

Wyoming

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/28/2017 5.20.14 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 809915796

Expiration Date 3/30/2018

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Wyoming Department of Health

Organizational Unit Behavioral Health Division

Mailing Address 6101 Yellowstone Rd. Ste 220

City Cheyenne

Zip Code 82002

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Chris

Last Name Newman

Agency Name Wyoming Department of Health

Mailing Address 6101 Yellowstone Rd. Ste 220

City Cheyenne

Zip Code 82002

Telephone 307-777-6494

Fax 307-777-5580

Email Address chris.newman@wyo.gov

State CMHS DUNS Number

Number 809915796

Expiration Date 3/30/2018

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Wyoming Department of Health

Organizational Unit Behavioral Health Division

Mailing Address 6101 Yellowstone Rd Ste 220

City Cheyenne

Zip Code 82002

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Chris

Last Name Newman

Agency Name Wyoming Department of Health

Mailing Address 6101 Yellowstone Rd

City cheyenne

Zip Code 82001

Telephone 307-777-7903

Fax (307) 777-5849

Email Address aurie.garcia@wyo.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date 8/28/2017 5:18:53 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Aurie

Last Name Garcia

Telephone 3077777903

Fax 3077775580

Email Address aurie.garcia@wyo.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas O. Forslund

Signature of CEO or Designee¹: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Office of the Governor

October 13, 2011

Ref.: F-2011-627

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

Community Mental Health and Substance Abuse Prevention and Treatment Plan and Report

This delegation of authority has been requested by the Wyoming Department of Health, Behavior Health Division, Mental Health and Substance Abuse Services Section. The purpose of this delegation is in regard to Community Mental Health and Substance Abuse Prevention and Treatment Plan and Report, pursuant to Section 529 of the Public Health Services Act, which requires that each funding agreement is made through certification from the Chief Executive Officer of a state.

I hereby delegate authority to Thomas O. Forslund, Director of the Wyoming Department of Health, to execute funding agreements and certification, provide assurances of compliance to the Secretary, and to perform similar acts relevant to the administration of the Community Mental Health and Substance Abuse Prevention and Treatment Plan and Report, until such time as this delegation of authority is rescinded in writing.

Best regards,


Matthew H. Mead
Governor

TOF/jg

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas O. Forslund

Signature of CEO or Designee¹:



Title: Director

Date Signed: 8/8/17

mm/dd/yyyy

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

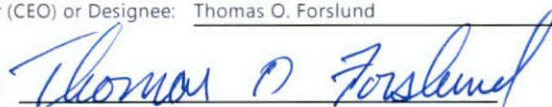
The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas O. Forslund

Signature of CEO or Designee¹:



Title: Director

Date Signed: 8/8/17

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas O. Forslund

Signature of CEO or Designee¹: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Office of the Governor

October 13, 2011

Ref.: F-2011-627

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

Community Mental Health and Substance Abuse Prevention and Treatment Plan and Report

This delegation of authority has been requested by the Wyoming Department of Health, Behavior Health Division, Mental Health and Substance Abuse Services Section. The purpose of this delegation is in regard to Community Mental Health and Substance Abuse Prevention and Treatment Plan and Report, pursuant to Section 529 of the Public Health Services Act, which requires that each funding agreement is made through certification from the Chief Executive Officer of a state.

I hereby delegate authority to Thomas O. Forslund, Director of the Wyoming Department of Health, to execute funding agreements and certification, provide assurances of compliance to the Secretary, and to perform similar acts relevant to the administration of the Community Mental Health and Substance Abuse Prevention and Treatment Plan and Report, until such time as this delegation of authority is rescinded in writing.

Best regards,


Matthew H. Mead
Governor

TOF/jg

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas O. Forslund

Signature of CEO or Designee¹:



Title: Director

Date Signed: 8/8/17

mm/dd/yyyy

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

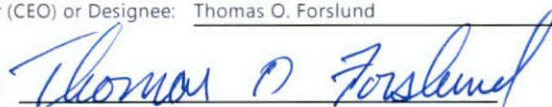
The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Thomas O. Forslund

Signature of CEO or Designee¹:



Title: Director

Date Signed: 8/8/17

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
[Standard Form LLL \(click here\)](#)

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Section B: Planning Step 1

As the least populous state in the nation, Wyoming contains 586,107 people in its 97,093 square miles (U.S. Census Bureau, 2015). Wyoming is a rural and frontier state. The two most populous towns are Cheyenne and Casper, which collectively account for about one-fifth of the state's population. The remaining residents live in small towns, rural communities, and frontier settings scattered throughout the state. Wyoming has six (6) persons per square mile, as compared with the national average of ninety-one (91) persons per square mile (U.S. Census Bureau, 2015).

The role of the Wyoming Department of Health (WDH), Behavioral Health Division (Division) is to develop and oversee the behavioral health service system in Wyoming. The Division includes four (4) major sections called Developmental Disabilities (DD), Mental Health and Substance Abuse (MHSA), Wyoming State Hospital, and Wyoming Life Resource Center. The MHSA section has various tasks such as quality management, contracts and monitoring, and substance use provider certification. The DD section oversees home and community based waiver services for people with developmental disabilities and acquired brain injuries. The Wyoming State Hospital provides acute psychiatric and forensic care to adults. The Wyoming Life Resource Center is a residential community with therapeutic and medical support services for adults. MHSA services in Wyoming are funded through the Division. The Division is the single state authority for the delivery of State funded mental health and substance abuse services.

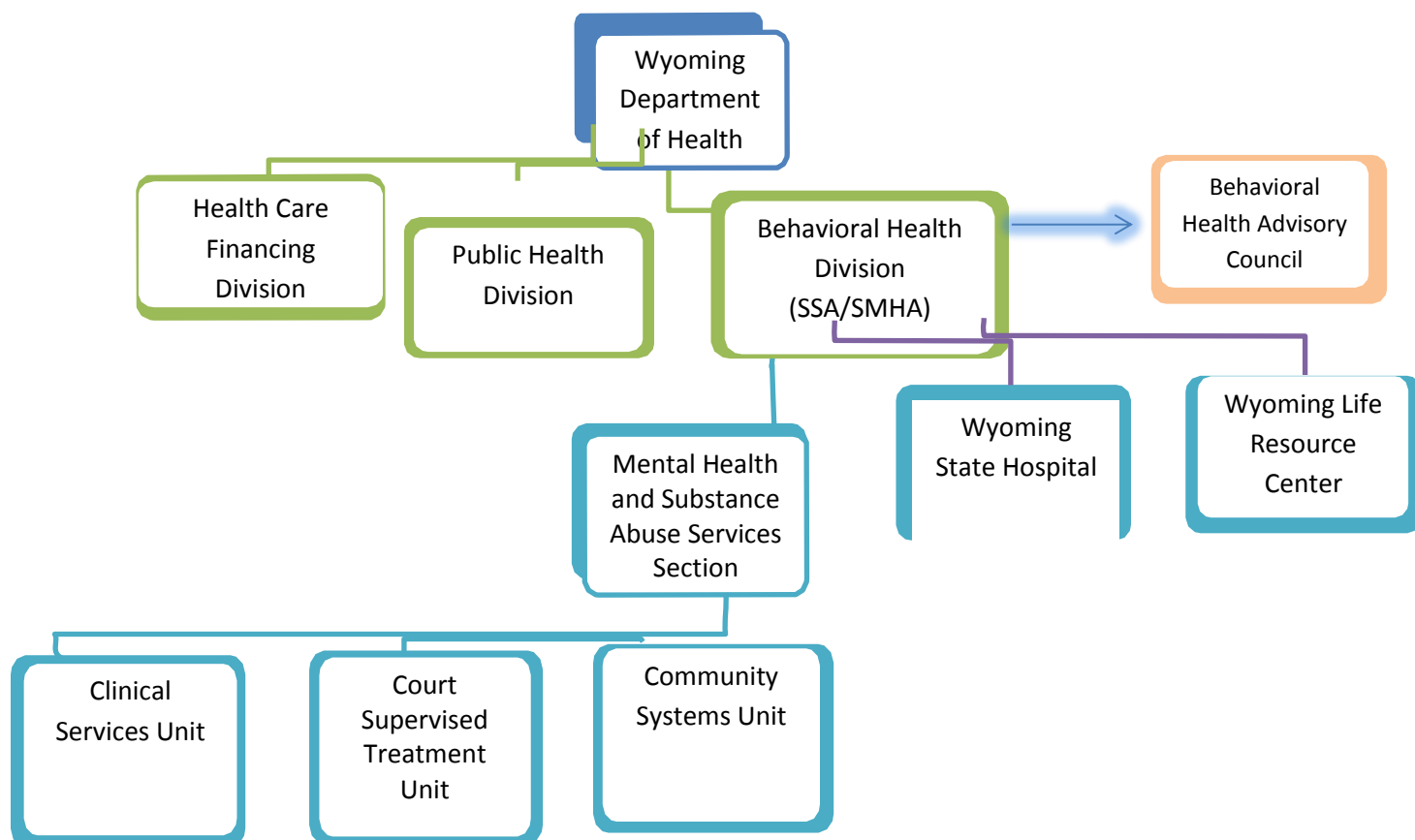
The Division contracts for outpatient and residential mental health and substance abuse services through contracts with eighteen (18) separate providers statewide. There are twelve (12) agencies that provide both mental health and substance abuse services, four (4) provide only substance abuse services, and two (2) provide mental health services only. Community Mental Health and Substance Abuse Centers (CMHCs) and (SACs) are obligated by contract to provide services and supports as indicated by individual treatment plans to all population groups even after State funding has been exhausted. The Drug Court program is also housed in the MHSA section and it includes adult, juvenile, tribal and DUI categories within twelve counties in Wyoming and nineteen state funded courts. Drug Court programs provide sentencing alternatives for the judicial system in cases stemming from substance abuse.

The WDH has five (5) divisions which include Administration and Support, Health Care Financing (Medicaid), Aging, Behavioral Health, and Public Health. The Public Health Division includes many units that are relevant to behavioral health such as Substance Abuse and Suicide Prevention, Communicable Diseases, and Tobacco Prevention and Control. The Division works closely with the Public Health Division as it relates to the block grant services. The Healthcare Financing Division oversees public healthcare programs such as Medicaid and Kid Care CHIP. The Aging Division provides care and services to older adults in Wyoming.

The Department of Family Services is currently being administered by the WDH. Analysis is underway to determine if the Department can be added to the WDH structure on a permanent basis. The Department of Family Services assists in the delivery of services and the welfare needs of individuals

with mental health and substance use disorders. The Wyoming Department of Corrections oversees the criminal justice and legal involvement of those in the criminal justice system who may also have mental health and substance use disorders.

Wyoming Behavioral Health System Organization



Substance Use Description of Service System

The MHSA section has recognized an increase in treatment demand for opioid and methamphetamine use both of which can be fatal. The Division's Wyoming Client Information System (WCIS) reports a fifty-four percent (54%) increase of clients with an opiate drug problem at admission. Likewise, methamphetamine as the first or second drug problem for clients in substance use treatment is on the

rise with a seventy-six (76%) increase over the past three (3) years. The data collection period spans from 2014 to 2017.

Specialized programs for intravenous drug users including individuals with opioid use disorders are in the implementation stage in Wyoming. The Division has received a federal Medication Assisted Treatment Prescription Drug Opioid Addiction (MAT-PDOA) grant to implement specialized programs with services such as behavioral therapy, medication, and recovery support services for individuals opioid use disorder. The federal State Targeted Response to Opioid Crisis (STR) grant was also awarded to the Division. These funds serve multiple purposes including addressing the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder. As a priority population, substance abuse providers are required by contract to provide treatment to this population according to the priority population hierarchy that is outlined in the provider contracts, i.e., pregnant Intravenous Drug User (IVDU) first, followed by pregnant women, then women with dependent children, and finally, IVDU.

The Division promotes the use of standardized screening and assessment tools and placement criteria to improve patient retention and treatment outcomes. The State of Wyoming Substance Abuse Rules and Regulations requires certified providers to utilize the American Medicine Patient Placement Criteria (ASAM) Criteria as well as the Addiction Severity Index (ASI).

The independent Peer Review occurs annually with both mental health and substance use providers. The Division randomly selects a percentage of providers to participate in the peer review. Selections are chosen based on provider performance, data, and relevant initiatives within the state. Providers visit other agencies and look at program areas such as clinical documentation, client satisfaction, and treatment. Providers are required to submit a report with their findings of the peer review to the Division by August of each year.

The Division collaborates with the Addiction Technology Transfer Center (ATTC) for all statewide provider trainings related to substance use. Prevention, treatment and recovery personnel within the state attended the 2016 SAMHSA National Block Grant Conference. In 2015, the Division hosted a Wyoming Medication Assisted Treatment conference and approximately one hundred (100) individuals attended including providers. In 2015, selected state staff also attended a training on government performance accountability with senior lecturer Dr. Bob Behn of Harvard University's John F. Kennedy School of Government.

According to State contract requirements, substance abuse services are to be prioritized to those persons who meet the special populations identified by SAMHSA Substance Abuse Prevention and Treatment (SAPT) grant requirements for admission preference. The SAPT block grant will be utilized to directly fund community substance use centers for outpatient and residential treatment services. A portion of the grant is utilized for women's outpatient services. The Public Health Division also utilizes a portion of the grant for community level prevention efforts. Although there is a low incidence of tuberculosis (TB) cases in Wyoming, the Public Health Division also funds treatment services for TB. Mental health and substance use providers are able to refer clients to the state TB program as needed.

