed.

TDS includes the Federal ID number for each substance abuse treatment provider within the database. Aside from the federal id numbers in the TDS and PMP systems, we also capture agency/provider name and addresses which can be used to cross check when aggregating data.

In PMP log in codes are needed. In the TDS system, log in codes are needed.

Client level data is available from most of the data systems listed above. The data systems do include client identifiers: The PMP uses an algorithm of multiple identifiers to identify a client; the TDS system uses a unique client id. Set by the state system which is uploaded into TEDS system. The unique client id is shared by our Medicaid system and Mental Health system. Both of these methods allow us to aggregate and subtract out duplicate counts from the data.

Maine has not switched to ICD-10 as of summer 2011, but are in the process of updating the PMP system to allow for this change (currently transitioning to ASAP 4.1 standards). Other state systems (Medicaid/Medicare, etc.) are scheduled to be switched to ICD-10 coding by 2013.

Medicaid data or linked Medicaid-behavioral health data are used occasionally, not on a regular basis. OSA is currently in communication with the Medicaid Office to get on their calendar for receiving regular reports around substance abuse.

Does your state's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, HER's, Federal IT requirements or similar issues?

Maine's Office of Information Technology (OIT) participates in HIT meetings held by the State Office of the Coordinator who received funding to move HIT forward in Maine. See below for more information. OIT, MaineCare, and the SSA participated the Design Management Care meetings hosted by MaineCare, to develop an integrated HRE system across the State.

Does your state have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

Is your state Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability behavioral health IT system reform, and meeting Federal IT data standards?

There was some funding for this, ARRA funding has been used for this, but it has to become self-sustaining system in the near future. OSA has participated in some of the meetings around Health Information Technology, but has not been at the table much around Health Information Exchange. It has been within the past few months that OSA's presence has been requested/invited to participate in these discussions.

Maine has a coordinating body responsible for the development of a statewide HIT strategy and the Department's Health and Human Services Commissioner is a member (SSA/SMHA are under this Commissioner). From the Governor's Office two entities were appointed with responsibility for expanding and coordinating Health Information Technology. The first is the Office of the State Coordinator for HIT (appointed through the "recovery act") which operates within the Governor's Office of Health Policy and Finance. The second is the Governor appointed "Health Information Technology Steering committee" made up of the following members: Director, Governor's Office of Health Policy & Finance; Commissioner of the Department of Health and Human Services; Commissioner of the Department of Professional and Financial Regulation; Superintendent of Insurance; Director of the Dirigo Health Agency; Director of health information exchange organization; and individuals representing or with expertise in hospital systems, health care providers, home health providers, FQHC's, health care quality, behavioral health provider, insurance industry, business, health care data information, University/college system, racial and ethnic minority communities, and a health law or health policy expert.

Maine is in the process of developing policies, standards, and technical protocols governing the HIT infrastructure. The SSA is engaged in conversations with the provider association and community to ensure they are developing the capacity to be able to fully participate in future reimbursement and data reporting systems. The provider association, with the support of the SSA is engaged in a technical

assistance project with NIATx (Network for Improving Addiction Treatment). This project was tailored to help providers ready themselves for the changes related to the healthcare reform.

The Medicaid System is going through a broad change in their IT system, and vendor. Now called Maine Integrated Health System (MIHS) Centers for Medicaid office is coming to certify the system September 2011. The first release of the system was in September 2010, testing and upgrades are continuing. They are expecting certification of the system in September 2011.

An optional strategy in the Prescription Monitoring Program (PMP) promotion project is to work with health care systems to incorporate PMP data into their EHR system.

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F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

OSA has a data platform that allows us to utilize data input into the system to gauge performance measures and outcomes. All contracted organizations have standard reporting requirements to ensure the same information is tracked across levels of care. Because of the work that OSA did with NIATx and the STAR-SI grant, all contracted outpatient and intensive outpatient providers hold incentivized contracts to increase performance. These measures have been in place for 3 years and OSA is looking at expansion of the measures to include basing contracted units targets/cost per unit in provider budgets, expansion into other levels of care, and in the RFP process for treatment services SFY 2014 utilizing historical data over the three years as a measure of successful applications being awarded.