The Division continues to ensure that treatment for women and women with dependent children comply with Wyoming State Treatment Standards and federal block grant requirements, e.g., primary medical care for women and dependent children, prenatal care, therapeutic child care, drug free housing, and education and employment training programs. The Division has implemented more specialized curriculum and evidence-based practicing programs for women with substance use issues.

Wyoming currently has several specific programs that meet federal requirements for priority populations. Not only are all funded providers required to meet the priority population guidelines, there are several programs that are specific to various populations. One main service area considered a strength for Wyoming is its Women's Treatment programs. The Division continues to provide technical assistance and federal funding to Pathfinder Women's Intensive Outpatient Program, Central Wyoming Counseling Center, Volunteers of America and the programs at Southwest Counseling Center for women and children's treatment. The Division also provides funding for substance abuse residential treatment for women and day treatment programs for women.

Mental Health Description of Service System

CMHC's and SAC's are private non-profit organizations with local volunteer governing boards. The citizen-board concept facilitates a natural attachment to the communities served. Citizen boards allow CMHC/SAC to be more responsive to local needs and provide advocacy and accountability at the local level. Local control is enhanced by the politically active Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC), which includes mental health and substance abuse center executive directors and board members.

The Wyoming State Hospital (WSH) is a part of the Division and works to coordinate continuity of care for those with serious mental illness (SMI). The WSH is located in the southwest corner of the state on 175 acres, encompassing 35 buildings and 475,000 square feet. The WSH provides inpatient care for the state's most severely mentally ill clients.

The foundation of Wyoming's mental health system is the philosophy that services should be available in all counties and/or regions, and that everyone, regardless of the severity of their need or ability to pay, should have access to these services. Historical funding has targeted adults with SMI and children with serious emotional disturbance (SED). While the majority of states have shifted public funding to only those persons who are the most severely ill, Wyoming has chosen to maintain the original focus of community mental health and substance abuse treatment by providing a range of services to broad populations throughout the state, with an access priority given to persons with SMI, SED and specified substance abuse populations.

The MHSA section has targeted several initiatives to increase access to the least restrictive environment for individuals who have been involuntarily hospitalized or who are at risk of hospitalization. Wyoming's involuntary hospitalization statute (Wyo. Stat. Ann. 25-10-101 - 128) (Title 25) allows individuals to be detained against their will if they are deemed to be a danger to self or others or have the inability to care for oneself because of mental illness. Engagement and cooperation between state staff, providers,

and other agencies strengthens partnerships by creating teams that work more closely together to implement initiatives and projects.

Adults with SMI are the primary clients served in the Title 25 system. MHSA assists the mental health system by focusing on clients with high needs through contracting strategies and conducting projects such as analyzing utilization and reducing the length of stay in mental health community housing options. Reducing the length of stay will assist in providing an increased number of available beds for individuals discharged from Title 25.

There are limited options for diversion from involuntary hospitalizations in areas of the state where the CMHC has limited or no involvement in Title 25 processes. To increase CMHC involvement in the Title 25 process, in April 2017, the Division executed ten contracts with agencies to begin implementing gatekeeper programs and processes. The gatekeeper role includes duties such as providing guidance to courts, healthcare providers, and other stakeholders on the detention and hospitalization process. Furthermore, gatekeepers are designed to monitor and facilitate effective client treatment prior to, during, and after any emergency detention or involuntary hospitalization. Gatekeepers also provide intensive case management to clients. A separate memorandum of understanding was created with CMHCs for purposes of outlining each center's role in the Title 25 process relevant to each county, and to formally "designate" the entity as the gatekeeper for the service area. Additional funding has also been made available to CMHCs for the development of diversionary services, such as gatekeeping and crisis stabilization. Through the gatekeeper grants and gatekeeper designations, providers can play a vital role in diverting individuals from the Title 25 system, including providing services under directed outpatient commitment. Directed outpatient commitment allows individuals to stay in the community under a required treatment plan as providers work together with other agencies to assist the individual in obtaining needed supports and services. The Division has received a federal Assisted Outpatient Treatment (AOT) grant to implement directed outpatient commitment in Wyoming. The AOT model is designed to work with families and courts, to allow individuals with SMI to obtain treatment while continuing to live in the community and their homes.

Emergency health service training also known as Crisis Intervention Team (CIT) is currently utilized to help provide law enforcement the tools to identify someone who is in a mental health crisis, to de-escalate a situation and possibly get the person to the right services instead of taking them to jail. This intensive training has gained increased recognition and support, as officers have experienced the positive benefits of early intervention with someone in crisis and the ability to immediately transfer the individual to mental health services for further care. Seven Wyoming communities have established CIT programs (Cheyenne, Laramie, Casper, Cody, Powell, Torrington, Gillette), two more are actively planning their CIT training program, and five locales have expressed high interest in starting a program. To support this growth, the Prevention Management Organization (PMO) has developed a CIT Quickstart Toolkit, which includes tools and sample documents from CIT programs and tools to assist communities in establishing their own CIT program without needing to reinvent forms, strategies, and protocols.

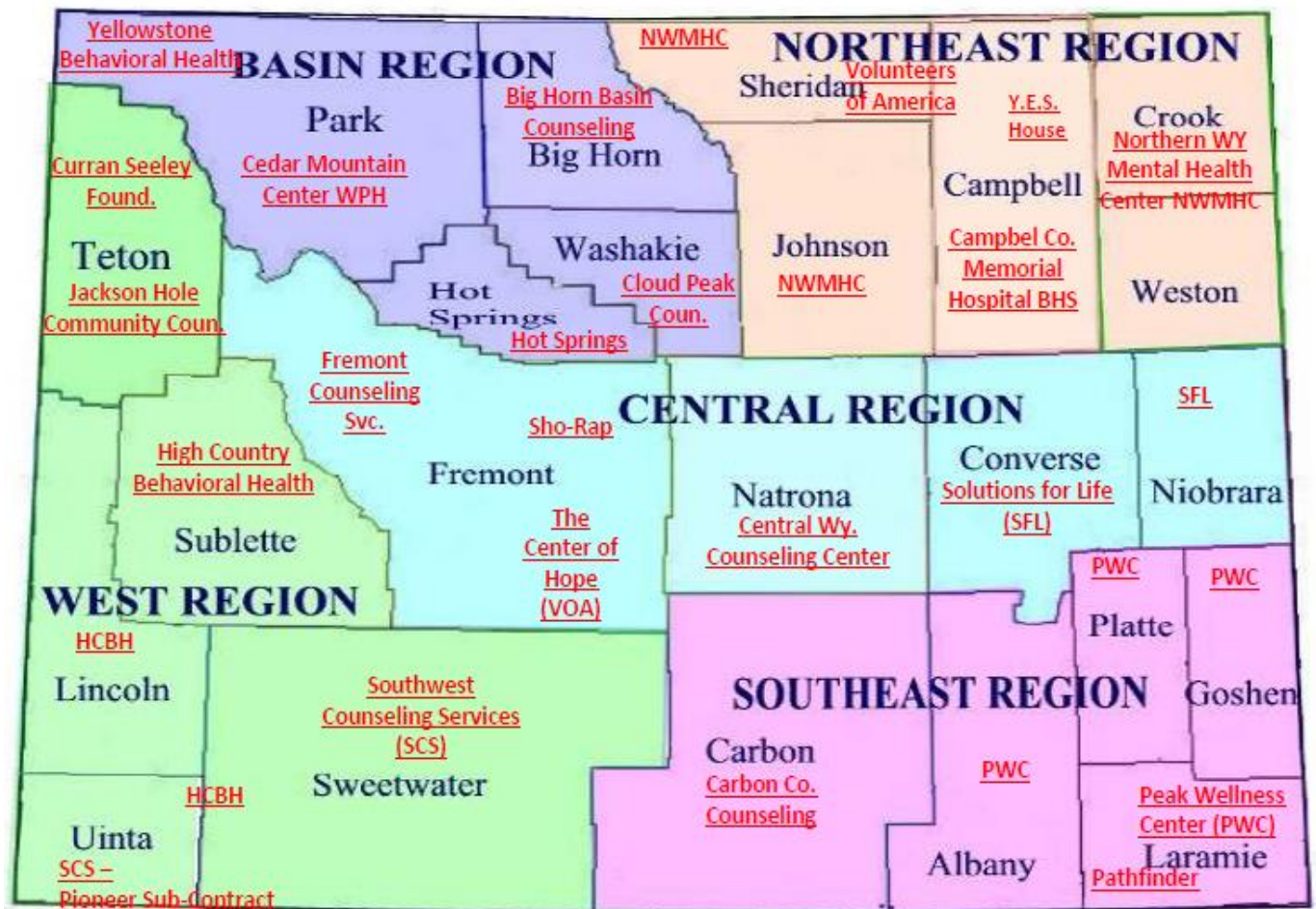
The Mental Health Block grant will be utilized to directly fund mental health providers for outpatient treatment services. Additional initiatives such as Housing First are also funded through the mental

health block grant. Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible and then providing voluntary supportive services as needed. The Division will utilize mental health block grant funds to continue a contract with a mental health Ombudsman through Wyoming Guardianship Corporation to advocate on behalf of individuals with mental health or substance use issues. First Episode Psychosis (FEP) services are also a priority and funded through the block grant to Southwest Counseling Services and Yellowstone Behavioral Health Center. Peak Wellness Center has chosen to utilize state funds to develop a FEP program in FY 18.

The following map portrays the comprehensive care regions in the state.

Comprehensive Care Regions

FY17 Wyoming Treatment Providers by Location (State Funded)



Wyoming is a rural/frontier state with limited access to specialized services for priority populations. The population density in Wyoming ranges from .92 persons per square mile to 6.1 persons per square mile. Travel in winter months is often restricted due to weather related conditions. Funding for specialized services was secured in 2007 under a regionalization framework, which allowed some services to be available in each region but not throughout all communities. Regional funding availability led the Division to require all CMHC/SACs to submit a regional service delivery plan in order to advance the goals of regionalization. These plans describe how regional services will be delivered to priority populations within Wyoming. Although much of the funding awarded in 2007 has since been lost due to budget reductions, the Division continues to support the regional concept of service delivery, specifically for high-cost services such as residential care.

In the application, Wyoming was asked to provide a summary of activities or programs that exist, are planned for, or that are needed to address three common areas: behavioral health primary care integration, recovery support, and individuals with co-occurring disorders.

Behavioral Health-Primary Care Integration

The Division, in collaboration with other departments and the Director's office within the WDH, completed phase one of a mental health and substance abuse modernization project in which system gaps, best practices, the Affordable Care Act, and maximizing Medicaid reimbursements were investigated and recommendations were made. Integrated care was one recommendation. The Division postponed the modernization project until further resources are available. Other efforts towards primary care integration include the Division's recent application for the SAMHSA grant Promoting Integration of Primary Care and Behavioral Health Care. If awarded, this grant will support providers in the implementation of the integration and collaboration in clinical practice between primary and behavioral healthcare. Additionally the grant would provide support in the improvement of integrated care models for primary and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness and individuals with substance use disorders.

Recovery Support

Wyoming has one Recovery Community Organization (RCO), Recover Wyoming, located in Cheyenne, Wyoming, and provides services only in the southeast region. RCOs are independent, non-profit entities governed and run by people in recovery which work to bridge the gap between treatment and long-term recovery. Recover Wyoming is closely connected to the national RCO network, allowing Wyoming to learn from the experience of others and gain access to tools and techniques proven effective in sustaining long-term recovery. Recover Wyoming is a community-based organization dedicated to advancing advocacy and involvement for persons in recovery from substance and alcohol addiction. Recover Wyoming conducts training for persons in recovery aiming to "equip people in recovery, their families, and friends to change how health, public safety, workplace, and criminal justice systems deal with alcohol and drug problems." The 12-24 Club, a 12-step and recovery organization, is located in Casper, Wyoming. 12-24 is recognized as the hub of recovery in Casper but it is not an RCO.

The Behavioral Health Division supports recovery coaches and peer specialists through four mechanisms:

- Peer specialist certification for persons with their own recovery history who have completed a 40-hour Division approved peer specialist training course or recovery coach course
- Funding from federal grants to support a Wyoming developed annual 40-hour peer specialist training course that is taught by experienced Wyoming peer specialists and recovery coaches
- Inclusion of optional peer support services in community mental health and substance use treatment contracts
- Inclusion of peer support services in federally funded special grant contracts

Wyoming recognizes recovery coaches as peer specialists. Both persons with mental health and substance use recovery may qualify as a peer specialist. Wyoming Medicaid includes peer support as a billable service.

From 2005-2016 the BHD provided small optional funding that supported the hiring of fourteen peer specialists in CMHC/SAC's in 2016. In 2017, those funds were removed but nine of these peer specialists were retained as a part of their agency's staff. Peer specialists are also employed through the substance use treatment contractor for the Wyoming Department of Corrections, at the Wyoming State Hospital, the veteran's hospitals, tribal and reservation providers, and private providers. The number of persons certified to provide peer support has increased over time:

Number of Certified Wyoming Peer Specialists				
2013	2014	2015	2016	2017
18	18	23	22	44

Thirty-five of the 44 persons with peer specialist certification in 2017 are employed in peer support roles.

Individuals and family members are frequently presented with opportunities to proactively engage and participate in treatment planning, shared decision-making, and the behavioral health services delivery system. The Consumer Survey project is a way to collect the overall satisfaction of consumers as it pertains to services. Consumers may also participate on agency level advisory boards. The Behavioral Health Advisory Council has consumer representation.