Prevention outcomes are identified and tracked in the KIT Prevention system. Quarterly monitoring and technical assistance are provided by OSA prevention staff and adjustments made throughout the provision of services to meet local needs and to reach identified outcomes.

Quarterly performance measures in contracts are reviewed and reconciled by OSA staff, this includes Agreement Administrators, Data and Research, and Treatment Team members working with inputs and making decision based on data if TA is necessary. Additionally, provider organizations receive monthly reports of their performance and quarterly reconciliations related to incentive payments. This allows them to track their performance and reach out for TA as needed.

Monthly, providers receive automated reports to continuously monitor their progress and outcomes. Quarterly, treatment specialists and agreement administrators reconcile the data by reviewing the performance measures and assessing progress on outcomes and payment as a result. Annually, contracts are reviewed and assessed for continuation, increase, decrease, or termination based on performance. Stakeholder input is requested and provided ongoing. Inclusion of individuals in recovery is garnered via the client satisfaction survey and focus groups and surveys conducted by the Women's Addiction Services Council (WASC), treatment specialists, and the Maine Alliance for Addiction and Recovery MAAR).

All licensed providers in the State of Maine are required in regulation to report critical incidents in their organizations. There is a work to standardize and improve this process with the use of an electronic means of reporting (the current process requires faxing or scanning an original document because of the need for staff and supervisor signatures).

Once these are reported, treatment staff at OSA reaches out to the agency to investigate if there is further information needed, whether the staff at the agency needs support, and if information is missing and needed; provides technical assistance to increase accuracy of data collection. Complaints about individuals within an organization are addressed by the Board of Alcohol and Drug Counselors or the board that is appropriate to that individual professional licensure. Information on the disposition of the complaint investigation are public information and accessible to all. All complaints about agencies/provider organizations are referred to the Division of Licensing and Regulatory Services. OSA works in tandem with DLRS and is notified should there be a Corrective Action Plan for a provider organization. If at all possible, OSA works with individuals and provider organizations to resolve grievances within the organization and to use that information to inform and improve practice. If resolutions cannot be achieved at that level, then it is referred to the DLRS or respective board of licensure.

Maine's Department of Health and Human Services, Office of Quality Improvement is currently working with the Commissioner and her team on creating a quality improvement plan for the department and its Offices which will include the Office of Substance Abuse. We do not currently have a formal written CQI plan.

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G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Through the continued relationship-building process with the five tribal communities, the Office of Substance Abuse is beginning to learn the strengths, needs and gaps that exist within the tribal communities and within the Native American population. In preparation of this particular planning application, staff from the Office of Substance Abuse met as a group, with three of the five tribes in September to begin discussions around strengths, gaps and resources that currently exist or are needed within these communities. OSA sees this as a beginning of a process that will help strengthen our ability to provide effective services statewide. The notes from the meeting between OSA and the tribes were shared with all five of the tribal communities, and in turn OSA asked for feedback from all five (the three that were present at the meeting and from the two that were not). The five tribal communities here in Maine are currently included in a variety of planning processes in connection with the Office of Substance Abuse:

- The Office of Minority Health participates on a variety of workgroups/planning/ and advisory boards.
- OSA has served as a liaison on several occasions, connecting tribal members with other State Agency partners.
- In 2011, LD 121 was passed which created a 9th public health district referred to as the Tribal Public Health District. This legislation will ensure that there is tribal representation actively involved in Maine's public health infrastructure. Maine's public health infrastructure covers the entire state and it is through this infrastructure that prevention invests in to address environmental prevention needs statewide.
- At this time, OSA is in the process of contract negotiations to include the Tribal Public Health District in the work being done across the state with the Healthy Maine Partnerships addressing substance abuse environmental strategies.
- OSA is also in the process of contract negotiations with the Tribal Public Health District to partner in the Prescription Monitoring Program Promotion Project along with the other eight public health districts in the state.
- OSA was recently awarded the SPF State Prevention Enhancement Grant through SAMHSA which will aide in the creation of a five year OSA Prevention Strategic Plan. As a result of this award, the two Tribal Public Health Liaisons have signed a letter of commitment agreeing to serve on the OSA Prevention Advisory Board for the next year thereby bringing tribal representation to the table during this planning process.
- When invited, OSA attends the Tribal Health Director's meetings that occur quarterly and participates in any other meetings/trainings that the Tribal Health Director's recommend.
- In 2009, all five tribes began the process of developing and implementing a Tribal Health Needs Assessment that will provide each tribe with data specific to each individual tribal regarding various health disparities among community members. OSA committed \$10,000 to the Tribal Health Needs Assessment to include questions pertaining to substance abuse. At this time the tribes are in the process of analyzing and discussing internally the results of their data.

The Office of Substance Abuse foresees the following needs for future planning and partnerships:

- OSA will continue to work with the Tribal Health Directors and other partners on the development of data sharing language between the Maine Office of Substance Abuse and the five tribal communities.
 - Working with all five tribes to develop culturally appropriate materials for the tribes in addressing substance abuse across the continuum; and
 - Increasing awareness around which tribes have law enforcement agencies, schools and worksites on the reservation in order for OSA to create appropriate partnerships with these entities.
- OSA will continue to consult with each tribal community in the State to ensure their involvement in the needs assessment, planning, and service delivery process. This will be done by continuing communication whether face to face, email or telephone on a regular basis to continue developing the relationship between the tribes and the Office of Substance Abuse.

OSA, when invited will continue to spend time with each individual tribe, learning about the culture and the needs. This will be done through active listening, learning and recognizing discussions regarding what works and what does not work

within their culture. OSA will continue to provide personal emails as one way of communicating pertinent information versus putting everyone on listserv and will support face to face meetings with tribal members over other forms of communication.

OSA will continue to invite tribal members to conferences, events and trainings. OSA will extend invitations for tribal members to participate on various planning committees, workgroups and/or advisory boards. Input from the tribal communities will be sought on any issue that has the potential to impact the tribes.

Grant opportunities will be communicated with the tribes in a timely fashion and whatever is written by OSA about the tribes in all grant applications will be shared and communicated with the tribes for feedback and input again in a timely fashion. OSA will work with the tribes during the application process and when discussing potential work/programming that will impact tribal communities. In addition, letters of support will be requested in a timely manner and OSA staff will be available to work with the tribes throughout the process. OSA will be cognizant of its reporting requirements and consider what is essential to meet those requirements. OSA is available for technical assistance and support and will offer a reminder of that service on a regular basis regardless of whether or not any of the tribes hold a current contract with OSA.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

OSA will work with existing providers to assess their readiness for full implementation of the Affordable Care Act by utilizing the assessment tool NIATX offers. OSA will then work with providers to gather baseline data on their current ability to bill commercial insurance.

OSA will work with providers to increase their ability to diversify their revenue streams and attempt to rely less on the SAPTBG and Medicaid funding. This will allow us to demonstrate to SAMHSA the over/underutilization of SAPTBG funding and better allocate resources and contracted services to better performers.

The necessary resources for OSA to implement utilization strategies would include increased knowledge of the commercial insurance structures/policies/rules/regulations/credentialing by insurers in Maine.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Youth and Young Adults at risk for Substance Use/Abuse	30 day alcohol, marijuana, prescription drug use (NSDUH)	<input type="checkbox"/>
Youth and Young Adults at risk for Substance Use/Abuse	30 day alcohol use, binge drinking, marijuana, and psychotherapeutics (NSDUH)	<input type="checkbox"/>
Pregnant Women with Substance Use Disorders	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Pregnant Women with Substance Use Disorders	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Pregnant Women with Substance Use Disorders	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
IVDU'ers	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
IVDU'ers	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>

Footnotes:

The Maine Office of Substance Abuse has information within the Maine Department of Health and Human Services' Performance Metrics Dashboard, available on line at:

<http://gatewaytest.maine.gov/dhhs-apps/dashboard/Default.aspx>

The Dashboard initiative promotes information sharing for DHHS managers, staff, stakeholders and customers. It has information on the work DHHS performs for the people of the State. This tool will provide access to many different types of measurement – from community level health indicators that are tracked for public health improvement purposes, to measures of service provision and quality across all DHHS Offices.

The Dashboard is also designed to assist in understanding the work of DHHS, monitoring performance, communicating results, identifying areas for increased focus, and supporting a culture of accountability and responsibility throughout the Department. This tool will continue to change overtime as measures are refined and improved, and as strategy changes based on program continuous improvement plans.