The Division wishes to continue to broaden current recovery initiatives, which provide care coordination and support for individuals with and family members of persons with SMI and SED, as well as those with substance use disorders.

The Division would like to see a broader use of peer specialist in Wyoming. Peer specialists may be utilized in many settings, including physical healthcare. We are working on a long term plan to sustain peer specialist credentialing which may lead to this broader use.

Individuals with Co-occurring Disorders

A majority of providers in Wyoming provide integrated mental health and substance abuse services. Integrated mental health and substance abuse services are delivered in both residential and outpatient programs. It is considered a standard of care to serve all of the needs of an individual, including those with co-occurring disorders.

Peak Wellness Center, located in southeast Wyoming, operated a residential service for persons with co-occurring disorders. Due to budget reductions, this program ended July 31, 2016. Central Wyoming

Counseling Center and Southwest Counseling Center provide co-occurring services through their outpatient and residential programming.

Children/Adolescents

Substance Use Services. Intensive outpatient substance use treatment programs for adolescents have been developed in some of the more populated areas of the state. Substance abuse residential services are available through Division funding at one location, in Casper, Wyoming through Central Wyoming Counseling Center. All SAC provide outpatient services for adolescents.

Mental Health Services. The mental health system of care for children and adolescents in Wyoming is the shared responsibility of several systems and the local providers with which they contract. CMHC provide a full range of mental health services for children/adolescents and their families. However, accessing these specialty services is more challenging in the more rural regions of the state.

The Wyoming Department of Education (WDE) oversees forty-eight (48) school districts, which are administered with considerable local autonomy. The WDE and local school districts are responsible for implementing PL 101-476 and its amendments. This law is the Education of the Handicapped Act Amendments of 1990 and also known as the Individuals with Disabilities Education Act (IDEA). This federal law amended and expanded The Education for All Handicapped Children Act of 1975. The act uses “people-first” language, replacing “handicapped children” with “individuals with disabilities” and the definition of those with disabilities was expanded. The law mandates special education services for children ages three to twenty-one and extends services for infants from birth to age two. School districts are responsible for providing or purchasing services to meet the needs of children with SED, including arranging for residential placement if needed. To be eligible for these services, a child’s serious emotional disturbance must adversely affect their educational performance. In some school districts, this is a fairly subjective decision and appropriate services for these children are difficult to access without intense advocacy.

The Children’s Mental Health Waiver (CMHW) is a Medicaid program for children with SED. The goal of the program is to keep youth with SED in their home communities with their parents/families involved in all aspects of their treatment, preventing custody relinquishment. The program works to strengthen families’ skills to support the physical, emotional, social, and educational needs of their children. The CMHW provides non-clinical mental health support services as a part of the overall children’s mental health system of care. The program seeks to reduce or prevent children from needing placement in psychiatric hospitals.

The CMHW serves children/youth ages 4-20. Participants must meet the definition of serious emotional disturbance, have a Diagnostic and Statistical Manual (DSM) Axis I or ICD diagnosis, meet at least one Medicaid criteria for inpatient psychiatric hospitalization, have a Child and Adolescent Service Intensity Instrument (CASII) composite score of 20-27 (ages 6-20) or Social/Emotional Assessment (ages 4-5). Participants must also be financially eligible for Medicaid based on their own resources and must receive services provided by certified waiver providers available in all counties in Wyoming. Through the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) grant program and statewide

implementation, Wyoming seeks to improve clinical, functional, and cost outcomes, access to home and community-based services, and youth and family resiliency of Medicaid children and youth with serious behavioral health challenges and historically high costs or at risk of high cost through implementation of a CME pilot in Wyoming. The care management entity for the CMHW is Magellan.

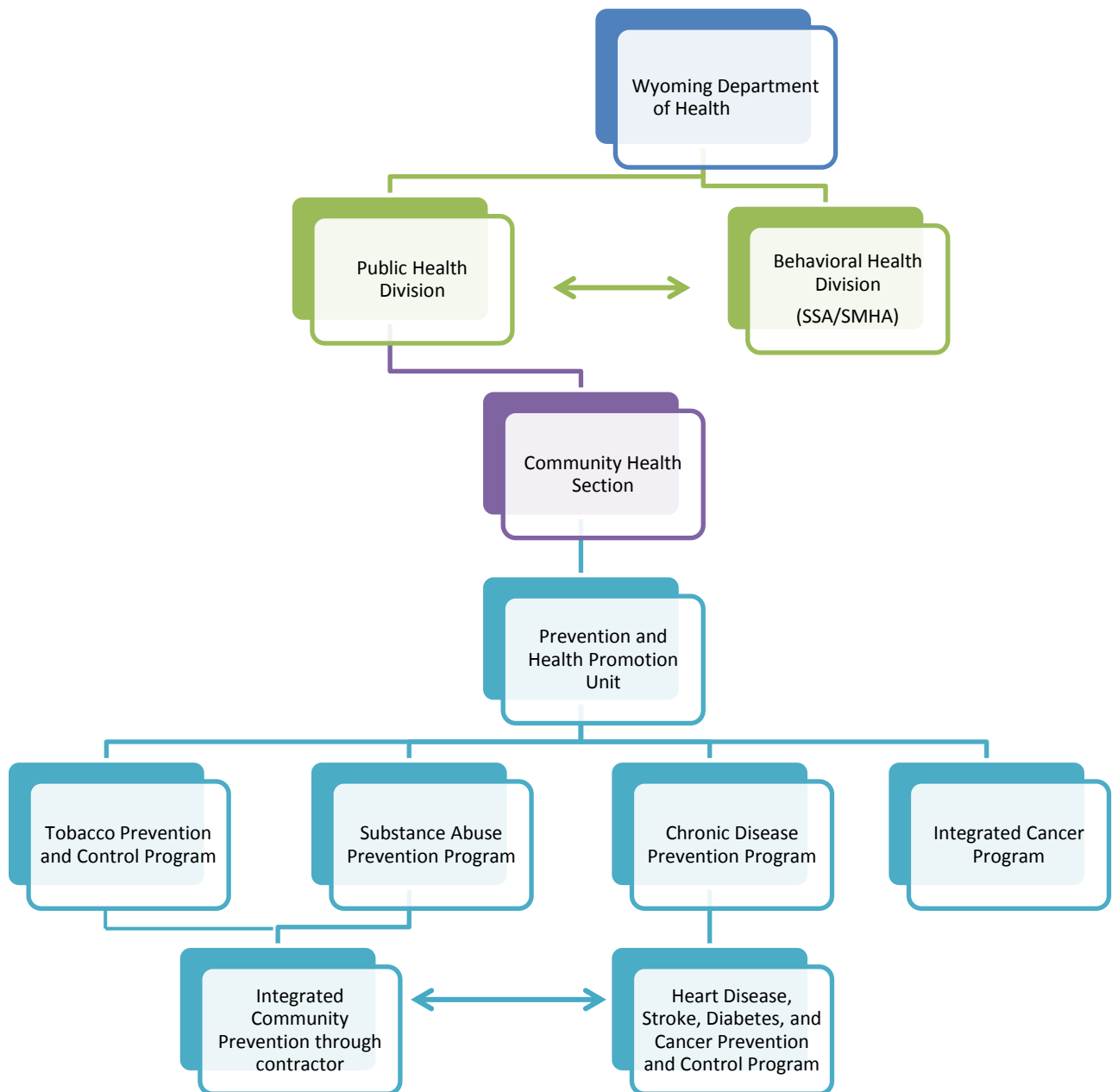
The Division has, in the past, invested extensive resources to train public and private community providers across the state in the implementation of the high fidelity wraparound model. Through contractual agreements the Division has fostered use of wraparound with children, youth, and their families in addition to those families served through the Children's Mental Health Waiver program. Successful implementation of a wraparound individual service plan will increase a child's opportunities for successful outcomes and enhance a family's potential for safely caring for their child through natural supports and community-based services. The Division piloted two programs in the state to demonstrate HFWA. The pilot programs were intended to advance the CMHW and CHIPRA efforts. Services provided through the CMHW include Family Care Coordination, Youth and Family Training and Support, and Respite care. The Division has made a concerted effort towards HFWA but with the budget restrictions, most of the projects were eliminated.

In FY2015, the Division retained Western Interstate Commission for Higher Education (WICHE) to facilitate a First Episode Psychosis training program for Wyoming provider agencies. These services were funded using the five percent (5%) set aside in the mental health block grant. Through WICHE, experts from Yale University and Early Assessment and Support Alliance (EASA) presented webcast trainings in February of 2016 covering the most important aspects of first episode psychosis and the day to day treatment of clients. The goal of this training was to increase provider agency's interest and competency in these areas. Overall, the outcome of the training was helpful to providers and the trainings are now posted on the Division's website at <https://health.wyo.gov/behavioralhealth/mhsa/initiatives/fep/>.

Prevention

Since 2012, the Substance Abuse Prevention Program and the Tobacco Prevention and Control Program have been a part of the Prevention and Health Promotion Unit in the Public Health Division, increasing collaboration with the Chronic Disease Prevention Program, as well as the Integrated Cancer Program. This has strengthened programs at the State and community level because of the shared populations and risk factors. The chart below depicts the current organization of primary prevention services in Wyoming.

Wyoming Substance Abuse Prevention Program Organization



The Substance Abuse Prevention Program works closely with the Tobacco Prevention and Control Program to provide prevention services. The integrated community prevention model includes funding to all 23 counties in Wyoming, including the Wind River Indian Reservation (WRIR), through the use of a single fiscal agent, currently the Prevention Management Organization of Wyoming (PMO). This model creates several strengths such as coordinated training efforts, an active network of prevention coalitions, strategic planning at the community level guided by the state, and long-standing relationships. The funding is a combination of the 20 percent set-aside from the SAPT, State General Funds, and State Tobacco Settlement Funds, which is contractually obligated to the single fiscal agent.

At both State and local levels, Wyoming employs a data-driven decision-making process. Both the Substance Abuse Prevention Program and the Tobacco Prevention and Control Program require all funded communities to implement the Strategic Prevention Framework (SPF) public health model in their prevention efforts, which obligates the community coalitions to engage in data-driven strategic planning. In the State Fiscal Year (SFY) 2013, each community was required to undertake a comprehensive alcohol, tobacco, and other drug (ATOD) needs assessment. In SFY 2016, communities updated their needs assessments and the associated strategic plans that identify best-practice environmental strategies and evidence-based programs designed to appropriately meet their identified needs. This approach allows the prevention efforts to have greater reach across the lifespan of Wyoming residents. Communities also have access to Insight Vision this year, a new strategy management system based on best practices that the PMO will be using to manage ATODS prevention activities in communities. The system imports data from sources to provide a centralized location where community prevention specialists can access and manage strategies.

All funded communities are required to participate in evaluation of prevention efforts at the community level. Both the Substance Abuse Prevention and Tobacco Prevention and Control Program evaluations are currently administered by the Wyoming Survey and Analysis Center (WYSAC). Though the evaluations are contractually separate, WYSAC researchers collaborate on the development and maintenance of the Prevention Evaluation and Reporting for Communities (PERC) data collection system. WYSAC works closely with the communities to collect and analyze data while also utilizing user-friendly reporting for both state and local prevention stakeholders. The Substance Abuse Prevention evaluation data is also reported annually to the SAMHSA with regards to the National Outcome Measures.

The Substance Abuse Prevention Program currently contracts with the PMO to provide technical assistance and training for all funded communities. The technical assistance team provides ongoing expert and tailored technical assistance to communities including strategic planning and implementation support, quality prevention workforce training and resources, and facilitation of community coalition meetings when requested. Additionally, the Substance Abuse Prevention Program works with the technical assistance contractor to identify strengths and weaknesses within the prevention infrastructure and is a key partner in prevention planning aimed at enhancing strengths and rectifying weaknesses.

The Substance Abuse Prevention Program strongly believes that Wyoming communities must strive for population-level change in order to create healthier community outcomes. By endeavoring for community-level change, disparate populations will be afforded the same health opportunities and benefits as the rest of the population. Wyoming's environmental approach creates healthier environments for people in recovery who are reentering the larger community. This approach is also flexible enough to target our disparate populations when necessary.

Diverse Racial, Ethnic and Sexual Gender Minorities

Wyoming's demographic and cultural characteristics are not highly diverse but recent data shows an increase in the minority population. According to the Wyoming Division of Economic Analysis, Hispanics in particular have diversified the state's population, increasing their numbers at a faster rate than the state overall¹. There are very few specialty programs that address minorities. The Division is partnered with the Office of Multi-cultural Health to address cultural health disparities. The Division has conversed with all provider agencies and reviewed their Commission on Accreditation for Rehabilitation Facilities (CARF) "Cultural Competency and Diversity Plan." The provider agencies address many areas of diversity including race, ethnicity, sexual orientation, gender, age, and socioeconomic backgrounds. Funded providers update and review their cultural competency plans for relevancy on an annual basis and provide diversity training to their staff as required in their CARF standards.

Fremont County Counseling is a contracted outpatient mental health and substance abuse treatment provider who serves clients in Fremont County including Native Americans. Sho-Rap Lodge provides housing and employment services, funded by the Division, on the Wind River Indian Reservation.

Challenges and Limitations

Some of the challenges and limitations of the state include continued economic downfall and budget restrictions. As a result Wyoming has reduced budgets for mental health and substance use services. In 2017, Wyoming qualified for a waiver of the maintenance of effort (MOE) requirement due to the fact that the state met criteria for revenue reductions and unemployment increases. The following program areas were impacted due to budget reductions: : children and adolescent services, Recovery Support Services, , residential treatment and housing, and the outreach and advocacy program for veterans. In addition, the state is experiencing prescriber and clinical staff shortages. The Division also works with the Behavioral Health Advisory Council on strategies to address these areas and limitations. Wyoming has applied for and received federal grants which augment current efforts and enable the Division to focus on specific areas of need such as opioids, and the implementation of directed outpatient commitment. In addition, Wyoming has worked collaboratively within each grant program to seek technical assistance when barriers arise.

1. Wyoming Division of Economic Analysis, (2015). *Wyoming's Minority Population Increases: 2015 Casper Star Tribune* by W. Liu Principal Economist, Casper, WY: Wyoming Division of Economic Analysis, Wyoming Department of Administration and Information.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Section B: Planning Step 2

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

Description of Behavioral Health Needs in Wyoming

The Division has taken several progressive steps to begin analyzing the behavioral health needs of the citizens of Wyoming to determine the unmet service need. Individuals who are defined as "most in need" of services are considered the first priority for Wyoming's public mental health system. The Division has identified a number of sources that help identify the needs and gaps of the populations relevant to determining priorities.

HealthStat

Development of the WDH performance management system, HealthStat, began in 2011 with the arrival of Director Thomas O. Forslund. Director Forslund had used a similar system as City Manager for the City of Casper and recognized the potential for change at the WDH. The process includes the identification, by program managers, of specific areas of challenge within their program areas and the identification of metrics through which improvements can be measured. Strategies are then developed to address the challenges, data is routinely monitored, regular updates are provided to Division staff, and an annual report is provided to the Director's office. HealthStat efforts have bolstered the WDH's reputation as a responsive agency committed to improvement and accountability, such that Governor Matt Mead adopted a similar system, WyoStat, in 2013 across all health and human service agencies in Wyoming. In the fall of 2014, Senior Leadership at the WDH met in a series of intensive workshops to analyze the overall performance of HealthStat and identified several areas for improvement. It was determined that the system had greatly enhanced reporting within the WDH, but lacked the follow-up needed for a true performance management system. In 2015, several changes under "HealthStat 2.0" are under way to increase follow-up and accountability, allowing the WDH to pursue its mission to promote, protect, and enhance the health of all Wyoming citizens, to the fullest extent and with the highest level of excellence that our stakeholders have come to expect.

The HealthStat process ultimately helps the Division identify deficit areas that need improvement. The Division has utilized HealthStat along with contract requirements, and monitoring through the Division's quality management process to enhance the accountability of the public behavioral health care system.

Statewide Data as of July 5, 2017

FY 17 reporting to date indicates 6,749 persons were served in substance abuse outpatient treatment. The average number of substance use service hours provided per client was 24.47. There were a total of 7,576 clients with SMI who received an average of 22.17 hours of mental health services. There were 2,205 children diagnosed as SED in FY 17. These children received an average of 22.63 hours per child. Many of these high need individuals benefit from additional services to help them achieve treatment and recovery goals. The mandate of Wyoming's publicly funded mental health and substance abuse system is to provide services to anyone who requests them. While this policy has a positive effect on the greater population, it can have significant impacts on the higher need populations in Wyoming. There is a limited amount of funding and ability to provide services and that must be spread among all who have no pay source. The Division is currently in the process of evaluating our system for gaps and deficiencies regarding services to persons with SMI and SED.

Although the data pulled at the time of this application submission was not yet final, the numbers have remained consistent over the years. The statewide penetration rate for substance abuse outpatient in FY 16 is 1.11% compared to FY 15 which was 1.07%. The statewide penetration rate for mental health outpatient services in FY 16 is 3.01% compared to FY 15 which was 2.91%.

The Division funds four Regional Crisis Stabilization programs and related facilities. These programs are intended to function as a process for which

individuals experiencing an acute mental health crisis may receive short term (1-30 days) intensive evaluation and treatment. Further, they provide support to stabilize the crisis in a safe environment as an intercept from higher levels of care such as hospitalization. These funds supported a total of 23 crisis beds.

Title 25, as described earlier in this application, provides a foundation and structure under which persons who are a danger to themselves or others or who are unable to satisfy their basic needs due to mental illness can be evaluated, detained and hospitalized if needed. The detention and hospitalization processes defined in the statute require the collaboration of several different community and state level organizations and services. Each county is empowered to determine the specific process, in keeping with the broad parameters outlined in statute. Given the state's disparate distribution of community resources the process varies by county.

The State's sole state hospital, located in Evanston is at times, at capacity. In the absence of bed availability at the state hospital, persons involuntarily hospitalized are served at local and regional hospitals until they can be transferred to the state hospital. Costs associated with care at local and regional hospitals have prompted the Wyoming Department of Health to examine Title 25 processes, including the role of CMHCs prior to and after a detention or hospitalization. This focus on community systems has prompted the Division to enter into a number of Title 25 initiatives mentioned earlier, including gatekeeping, implementation of directed outpatient commitment, and development of diversion services.

Transition age youth continue to be a group that is severely underserved in Wyoming.

This population is high need, as evidenced by the growing substance abuse population, escalating youth crime rates, increasing jail populations and a high suicide rate among youth ages 16-24. Age appropriate services are needed for youth to develop independent living skills, acquire jobs, and avoid substances. Another way to provide better service to this population is to work on developing peer supports within the CMHCs and SAC in Wyoming. This would help develop youth-oriented services to improve access and retain youth in services as they develop skills to become functional adults within the communities.

Employment has been recognized nationally and through the literature as being an important part of recovery and community integration for persons with serious mental illness. Approximately 60 – 70% of persons with SMI express a desire to work in competitive employment, however the employment rate of this population nationally remains at about 15%.¹ According to recent data for FY17 YTD (year-end data not yet available) 4307.25 hours of supported employment activity was reported for 7525 identified individuals as seriously mentally ill, and 141 hours for 8008 non-seriously mentally ill individuals. As of July 2017, 30.66% of clients with SMI who were unemployed at admission were employed upon discharge. The strategy is to utilize Supported Employment, evidence based practice, to increase the number of persons with SMI receiving treatment in CMHC/SACs who obtain competitive employment to 40%. It is expected that the substance abuse population will mirror this strategy.

The National Council for Behavioral Health, a longtime leader in the mental health and substance use treatment field has established that the sooner an individual can get into, and engage in treatment services the greater likelihood of a positive treatment outcome. Recent information indicates the national benchmark for wait time has now moved to 5 days or less. For FY17, the Division has required that individuals are given a treatment appointment in 7 days or less. The Wyoming statewide average wait time for FY 17 YTD for Substance Abuse is 2.74 days. For mental health the data indicates an average wait time of 2.18 days. The strategy taken by the BHD is for 100% of community mental health centers to show wait times for SMI/SED clients as less than or equal to the wait times of other populations. ¹Substance Abuse and Mental Health Services Administration, Supported Employment: The Evidence. DHHS Pub. No. SMA-0804364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009

Wyoming Consumer Survey

According to the 2016 Wyoming Consumer Survey results for mental health, 86% of clients are generally satisfied with the services they received in 2016 compared to 2015 which was 88.3%. For substance abuse, the consumer survey general satisfaction in 2016 was 82% compared to 2015 which was 82.2%. The Consumer Survey is used by

CMHCs and SACs to evaluate their programming and make qualitative changes in service provision.

Wyoming Survey and Analysis Center (WYSAC)

The Division is currently under contract with the University of Wyoming to prepare a treatment needs assessment for clients with opioid use disorder. This assessment is funded through the State Targeted Response to the Opioid Crisis grant. Key findings will be summarized and utilized in future funding and strategic planning decisions.

2015 Wyoming Behavioral Health Barometer

The 2015 Wyoming Behavioral Health Barometer report presents a set of substance use and mental health indicators as measured through data collection efforts sponsored by SAMHSA, including the National Survey on Drug Use and Health and the Uniform Reporting System. This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking change and trends over time. As new data become available, indicators highlighted in these reports will be updated to reflect the current state of the science and incorporate new measures of interest. The Behavioral Health Barometers will provide critical information to a variety of audiences in support of SAMHSA's mission of reducing the impact of substance abuse and mental illness on America's communities. Overall, the barometer places Wyoming close to the national averages. Some metrics such as binge alcohol use for youth are higher than the national percentage. To view the full 2015 Wyoming Behavioral Health Barometer report, the publication may be downloaded at: <https://www.samhsa.gov/data/browse-report-document-type?tab=46> (Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Wyoming, 2015. HHS Publication No. SMA-16-Baro-2015-WY. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.)

Prevention

Wyoming continually collects data to address unmet service needs and critical gaps within the current prevention system in order to reach individuals in need of primary substance abuse prevention. Data sources used to identify primary prevention needs include the National Survey on Drug Use and Health, the Behavioral Risk Factor Surveillance System, the Wyoming Prevention Needs Assessment, American Communities Survey, Adult Criminal Investigation, Fatal Accident Reporting System, Hospital Discharge Database, Pregnancy Risk Assessment Monitoring System, Synar, Uniform Crime Reports, United States Census, WASCOP-Compliance Checks, web-based Injury Statistics Query and Reporting System, Wyoming Vital Statistics, and Wyoming Department of Transportation Crash Reports.

The Statewide Epidemiological Outcomes Workgroup (SEOW) continues to be one of the most valuable aspects of the prevention system. The SEOW has a wide range of membership including representation from the WDH, the Wyoming Survey Analysis Center (who serves as the evaluator), the Prevention Management Organization of Wyoming, the Wyoming Pharmacy Board, Department of Corrections, Department of Family Services, Department of Transportation, and Wyoming community members. The WDH works with the SEOW to review consequences, consumption, and risk/protective factor data. The SEOW contributes to prevention planning by providing state and community profiles on alcohol, tobacco, and other drugs as well as mental health for state and community use and providing guidance to numerous data collection efforts around the state.

The SEOW focuses on six areas including alcohol, tobacco, illicit drug use, prescription drug abuse, mental health, and general related factors, with subcommittees focusing on a particular area when necessary. The SEOW guides many efforts to address data gaps. Currently, the group is addressing the prescription drug data gaps by completing a prescription drug data report that will detail what information currently exists and what information would be helpful moving forward.

Conclusion

By knowing how many individuals in Wyoming need public behavioral health services and how many are currently accessing these services, the Division can estimate how many people would benefit from services, and have not yet accessed them. The evidence from the various sources enables the state and its behavioral health stakeholders to create positive change within the statewide system of care, develop targeted plans for individuals to receive services, better advocate for the needs of high risk populations, improve access to services by underserved populations, analyze outcomes of services, and contract and finance services based on individual need, capacity, and performance. The data sources provide an excellent foundation for fulfilling the mission of responding to behavioral health needs of Wyoming

residents. Although the Division has not formally embarked on a formal needs assessment since 2011, the Division has identified some trends for unmet needs to include

1. Need for co-occurring youth services
2. Need for recovery support services
3. Need for behavioral health professionals including prescribers
4. Need for increased access to least restrictive levels of care

Wyoming is confident that despite recent budget reductions the state can address some the above mentioned gaps. The American Health Care Act of 2017 will impact the state's behavioral health system in a number of ways which are being considered by the Division in relation to the planning and utilization of the block grant funds. The Behavioral Health Advisory Council will play a critical role in the assistance of how to best dedicate the block grant funds to prevention, treatment, early intervention, and recovery efforts.

Co-occurring Youth Services

Wyoming will continue to collaborate with other state agencies, providers and the Behavioral Health Advisory Council to determine additional needs for this population. Wyoming will continue to purchase outpatient behavioral health services from community based agencies. Early intervention services for first episode psychosis will be replicated in counties around the state.

Recovery Support Services

Wyoming will continue to provide opportunities for training of peer specialists in the state. The Division will collaborate with Recovery Community Organizations in the state such as Recover Wyoming to support individuals in recovery.

Behavioral Health Workforce

Currently there is a gap in the behavioral health workforce in Wyoming. The Division has a partnership with the University of Wyoming Echo program which is planning to host a learning community that consists of experts and various technologies to assist in obtaining resources for the behavioral health field. This partnership could be utilized as a resource for new graduates looking to work in the field. However, more effort is needed to explore this gap.

Least Restrictive Levels of Care

The Division has made several efforts towards increasing access to the least restrictive levels of care. These activities include the implementation of Directed Outpatient Commitment, gatekeeping pilot program development, and various trainings and monitoring efforts.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
Wyoming has a history of successfully collecting and reporting required data and performance measures. The Division currently collects, analyzes, and reports client level and service level data submitted by provider agencies into the Wyoming Client Information System (WCIS). Wyoming community based grantees successfully fulfill the data reporting requirements of the block grant as part of local prevention, treatment, and recovery support efforts. The Division has also used the data to improve efforts and make decisions at the state and local level. This system collects client and service data at the program and provider levels only. Funded CMHCs/SAC's are required by contract to collect and report client demographic, clinical, and key indicator data. Some of the performance indicator data collected and reported include the following:
 - Treatment completion rate
 - GAF improvement rate
 - Unemployment improvement rate
 - Homelessness improvement rate
 - Treatment service wait time
 - Treatment length of stay
 - Mental health and/or substance use disorder diagnoses
 - Client demographics
 - Service type/duration/frequency data
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
The WCIS is not part of a larger data system and it is specific to substance abuse and mental health services.
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
Yes the state is able to collect and report measures at the individual client level.
4. If not, what changes will the state need to make to be able to collect and report on these measures?
Not applicable.
Please indicate areas of technical assistance needed related to this section.
There are no areas of technical assistance needed related to this section.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Primary Prevention: Adult Alcohol Use
Priority Type: SAP
Population(s): PP, Other (Rural)

Goal of the priority area:

Reduce harmful consequences associated with alcohol misuse among adults

Objective:

To decrease adult binge drinking rates to 14% or lower

Strategies to attain the objective:

- A. Continue to support community prevention planning and implementation activities, which utilize the Strategic Prevention Framework (SPF) model, under which each community is required to implement evidence-based/best-practice strategies to address tobacco use; underage drinking and adult binge drinking; and prescription, over-the-counter and illicit drug misuse/abuse (when there is a demonstrated need)
- B. Continue State Epidemiological Outcome Workgroup meetings aimed at informing prevention efforts
- C. Continue and enhance, where necessary, statewide efforts to reduce harmful consequences associated with alcohol misuse

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Adult binge drinking rates
Baseline Measurement: 16% (BRFSS 2015)
First-year target/outcome measurement: 15%
Second-year target/outcome measurement: 14%

Data Source:

Behavioral Risk Factor Surveillance System

Description of Data:

(The "Behavioral Risk Factor Surveillance System" BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984." (CDC, 2013b).

Data issues/caveats that affect outcome measures::

BRFSS: Reporting lag may occur due to the timeliness of when the data is published. For example, in reporting for State Fiscal Year 2012, the most current data available to use was 2010, even though the survey is conducted on an annual basis.

Priority #: 2
Priority Area: Primary Prevention: Alcohol Use among Youth
Priority Type: SAP
Population(s): PP, Other (Rural)

Goal of the priority area:

To reduce harmful consequences of alcohol misuse in youth

Objective:

To decrease youth 30-day use rates to less than 30% in high school and less than 8.5% in middle school.

Strategies to attain the objective:

- A. Continue to support community prevention planning and implementation activities, which utilize the Strategic Prevention Framework (SPF) model, under which each community is required to implement evidence-based/best-practice strategies to address tobacco use; underage drinking and adult binge drinking; and prescription, over-the-counter and illicit drug misuse/abuse (when there is a demonstrated need)
- B. Continue State Epidemiological Outcome Workgroup meetings aimed at informing prevention efforts
- C. Continue and enhance, where necessary, statewide efforts to reduce harmful consequences associated with alcohol misuse

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Youth 30-day alcohol use rates

Baseline Measurement: Middle School: 8.7%; High School: 31.6% (PNA 2016)

First-year target/outcome measurement: Middle School: 8%; High School: 30%

Second-year target/outcome measurement: Middle School: 7.5%; High School: 28.5%

Data Source:

Prevention Needs Assessment (PNA)

Description of Data:

The PNA is a Wyoming Department of Health (WDH) funded student survey of 6th, 8th, 10th, and 12th grade students in participating school districts. The PNA measures students' self-reported substance use and participation in problem behaviors, which includes the assessment of 21 intermediate attitudes, beliefs, and perceptions (risk and protective factors) that influence students' substance use and participation in problem behaviors.

Data issues/caveats that affect outcome measures::

The PNA has been experiencing lack of recruitment and participation of school districts. This impacts our ability to provide all communities with community-level data. Additionally, the PNA is administered in even-numbered years, which causes a reporting lag. The Youth Risk Behavior Surveillance System (YRBSS) was previously used to collect data in odd years to supplement data. Wyoming no longer has funded to participate in the YRBSS, we are expecting this will help increase the number of communities participating in the PNA.

Priority #: 3

Priority Area: Primary Prevention: Tobacco Use

Priority Type: SAP

Population(s): PP, Other (Rural)

Goal of the priority area:

To reduce harmful consequences of tobacco use in the State of Wyoming

Objective:

To decrease the percentage of Wyoming residents who use tobacco

Strategies to attain the objective:

- A. Continued to support community prevention planning and implementation activities, which utilize the Strategic Prevention (SPF) model, under which each community is required to implement evidence-based/best-practice strategies to address tobacco use; underage drinking and adult binge drinking; and prescription, over-the-counter and illicit drug misuse/abuse (when there is a demonstrated need). This includes providing communities with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other resources.
- B. Continue developing statewide tobacco prevention and control coalition.
- C. Continue statewide media efforts for tobacco cessation promotion.
- D. Continue to fund, and enhance where necessary, the Wyoming Quit Tobacco Program.
- E. Continue State Epidemiological Outcome Workgroup meetings aimed at informing prevention efforts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of students who smoked before the age of 11

Baseline Measurement: Middle School: 13.4%; High School: 34.1% (PNA 2016)

First-year target/outcome measurement: Middle School: 13%; High School: 32%

Second-year target/outcome measurement: Middle School: 12.5%; High School: 30%

Data Source:

Prevention Needs Assessment (PNA)

Description of Data:

The PNA is a Wyoming Department of Health (WDH) funded student survey of 6th, 8th, 10th, and 12th grade students in participating school districts. The PNA measures students' self-reported substance use and participation in problem behaviors, which includes the assessment of 21 intermediate attitudes, beliefs, and perceptions (risk and protective factors) that influence students' substance use and participation in problem behaviors.

Data issues/caveats that affect outcome measures::

The PNA has been experiencing lack of recruitment and participation of school districts. This impacts our ability to provide all communities with community-level data. Additionally, the PNA is administered in even-numbered years, which causes a reporting lag. The Youth Risk Behavior Surveillance System (YRBSS) was previously used to collect data in odd years to supplement data. Wyoming no longer has funded to participate in the YRBSS, we are expecting this will help increase the number of communities participating in the PNA.

Indicator #: 2

Indicator: Use of chewing tobacco before age 17

Baseline Measurement: Middle School: 4.6%; High School: 19.2% (PNA 2016)

First-year target/outcome measurement: Middle School: 4.3%; High School: 18.7% (PNA 2016)

Second-year target/outcome measurement: Middle School: 4%; High School: 18.2% (PNA 2016)

Data Source:

Prevention Needs Assessment

Description of Data:

The PNA is a Wyoming Department of Health (WDH) funded student survey of 6th, 8th, 10th, and 12th grade students in participating school districts. The PNA measures students' self-reported substance use and participation in problem behaviors, which includes the assessment of 21 intermediate attitudes, beliefs, and perceptions (risk and protective factors) that influence students' substance use and participation in problem behaviors.

Data issues/caveats that affect outcome measures::

The PNA has been experiencing lack of recruitment and participation of school districts. This impacts our ability to provide all communities with community-level data. Additionally, the PNA is administered in even-numbered years, which causes a reporting lag. The Youth Risk Behavior Surveillance System (YRBSS) was previously used to collect data in odd years to supplement data. Wyoming no longer has funded to participate in the YRBSS, we are expecting this will help increase the number of communities participating in the PNA.

Priority #: 4

Priority Area: Improve access to behavioral health treatment services for individuals in the most need.

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Increase number of individuals receiving Gatekeeper services.

Objective:

Collect baseline data through state fiscal year 17 and 18. Begin determination of targets for numbers of individuals served.

Strategies to attain the objective:

Increase the number of individuals receiving gatekeeping services by implementing gatekeeping pilot programs and gatekeeper designations throughout the state .

Provide targeted technical assistance to providers acting in gatekeeper roles.

Provide continued monitoring of gatekeepers through FY20 and transition gatekeeper services to new contracts to continue services.

Provide gatekeeper trainings to stakeholders throughout the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Collect Baseline Data through SFY 17

Baseline Measurement: To be determined in State Fiscal Year 18

First-year target/outcome measurement: To be determined in State Fiscal Year 18

Second-year target/outcome measurement: To be determined in State Fiscal Year 18

Data Source:

Gatekeeper client data will be collected from all gatekeeper pilot programs and reported into Wyoming Client Information System.

Description of Data:

Gatekeeper pilot providers will report data into the WCIS on an electronic service record. Providers will report numbers served and the amount of time spent delivering gatekeeping services per client.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 5

Priority Area: Improve access to behavioral health treatment services for individuals in the most need

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Decrease average length of stay in Mental Health Housing.

Objective:

Average length of stay in Mental Health Housing will decrease from 525 days in SFY 16 to 485 days in SFY 18.

Strategies to attain the objective:

Develop an inventory of mental health housing beds for each facility to identify how each type is utilized
Determine the appropriate length of stay for mental health housing programs including criteria for length of stay.
Execute provider contract requirements for each mental health housing program to reduce length of stay.

Priority #: 6

Priority Area: Work closely with provider agencies to initiate individualized outcomes for individuals with methamphetamine use disorder

Priority Type: SAT
Population(s): PWWDC, PWID

Goal of the priority area:

Increase treatment completion rate for clients with a primary, secondary, or tertiary methamphetamine drug problem

Objective:

Increase treatment completion rate for clients with a primary, secondary, or tertiary methamphetamine drug problem from 57.87% in SFY 16 to 63% in SFY 18.

Strategies to attain the objective:

Develop individual provider contract targets that focus on individuals with methamphetamine use disorder.
Provide technical assistance and training on evidence based practices for methamphetamine use disorder.
Identify providers who experience challenges in meeting contract metrics and strategize corrective action plans.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase treatment completion rate for clients with a primary, secondary, or tertiary methamphetamine drug problem
Baseline Measurement: 57.87%
First-year target/outcome measurement: FY 18: 63%
Second-year target/outcome measurement: FY19: 68%

Data Source:

Treatment completion rate data is collected from all Division funded MH and SA providers and reported in the Wyoming Client Information System. Through contract all providers are required to provide data including treatment completion to the Division.

Description of Data:

Individual's treatment completion status is noted in their discharge information through the Wyoming Client Information System.

Data issues/caveats that affect outcome measures::

None

Priority #: 7
Priority Area: Work closely with provider agencies to initiate individualized outcomes for individuals with opioid use disorder
Priority Type: SAT
Population(s): PWWDC, PWID

Goal of the priority area:

Increase treatment completion rate for clients with a primary, secondary, or tertiary opioid drug problem

Objective:

Increase treatment completion rate for clients with a primary, secondary, or tertiary methamphetamine drug problem from 54.94% in SFY 16 to 57.56% in SFY 18.

Strategies to attain the objective:

Expand MAT services by implementing these programs throughout the state, utilizing a combination of MAT grant funds, state funds, and STR grant funds.
Develop individual provider contract targets that focus on individuals with opioid use disorder.
Provide technical assistance and training on evidence based practices for opioids.
Facilitate provider discussions to showcase shared success stories and lessons learned from providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase treatment completion rate for clients with a primary, secondary, or tertiary opioid drug problem

Baseline Measurement: 54.94%

First-year target/outcome measurement: FY 18 : 57.56%

Second-year target/outcome measurement: FY19: 62.00%

Data Source:

Treatment completion rate data is collected from all Division funded MH and SA providers and reported in the Wyoming Client Information System. Through contract all providers are required to provide data including treatment completion to the Division.

Description of Data:

Individual's treatment completion status is noted in their discharge information through the Wyoming Client Information System.

Data issues/caveats that affect outcome measures::

None

Footnotes:

The Division has not yet finalized SFY 17 data outcomes. Therefore, the most recent final set of data is SFY 16.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$6,229,178		\$0	\$4,907,850	\$38,047,439	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$1,207,778		\$0	\$0	\$3,539,280	\$0	\$0
b. All Other	\$5,021,400		\$0	\$4,907,850	\$34,508,159	\$0	\$0
2. Primary Prevention	\$1,679,024		\$0	\$5,296,376	\$8,900,000	\$0	\$0
a. Substance Abuse Primary Prevention	\$1,679,024		\$0	\$5,296,376	\$8,900,000	\$0	\$0
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	\$67,160		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$419,756		\$0	\$0	\$4,437,082	\$0	\$0
10. SubTotal (1,2,3,4,9)	\$6,716,094	\$0	\$0	\$4,907,850	\$42,484,521	\$0	\$0
11. SubTotal (5,6,7,8)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12. Total	\$8,395,118	\$0	\$0	\$10,204,226	\$51,384,521	\$0	\$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Column A: State Fiscal Year 18 and 19 include 2 SABG awards. Each award is \$4,197,559 for a total of \$8,395,118 over two state fiscal years.

Column D Row 1b: Includes MAT-PDOA and STR federal grant funds for two state fiscal years combined

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		\$0	\$0	\$0	\$0	\$0	\$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary			\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$128,441	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$0	\$0	\$0
7. Other 24 Hour Care		\$0	\$0	\$2,600,000	\$26,490,472	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$1,091,749	\$0	\$0	\$0	\$0	\$0
9. Administration (Excluding Program and Provider Level)		\$64,220	\$0	\$0	\$1,624,301	\$0	\$0
10. SubTotal (1,2,3,4,9)	\$0	\$64,220	\$0	\$0	\$1,624,301	\$0	\$0
11. SubTotal (5,6,7,8)	\$0	\$1,220,190	\$0	\$2,600,000	\$26,490,472	\$0	\$0
12. Total	\$0	\$1,284,410	\$0	\$2,600,000	\$28,114,773	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Column B: State Fiscal Year 18 and 19 include 2 MHBG awards. Each award is \$642,205 for a total of \$1,284,410 to be expended over two state fiscal years.

Column D: Assisted Outpatient Treatment Grant and PATH Grant amount for FY 18-19

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	246	98
Women with Dependent Children	1479	1256
Individuals with a co-occurring M/SUD	155000	2572
Persons who inject drugs	1451	804
Persons experiencing homelessness	64	175
Pregnant Women	246	98
Women with Dependent Children	1479	1256
Individuals with a co-occurring M/SUD	155000	2572
Persons who inject drugs	1451	804
Persons experiencing homelessness	64	175

Please provide an explanation for any data cells for which the stats does not have a data source.

Treatment data is not final data. Not all FY17 is in the system as of date run (7/7/2017) Pregnant women – 2010 data march of dimes notes 4%. Entered 4%

of Wyoming's population of pregnant women as noted by CDC Women with children – 2010 paper from NIH on drug abuse noted 2%. Entered 2% of Wyoming census of household information Co-occurring - National survey on Drug Use and health 2014-2015 155,000. May be a duplicate count Inject drugs – NIH 2016 paper noted 0.30% Entered 1,451 0.30% of Wyoming's population of 13 years of age and older Homelessness – HUD 2016 CoC report 128. compiled by cn, validated by pt, lt fy180040

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$3,114,589
2 . Primary Substance Abuse Prevention	\$839,512
3 . Early Intervention Services for HIV*	\$0
4 . Tuberculosis Services	\$33,580
5 . Administration (SSA Level Only)	\$209,878
6. Total	\$4,197,559

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Amount of primary prevention funds planned for primary prevention programs \$759,512.

Amount of primary prevention funds planned for Prevention-SA resource development \$80,000.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy		IOM Target	FY 2018
			SA Block Grant Award
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Education	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$0
Total SABG Award*		\$4,197,559
Planned Primary Prevention Percentage		0.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity		FY 2018 SA Block Grant Award	
Universal Direct		\$113,750	
Universal Indirect		\$556,762	
Selective		\$86,750	
Indicated		\$2,250	
Column Total		\$759,512	
Total SABG Award*		\$4,197,559	
Planned Primary Prevention Percentage		18.09 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	b
Tobacco	e
Marijuana	e
Prescription Drugs	e
Cocaine	e
Heroin	e
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	e
Military Families	e
LGBT	e
American Indians/Alaska Natives	e
African American	e
Hispanic	e
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	b
Underserved Racial and Ethnic Minorities	e

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems				
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment				
4. Planning Council Activities (MHBG required, SABG optional)	\$15,000			
5. Quality Assurance and Improvement		\$5,000		
6. Research and Evaluation			\$80,000	
7. Training and Education				
8. Total	\$15,000	\$5,000	\$80,000	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102?123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52?77

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nlm.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- ³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- ³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
- ³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- ³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- ³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707
- ⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218
- ⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

- Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Although the state has not formally integrated mental health and primary health care including co-occurring mental and substance use disorders, the Division contracts with community mental health and substance use centers who are working towards becoming Federally Qualified Health Centers. There are also some community mental health and substance use centers with nursing and primary care services available on site. Each agency arranges for primary care and specialty services based on individual client need. The Division has applied for the Promoting Integration of Primary Care and Behavioral Health Care (PIPBHC) Grant. This grant is designed to support providers in the implementation of integration and collaboration in clinical practice between primary and behavioral healthcare. If awarded, the grant will provide support in the improvement of integrated care models for primary care and behavioral health care to improve overall wellness and physical health stats of adults with serious mental illness and invidiously with substance use disorders. Funding under this grant will be provided to community mental health centers in order to develop state capacity; provide primary care services for the populations of focus and improve health outcomes for individuals in need.
- Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The state does not currently provide services and supports towards integrated systems of care however, if the Division is awarded the PIPBHC federal grant opportunity these services can begin implementation.
- Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?

and Medicaid?

☒ Yes ☐ No

☒ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?
If a client is covered by Wyoming Medicaid, the Behavioral Health Program Manager and the Program Integrity Unit of the Healthcare Financing Division are responsible for monitoring access to M/SUD services.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? j n Yes j n No
6. Do the behavioral health providers screen and refer for:
- a) Prevention and wellness education j n Yes j n No
 - b) Health risks such as
 - i) heart disease j n Yes j n No
 - ii) hypertension j n Yes j n No
 - viii) high cholesterol j n Yes j n No
 - ix) diabetes j n Yes j n No
 - c) Recovery supports j n Yes j n No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? j n Yes j n No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? j n Yes j n No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
The Division is not aware of any issues related to the implementation and enforcement of parity provisions.
10. Does the state have any activities related to this section that you would like to highlight?
N/A
Please indicate areas of technical assistance needed related to this section
N/A

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵¹ http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
 - a) Race ☐ Yes ☐ No
 - b) Ethnicity ☐ Yes ☐ No
 - c) Gender ☐ Yes ☐ No
 - d) Sexual orientation ☐ Yes ☐ No
 - e) Gender identity ☐ Yes ☐ No
 - f) Age ☐ Yes ☐ No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ☐ Yes ☐ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ☐ Yes ☐ No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ☐ Yes ☐ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? ☐ Yes ☐ No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ☐ Yes ☐ No
7. Does the state have any activities related to this section that you would like to highlight?
No
Please indicate areas of technical assistance needed related to this section
None

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, ($V = Q ? C$)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? j n Yes j n No
2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) ☒ Leadership support, including investment of human and financial resources.
 - b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) ☒ Use of financial and non-financial incentives for providers or consumers.
 - d) ☐ Provider involvement in planning value-based purchasing.
 - e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
 - f) ☒ Quality measures focus on consumer outcomes rather than care processes.
 - g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) ☒ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ☒ Yes ☐ No
2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ☒ Yes ☐ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Two providers implementing First Episode Psychosis (FEP) treatment programs have utilized EBP's and are exploring how to best implement the EBP's in a rural and frontier state. Providers have experienced challenges with some of the models including how to tailor the models to fit the frontier nature of the state. Fidelity to an FEP model is difficult in a rural setting due to limited community resources and geography challenges. Also, family education and involvement in treatment is critical to helping clients develop resiliency to psychotic triggers and symptoms. When there is no family, natural supports are a viable alternative, but limited community and social resources in a rural environment can be an impediment to adequate treatment. Yellowstone Behavioral Health Center (YBHC) in Cody, WY has utilized the group home for one adult client to simulate a 'family type' environment. It has provided some, but limited benefit, mainly in structured social activities

A third provider, Peak Wellness Center, in the Southeast region of the state will be funded for an FEP program with state general funds in fiscal year 2018. This provider is in the exploration stage of implementing an FEP program.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
The state requires through a services contract for the funded FEP providers to utilize EBP's but does not specify which EBP's should be used. A webinar series was presented to Wyoming providers regarding the use of EBP's for early psychosis programs. The state encourages providers to engage with other state's FEP programs to explore different EBP's and learn the successes.
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ☒ Yes ☐ No

5. Does the state collect data specifically related to ESMI? ☒ Yes ☐ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☐ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Although Wyoming has explored utilizing Coordinated Specialty Care (CSC) model, the state has not prescribed a specific EBP for providers to use. The providers are required through a services contract to utilize an EBP and report quarterly. Currently, Southwest Counseling Services has been following the RAISE Model but is also interested in utilizing components of the On Track New York Model. In addition to these models, Southwest Counseling Services also utilizes Cognitive Behavioral Therapy, Psychiatric Medication Assessment and Management, wrap around services including peer specialist services and case management. Current evidenced based models such as PIER, Navigate and OnTrack have some components that are useful in a rural environment, but fidelity to each of these models is virtually impossible to achieve. YBHC would like to pull some of these components together and develop a model that is usable and tailored to the unique attributes of a frontier environment.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

The planned activities for 2018 and 2019 include that the project will fully implement services in 2018. In 2018 and 2019 providers will continue to provide outreach to various primary care, schools, and other agencies and disseminate outcome information. Priorities include engaging the Behavioral Health Advisory Council and promoting awareness and support towards potential growth and sustainability.

The proposed activities for FFY 2018 and FFY2019 are:

- a. Continue first episode psychosis treatment implementation with Yellowstone Behavioral Health Center and Southwest Counseling Services
- b. Identify any areas of technical assistance and training needs
- c. Provide state funding to Peak Wellness Center to replicate FEP treatment.
- d. Evaluate client outcomes for FEP treatment
- e. Present client outcomes to Behavioral Health Advisory Council
- f. Collect and report data and other information to Substance Abuse and Mental Health Services Administration and state stakeholders.
- g. Utilize outcome data to inform providers of FEP treatment should they choose to use state funds towards the services. Continue to link providers together to replicate programs. This includes provider peer reviews.
- h. Develop sustainability plan.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

At this time the Division utilizes the Wyoming Client Information System (WCIS) to collect data by age, gender, race, diagnostic category, and agency code. Therefore, the Division collects data to demonstrate the impact of the set aside for first episode psychosis. Further evaluation of data is needed and has been described in the future activities section above. Both FEP agencies are currently reporting into the WCIS. Providers have submitted four quarterly reports to the Division. These reports list critical details such as the number of outreach activities conducted over the quarter.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The diagnostic categories in the programs are:

- a. Schizophrenia
- b. Bi-Polar Disorder
- c. Schizoaffective Disorder
- d. Borderline Personality Disorder
- e. Schizoaffective Disorder Bipolar Type, and other Unspecified Stimulant Use Disorder, and Cannabis Use Disorder, and Alcohol Use Disorder
- f. Major Depressive Disorder, Severe with Psychotic Features
- g. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, and Generalized Anxiety Disorder and Nightmare Disorder
- h. Major Depressive Disorder with Mood Congruent Psychotic Features
- i. Bipolar Disorder with Psychotic Features, and Gender Identity Dysphoria, ADHD combined type
- j. Major Depressive Disorder with Anxious Distress and Mood Congruent Psychotic features.

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

Training specific to psychosis has been requested by the FEP providers and team members. The clinicians on the teams are licensed family and child therapists and have significant training and experience in engaging families and providing systemic family treatment. However, they would benefit from training and education specific to the pathology of psychosis, as well as any unique impact of psychosis on family systems. This training was anticipated but not received at the recent PIER workshop in Utah.

2. It continues to be difficult, if not impossible, to meet fidelity of current evidenced based practices for FEP, in a rural frontier environment. Multifamily groups are challenging to provide when often there are not enough families in treatment at one time, or families are dispersed around the county and transportation and/or family schedules make it difficult to bring families together. Further, clients of adult age may not have families in the area, or refuse to include family in treatment. The inclusion of natural supports can be a beneficial substitute in these cases, but can also be challenging in environments with limited community resources. Provider agencies believe it is necessary to be proactive in developing an effective FEP model for rural environments that pull effective components from such models as PIER, Navigate, and OnTrack, and modifying them as necessary to support effective FEP treatment in frontier communities. Assistance from SAMHSA would be appreciated to allow Wyoming this upcoming year to pursue a modification of FEP treatment components into a more effective rural program.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? j n Yes j n No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
The Division contracts with provider agencies who are responsible for engaging consumers through surveys, consumer driven boards, and other methods of care coordination including primary care. The state can provide ongoing technical assistance to providers who may need assistance with health care decisions.
4. Describe the person-centered planning process in your state.
The process for person centered planning at the state level includes contracting with nationally accredited provider agencies who can involve the client in the planning of services and care. Provider agencies are required through national accreditation to provide person centered services. Wyoming Community Mental Health and Substance Abuse Rules and Regulations also require that clients have an individualized treatment plan which means an action plan based on initial and ongoing assessment information identifying the client's needs, strategy for providing services to meet those needs, measurable treatment goals and objectives and criteria for discharge. Initial treatment plans are developed with the client. The treatment planning process can involve other collateral entities working with the client. In most agencies a clinical team can help integrate the assessment with the treatment plan while also involving the family and any necessary medical liaisons.
Does the state have any activities related to this section that you would like to highlight?
No
Please indicate areas of technical assistance needed related to this section.
None

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ☐ Yes ☒ No
2. Are there any concretely planned initiatives in our state specific to self-direction? ☐ Yes ☒ No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed to this section.

None

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒ Yes ☐ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ☐ Yes ☒ No

Does the state have any activities related to this section that you would like to highlight?

The rigorous contract performance management process begins with the separation of duties to maximize validity and accountability. The Knowledge-Management, Analysis, and Technology (KMAT) unit maintains the Wyoming Client Information System (WCIS) which collects and records the data directly from the providers. This system contains numerous data validation sequences to ensure the input of high quality and reliable data. Next, the Quality Program Manager places a data request to KMAT with various parameters such as timelines, performance indicators, and number of clients. KMAT will then generate a data report which includes a peer validation process to ensure the accuracy of the report. These reports are then used by the Division to analyze contract performance and set future target goals. Underperforming providers will go through a progressive process of improvement planning and corrective action. These reports are reviewed on a monthly basis to identify problematic trends as soon as possible. This comprehensive contract management process allows providers the opportunity to compare their outcomes with other providers across the state. In turn, providers are able to network with high performers and learn new strategies. Provider on site visits are typically planned every other year unless there is an investigation or complaint prompting the Division's response. The purpose of these visits are to monitor block grant and contract requirements.

The Division's Substance Use Disorder Certification Program is responsible for overseeing state certification of substance use providers. State certification means the Division formally recognizes the provider's substance use disorder program as having met the requirements of the current Wyoming rules and regulations that pertain to specific substance abuse prevention, early intervention, recovery support services and treatment services provided. Individual providers are required to be licensed by the Wyoming Mental Health Professions Licensing Board. In addition to state certification, all state funded providers are required to

hold a national accreditation.

Please indicate areas of technical assistance needed to this section

None

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. 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 that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, 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 be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The Wyoming Department of Health (WDH) meets quarterly with the Tribal Leadership Advisory Council to discuss health care in Wyoming. Various individuals participate from different entities including WDH Behavioral Health Division, WDH Public Health Division, WDH Healthcare Financing, WDH Aging Division, and Vital Statistics.

2. What specific concerns were raised during the consultation session(s) noted above?

According to the most recent minutes from the meeting, there are no major concerns however, there are questions regarding service availability within the state and those questions are answered by each responsible state agency representative. The meetings focus on providing updates regarding funding for services and health care program availability. For example, the WDH Rural Health office presented an update recently on the American Indian Commercial Tobacco Program. Questions regarding alcohol prevention services contracts with WDH and the fetal alcohol syndrome program were also addressed.

Does the state have any activities related to this section that you would like to highlight?

Governor Mead places a high priority on establishing and maintaining a positive relationship with both the Northern Arapaho and Eastern Shoshone tribes. The Governor meets with the tribes two to four times per year, both in Cheyenne and on the reservation. In addition, both tribes have a Tribal Liaison who serves as a link to the Governor's Office. These liaisons advise the Governor's Office of matters on concern or accomplishments and also provide feedback from the Governor's Office to the tribes.

Please indicate areas of technical assistance needed to this section

None

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ☒ Yes ☐ No
 - ☒ Data on consequences of substance using behaviors
 - ☒ Substance-using behaviors
 - ☒ Intervening variables (including risk and protective factors)
 - ☐ Others (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - ☐ Children (under age 12)
 - ☒ Youth (ages 12-17)
 - ☒ Young adults/college age (ages 18-26)
 - ☒ Adults (ages 27-54)
 - ☒ Older adults (age 55 and above)
 - ☒ Cultural/ethnic minorities
 - ☐ Sexual/gender minorities
 - ☒ Rural communities
 - ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

☒ Archival indicators (Please list)

Archival indicators include but are not limited to hospital discharge data and arrest data.

☒ National survey on Drug Use and Health (NSDUH)

☒ Behavioral Risk Factor Surveillance System (BRFSS)

☐ Youth Risk Behavioral Surveillance System (YRBS)

☐ Monitoring the Future

☐ Communities that Care

☒ State - developed survey instrument

☐ Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?

☒ Yes ☐ No

If yes, (please explain)

Allocation of resources and Substance Abuse and Treatment Block Grant primary prevention fund is based on annual community epidemiological profiles created by the SEOW and community-level comprehensive alcohol, tobacco, and other drug (ATOD) needs assessments. As Wyoming's population density is sparse with very few populous areas, funding all twenty three (23) counties and the Wind River Indian Reservation for prevention services is a necessity. Funding levels are determined on a needs-based funding model that considers rates of abuse for targeted populations, size of target populations, and other disparities. Wyoming utilizes this calculation to rank communities of highest need and apply appropriate levels of funding to each community. This year, the results from a coalition and community capacity assessment will also be used as part of the decision-making process for resource allocation.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ☒ Yes ☐ No

If yes, please describe

Wyoming requires all funded prevention specialists to be trained in Substance Abuse Prevention Skills Training (SAPST) within six months of employment. Additionally the substance abuse prevention unit established an International Certification and Reciprocity Consortium (IC&RC) Prevention Specialist credential in Wyoming in the beginning of 2017. This credential helps establish standardized expectations and qualifications for the prevention workforce and other interested individuals who oversee alcohol, tobacco, other drug (ATOD) within the state. We encourage all prevention professionals who are or will be funded by the Wyoming Department of Health to be certified. This allows the prevention certification to remain voluntary, but emphasizes the importance that Wyoming places on the need for highly qualified professionals providing the service.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ☒ Yes ☐ No

If yes, please describe mechanism used

WDH provides state and national level support through consultation and resources to address organizational and community level technical assistance. Technical assistance through WDH is targeted and customized by professionals with subject matter expertise for the purpose of developing or strengthening process, knowledge application, or implementation of services. Strategies include development and dissemination of tools and resources to help identify and implement prevention programs and strategies using the best available evidence; identification and promotion of effective strategies in rural settings; provisions of proactive technical assistance to prevention staff to support coordination, implementation, dissemination, and evaluation of prevention efforts; and enhancement of capacity.

WDH also contracts with a technical assistance (TA) provider is responsible for providing the resources and training necessary to develop, implement, and improve strategies and programs. In coordination with WDH, the TA provider develops and implements a training plan for every community prevention specialist (CPS) on identified workforce needs to reinforce and supplement core competencies for ATOD prevention.

The TA provider, in partnership with WDH, provides prevention training opportunities. At least one Substance Abuse Prevention Skills Training (SAPST) is held annually. Once per quarter the TA provider hosts a multi-party trainings that are structured to address disparate populations, regional, geographical concerns, specific substance abuse prevention strategies, or integration of services. Opportunities for sustainability or capacity building within communities is enhanced through the development of training curriculums, partnerships with prevention stakeholders to provide education opportunities, and coordination or

trainings or train the trainers, such as TiPS.

The TA provider also provides expert TA to both CPSs and coalitions to strengthen and enhance grassroots support, community engagement, and capacity building. This include proactively providing TA to communities in policy development, policy changes, and the strategic use of media. The TA provider also works with coalitions to use evidence-based practices and objectives within a comprehensive, multi-year strategic plan. The TA provider supports the community prevention workforce with building capacity, engaging the community, and developing media.

The TA provider also works to support the community prevention workforce in the advancement of strategy management by implementation of the strategic performance management system, InsightVision, at the local level to streamline needs assessment data, manage and monitor strategy execution, build assets and capacity to address prevention, and align partners around objectives and actions. InsightVision is used to incorporate key strategic prevention framework (SPF) model components. The TA provider works with the community prevention workforce to make local level adjustments and modifications to strategy maps and scorecards as needed.

TA occurs on an as-needed basis with contact frequency ranging from daily to weekly. TA also occurs through peer-to-peer interaction. Each CPS is paired with a mentor partner. These partnership are specifically designed so that each employee is paired with someone who has skills or knowledge in an area they are deficient. This allows county programs to share concerns, struggles, questions and successes. If further support is sought, a listserv designed specifically for programmatic information dissemination can be utilized to discuss issues on a wider scale with all prevention personnel in Wyoming.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No

If yes, please describe mechanism used

Capacity assessments were conducting in Wyoming, establishing a 2016 baseline of existing capacity for all 23 counties in Wyoming. The capacity assessments identified key ingredients including prevention workforce, resources, effective community, community engagement, active leadership, readiness for change, and sustainability. A rubric was then created to describe these key ingredients and rank the capacity of the community from 1 to 5. Ranking was based on interviews with the Community Prevention Specialists (CPSs), community focus groups, and results from a coalition member survey to determine readiness. Overall, Wyoming communities ranked some to most capacity in most areas. An assessment will be conducted again in 2020.

Based on individual capacity assessments, all communities have developed capacity-building strategic plans. Six communities were identified as in need for extensive Technical Assistance (TA), although all communities will be provided with TA to ensure plans include a wide range of capacity-building strategies (such as trainings, case studies, field visits, etc.) ensuring the most effective and cost-efficient approach. Evaluation will be utilized to determine success of strategies by an independent evaluator. The SEOW and WDH will make recommendations for continued and long-term capacity building with provided technical assistance to include capacity building within upcoming educational and community mobilization strategic plans.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

- Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? jn Yes jn No
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
- Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) jn Yes jn No jn N/A
- Does your state's prevention strategic plan include the following components? (check all that apply):
 - ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - ☐ Timelines
 - ☐ Roles and responsibilities
 - ☐ Process indicators
 - ☐ Outcome indicators
 - ☐ Cultural competence component
 - ☐ Sustainability component
 - ☐ Other (please list):
 - ☐ Not applicable/no prevention strategic plan
- Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? jn Yes jn No
- Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? jn Yes jn No
If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Wyoming's substance abuse treatment and prevention rules require the use of evidence-based substance abuse prevention practices and programs. The Evidence-Based Workgroup is a subcommittee of the SEOW. The group ensures that funded communities are utilizing Evidence Based Practices (EBPs) in their prevention work. This group includes WDH program managers and epidemiologists, senior leadership from the community services provider, currently the PMO, and researchers from WYSAC, our

current outside evaluators for prevention efforts administered by WDH and implemented by the PMO. This group meets on an as-needed basis to discuss ongoing progress and challenges in the design and implementation of EBPs in Wyoming communities.

The determination of which programs, policies, and strategies are evidence based are guided by the National Registry of Evidence-based Programs and Practices (NREPP) and the community guide. Wyoming also uses the Catalog of Environmental Prevention Strategies, which was developed by the Wyoming Survey & Analysis Center at the University of Wyoming, under contract to the Public Health Division of the Wyoming Department of Health. This document is an inventory of environmental substance abuse prevention strategies targeting alcohol, tobacco, and other drugs assessed to determine the evidence base and effectiveness of the evidence for each identified strategy.

In Wyoming, substance abuse prevention and tobacco prevention are fully integrated at both state and local levels. At the state level, the WDH, Substance Abuse Prevention Program (SAPP) Manager oversees the management of alcohol/drug abuse and misuse and ensures efforts are complementary and coordinated. Tobacco Prevention and Control Program (TCP) works closely with the SAPP through shared data, resources, and other means. Within community efforts, each Wyoming county has at least one Community Prevention Specialist (CPS) whose primary responsibility is facilitating local coalitions in identifying programs, practices, and policy change in drinking, prescription drug misuse, and tobacco prevention within a single umbrella. Local coalitions work with the CPS to develop a strategic plan that outlines goals and strategies to achieve those goals. These strategic plans are reviewed by SAPP and TCP to ensure that all strategies are evidence-based.

Does the state have any activities related to this section that you would like to highlight?

We are currently working on updating and improving the state strategic plan to reduce harmful consequences associated with alcohol misuse. We are also working on a state strategic plan to address opioid misuse/abuse. Each county prepares a strategic plan based on the needs assessment conducted in their county. WDH plays a vital role in approving strategic plans, ensuring the use of evidence-based/best practice strategies.

Please indicate areas of technical assistance needed related to this section.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- a) ☐ SSA staff directly implements primary prevention programs and strategies.
- b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- d) ☐ The SSA funds regional entities that provide training and technical assistance.
- e) ☐ The SSA funds regional entities to provide prevention services.
- f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- g) ☐ The SSA funds community coalitions to provide prevention services.
- h) ☐ The SSA funds individual programs that are not part of a larger community effort.
- i) ☐ The SSA directly funds other state agency prevention programs.
- j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

All 23 counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Information dissemination strategies include:

- Social media campaigns that target underage drinking by targeting youth or parents
- Radio Announcements
- Speaking Engagements
- Partnership with Wyoming High School Activities Association to target youth and their guardians

b) Education:

All 23 counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Education strategies include:

- Responsible Beverage Service Training through TIPS (Training for Intervention Procedures)

- Law Enforcement training through ARIDE (Advanced Roadside Impaired Driving Enforcement)
- Educating parents about the health and safety risks of providing alcohol to you through programs such as Parents who Host Lose the Most
- Educating youth on use of texting tip lines, such as Safe2Tell

c) Alternatives:

All 23 counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Alternatives strategies include:

- Substance abuse free drop-in activities targeted at college students
- Substance Abuse Free activities such as after-prom targeted at high school students

d) Problem Identification and Referral:

All 23 counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Problem Identification and Referral strategies include:

- Promotion of policies and procedures that align with best-practices of employee assistance programs
- Driving while under the influence/driving while intoxicated education programs

e) Community-Based Processes:

All 23 counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected community-based strategies include:

- Community-based strategic planning through local coalitions, CPS, and stakeholders
- Prevention training of coalition members and CPS through online webinars, conferences, annual meetings, and technical-assistance
- Community team-building through planned activities and technical-assistance when needed
- Strengthening coalition capacity by increasing multi-agency coordination and collaboration ensuring that stakeholders are involved

f) Environmental:

All 23 counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected environmental strategies include:

- Implementing policies and procedures for alcohol restrictions at community events through increased use of ID scanners, breathalyzers, and other evidence-based tools
- Implementing policies such as social host liability
- Implementing drug-free policies for schools that include extracurricular activities
- Providing technical-assistance to coalitions

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ☒ Yes ☐ No

If yes, please describe

Block grant dollars in Wyoming are used to supplement prevention services primarily funded through other sources. Through the Request for Proposal/Application process used for selection of vendors and the contracting process, Wyoming ensures that all SABG funded activities compliments and supplements existing substance abuse prevention services. Oversight of the SABG funding continues with the contract payment process. The SABG funds are utilized within the single-fiscal agent community services contract with multiple funding streams for a variety of prevention services. All expenses are coded as to the prevention service, purpose, and appropriate funding stream is applied.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ☒ Yes ☐ No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) ☒ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) ☒ Includes evaluation information from sub-recipients
- c) ☒ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) ☒ Establishes a process for providing timely evaluation information to stakeholders
- e) ☒ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) ☒ Other (please list:)

Strategy evaluation workbook providing guidance on how each county can do an in-depth evaluation of one strategy.

- g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) ☒ Numbers served
- b) ☐ Implementation fidelity
- c) ☐ Participant satisfaction
- d) ☒ Number of evidence based programs/practices/policies implemented
- e) ☒ Attendance
- f) ☒ Demographic information
- g) ☒ Other (please describe):

Collection of county demographics for environmental strategies and media campaigns.

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc
- b) ☐ Heavy use
 - ☐ Binge use
 - ☐ Perception of harm
- c) ☐ Disapproval of use
- d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) ☐ Other (please describe):

Footnotes:



Wyoming Partnerships for Success

State and Community Level Evaluation Plan

Rodney Wambeam, PhD
Senior Research Scientist

Wyoming Survey & Analysis Center
University of Wyoming
1000 E. University Avenue, Department 3925
Laramie, Wyoming 82071
307.766.2189 | wysac@uwyo.edu
www.uwyo.edu/wysac

ABOUT THIS REPORT

This publication was produced for the Wyoming Department of Health, Public Health Division and the Substance Abuse Mental Health Services Administration, Center for Substance Abuse Prevention.

CITATION

WYSAC (2015). *Wyoming Partnerships for Success: State and Community Level Evaluation Plan*. By R. Wambeam. (WYSAC Technical Report No. CHES-1549). Laramie, WY: Wyoming Survey & Analysis Center, University of Wyoming.

Short Reference: Wyoming PFS Evaluation Plan.

© 2016 WYOMING SURVEY & ANALYSIS CENTER



Contents

Contents.....	3
Introduction	4
PFS Evaluation Goals	5
Evaluation Questions	6
Required Performance Measures.....	7
Required Outcome Measures and Measurement.....	9
Behavioral Health Disparities	13
Analysis Plan	15
Participation in the National Cross-Site Evaluation	16
Reporting Plan.....	16

Introduction

Wyoming received the Strategic Prevention Framework Partnerships for Success grant (PFS) from the Federal Substance Abuse Mental Health Services Administration's (SAMSHA) Center for Substance Abuse Prevention (CSAP) in October 2015 as part of the PFS 2015 cohort of state grantees. The purpose of the project is to implement the SPF planning model at the state and community levels in Wyoming, with a focus upon underage drinking, adult high-risk drinking, and prescription drug abuse. The PFS project in Wyoming follows Wyoming's PFS II project and Strategic Prevention Framework State Incentive Grant (SPF SIG) project.

This report documents and details the state and community level evaluation design for Wyoming's PFS project. The unit of analysis for this research is the community. The evaluation will involve the gathering and tracking of numerous indicators at both state and community levels. However, communities will also target specific local conditions and health disparities, meaning the evaluation will drill deeper than was possible in Wyoming's SPF SIG.

The State of Wyoming plans to fund all 23 counties as sub-recipient communities to address the above targets, and these sub-recipient communities will begin implementing the PFS during the spring of 2016. This evaluation design describes the plan for measuring the processes and outcomes of the Wyoming PFS project at both the state and community levels as well as meeting federal reporting and national cross-site evaluation requirements.

PFS Evaluation Goals

Again, Wyoming chose to target underage drinking, adult high-risk drinking, and prescription drug abuse for the PFS project. In collaboration with the State Epidemiological and Outcomes Workgroup (SEOW), the State decided to fund all 23 counties to implement the SPF process as part of the PFS project. This includes several specific goals.

Wyoming PFS Goals

1. Reduce underage drinking among 12 to 17 year olds
2. Reduce binge-drinking among 18 to 29 year olds
3. Reduce prescription drug misuse among 12 to 17 year olds
4. Reduce prescription drug misuse among 18 to 29 year olds
5. Reduce alcohol-related consequences among 12 to 29 year olds, including crime and motor vehicle crashes
6. Reduce prescription drug related consequences among 12 to 29 year olds, including opiate overdoses
7. Build prevention capacity at the state and community levels to address the above targets
8. Leverage, redirect, and align funding to improve prevention efforts

The aim of the evaluation, then, is to assess progress at the grantee (state) and sub-recipient (community) levels toward meeting these specific goals.

In order to assess the impact of the PFS and monitor progress toward accomplishing these goals, evaluators will gather and analyze data in numerous areas. Some are required by SAMHSA, some are part of the national cross-site evaluation, and some are part of the unique evaluation of Wyoming's prevention efforts. All measures capture the processes and outcomes of the PFS project.

Evaluation Questions

The evaluation of Wyoming's PFS project attempts to answer several research questions at the state and community levels.

State Level Questions

Has the SPF PFS increased state capacity to support community efforts to prevent underage drinking, adult high-risk drinking, and prescription drug abuse?

Has the SPF PFS increased state capacity to identify high need communities and health disparities related to underage drinking, adult high-risk drinking, and prescription drug abuse?

Have rates of underage drinking, adult high-risk drinking, and prescription drug abuse decreased in funded communities relative to unfunded communities?

Has the PFS impacted the consequences related to underage drinking, adult high-risk drinking, and prescription drug abuse at the state level?

Community Level Questions

Have funded communities decreased rates of underage drinking, adult high-risk drinking, and prescription drug abuse?

Have funded communities increased their capacity to address underage drinking, adult high-risk drinking, and prescription drug abuse?

Have funded communities identified and addressed health disparities related to underage drinking, adult high-risk drinking, and prescription drug abuse?

Have funded communities impacted targeted local conditions with at least one major prevention strategy?

Have rates of underage drinking, adult high-risk drinking, and prescription drug abuse decreased in each funded community?

Has the PFS impacted the consequences related to underage drinking, adult high-risk drinking, and prescription drug abuse at the community level?

Required Performance Measures

An important goal of the PFS in Wyoming is to build capacity around underage drinking, adult high-risk drinking, and prescription drug abuse. As such, it is very important for the evaluation to monitor performance at the state and community levels. Fortunately, many important performance indicators overlap with SAMHSA and national cross-site requirements. These are submitted via the Management Reporting Tool (MRT), the Grantee Level Instrument (GLI), and Community Level Instrument (CLI). Wyoming will use this data to full effect along with a unique evaluation of capacity that involves a mixed method pre/post assessment of capacity. Table 1 below details the performance measures, data sources, frequency, and method of

Table 1: Grantee Level Performance Measures

	Data Source	Frequency	Method of Collection
Number of training and technical assistance activities	MRT	Quarterly	National Cross-Site Evaluation
Number of people served at training and technical assistance activities	MRT	Quarterly	National Cross-Site Evaluation
Number and percentage of evidence-based strategies	MRT	Quarterly	National Cross-Site Evaluation
Increase in prevention activities supported by leveraging funding	MRT	Quarterly	National Cross-Site Evaluation
Percentage of sub-recipient communities that submit data	MRT	Quarterly	National Cross-Site Evaluation
Number of active partners	MRT	Quarterly	National Cross-Site Evaluation
Number of people served by prevention strategies	CLI	Quarterly	National Cross-Site Evaluation
Prevention capacity	Mixed Method Capacity Assessment Tools	First and Last Year	Interviews, focus groups,

collection at the grantee (state) level. Table 2 details the performance measures, data sources, frequency, and method of collection at the sub-recipient (community) level.

Table 2: Sub-Recipient Level Performance Measures

	Data Source	Frequency	Method of Collection
Number of training and technical assistance activities	CLI	Quarterly	Sub-recipient reporting
Number of people served at training and technical assistance activities	CLI	Quarterly	Sub-recipient reporting
Number, type, and percentage of evidence-based interventions by CSAPs' 6 prevention strategies	CLI	Quarterly	Sub-recipient reporting
Increase in prevention activities supported by collaboration and leveraging of funding	CLI	Quarterly	Sub-recipient reporting
Percentage of sub-recipient communities that submit data	CLI	Quarterly	Sub-recipient reporting
Number of active partners Supporting the PFS Initiative	CLI	Quarterly	Sub-recipient reporting
Number of people served by IOM prevention category and by CSAP's 6 prevention strategies	CLI	Quarterly	Sub-recipient reporting
Number of people reached by demographic category	CLI	Quarterly	Sub-recipient reporting
Prevention capacity	Mixed Method Capacity Assessment Tools	First and Last Year	Interviews, focus groups,

Required Outcome Measures and Measurement

Ultimately, the PFS will attempt to impact the consequences, consumption rates, and intervening variables related to underage drinking, adult-high risk drinking, and prescription drug abuse. At the grantee level these outcomes are often measured and reported in the National Survey on Drug Use and Health (NSDUH). Other data are available from Wyoming agencies like the Division of Criminal Investigation, the Department of Transportation, or the Prescription Drug Monitoring Program (PDMP). At the sub-recipient level many outcome measures are available from youth surveys and from Wyoming agencies. Evaluators will also work with the University of Wyoming Survey Research Center (SRC) to biannually survey 1,000 18 to 29 year olds across Wyoming using a cell phone methodology. This will provide a statewide sample, but, unfortunately, the small rural population of Wyoming does not make community samples possible. The survey will first be administered in the winter of 2016, and again in 2018 and 2020. The survey is a product of the SEOW, and it is made up of questions taken from sources such as the BRFSS and NSDUH. These include valid and reliable measures of binge drinking, heavy drinking, and prescription drug abuse.

While the unit of analysis for the PFS evaluation is the community (meaning county), the evaluation takes place at multiple levels. First, numerous indicators will be reported at the state (grantee) level. These mostly come from either the NSDUH or combined community data. For example, perceived risk of harm comes from the NSDUH; and, number of evidence-based strategies comes from combining data from all funded communities. At the sub-recipient level, many indicators are common but many are unique to the community. Common indicators include answer to CLI questions, crime rates from the Uniform Crime Reports, or consumption rates from Wyoming's Prevention Needs Assessment (PNA) Survey. In each case a pre/post or time series design will be used to look at changes in outcome indicators.

Two of the most important tool for the PFS evaluation include the PNA and WYSAC's survey of young adults. The PNA is a census survey of 6th, 8th, 10th, and 12th graders across Wyoming. As such, it provides accurate estimates of youth substance use and risk and protective factors in each county. This data is important for community assessment, planning, and evaluation, and the lead researcher is an active member of the SEOW. For more information on this survey see <http://pnasurvey.org/>. Table 3 below details the outcome measures, data sources, frequency, and method of collection at the grantee (state) level. Table 4 details the outcome measures, data sources, frequency, and method of collection at the sub-recipient (community) level.

Table 3: Grantee Level Outcome Measures

	Data Source	Frequency	Method of Collection
30 day alcohol use among youth	National Survey on Drug Use and Health	Annually	In-person survey
30 day prescription drug misuse among youth	National Survey on Drug Use and Health	Annually	In-person survey
30 day binge drinking among youth	National Survey on Drug Use and Health	Annually	In-person survey
Young adult binge drinking	National Survey on Drug Use and Health	Annually	In-person survey
Young adult prescription drug misuse	National Survey on Drug Use and Health	Annually	In-person survey
Perception of risk or harm of use	National Survey on Drug Use and Health	Annually	In-person survey
Disapproval of use	National Survey on Drug Use and Health	Annually	In-person survey
Perception of parental and peer disapproval/attitude	National Survey on Drug Use and Health	Annually	In-person survey
Family communication around drug use	National Survey on Drug Use and Health	Annually	In-person survey
Alcohol- and drug-related motor vehicle crashes	Wyoming Department of Transportation	Annually	Administrative Data
Alcohol- and drug-related crime	Uniform Crime Reports	Annually	Administrative Data
Prescription drug-related poisonings	Wyoming Hospital Association	Annually	Administrative Data

WYSAC's survey of young adults (18 to 29 year olds) will be done as a random sample using a cell phone methodology. For the PFS, this will include 1000 completed surveys across the state. Unfortunately, young adults are very difficult to contact and convince to answer survey questions. Past response rates on young adult surveys are typically below 10%, but the SEOW has decided to target young adults up to 29 years old to improve response rates and rigor and because Wyoming has included this age group as a target of the PFS project. The WYSAC survey is the only data source that weights data. Past young adult surveys used 1.4 as the threshold for weighting state data back up to population estimates.

Table 4: Sub-Recipient Level Outcome Measures

	Data Source	Frequency	Method of Collection
30 day alcohol use among youth	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
30 day prescription drug misuse among youth	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
30 day binge drinking among youth	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
Perception of risk or harm of use	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
Perception of parental and peer disapproval/attitude	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
Disapproval of Use	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
Family communication around drug use	PNA	Every Other Year	In-person collection in public schools grades 6, 8, 10, and 12
Young adult binge drinking	WYSAC Survey of Young Adults	Every Other Year	Cell-phone survey of 18-29 year olds
Young adult prescription drug misuse	WYSAC Survey of Young Adults	Every Other Year	Cell-phone survey of 18-29 year olds
Alcohol- and drug-related motor vehicle crashes	Wyoming Department of Transportation	Annually	Administrative Data
Alcohol- and drug-related crime	Uniform Crime Reports	Annually	Administrative Data
Prescription drug-related poisonings	Wyoming Hospital Association	Annually	Administrative Data
Sub-recipient intervening variable data	To be determined by funded communities	Annually	Mixed Methods

WYOMING SURVEY & ANALYSIS CENTER

Both PNA and Young adult survey data will use a pre/post-test design across common measures like 30 day use of alcohol to measure changes in targeted outcomes. Communities will also collect data on specific local conditions and behavioral health disparities as part of their needs assessments and evaluations. This local data will be integrated into the local evaluation.

All questions used in both surveys are taken from other sources (like the NSDUH, BRFSS, or Communities that Cares survey), and they have been previously analyzed for validity and reliability. Other important indicators come from the NSDUH itself or from secondary data sources like Department of Transportation or the Uniform Crime Reports. Less rigorous are unique indicators communities may choose to use in their local assessments. These will vary by community as each sub-recipient completes a needs assessment and eventually a local evaluation.

Finally, Wyoming PFS evaluators have worked with prevention researchers and PFS evaluators in Oregon, North Dakota, and Colorado to develop a cutting edge research design for evaluating capacity change at state and community levels. This includes a coalition survey, consensus building focus groups with key stakeholders, interviews of prevention coordinators, and archival data. The design, tools, and methodology are new and based upon past capacity, readiness, and infrastructure assessments completed in a number of states. Researchers hope to develop a rigorous way to formatively and summatively evaluate prevention capacity change as part of the PFS project. These measures will be subject to validity and reliability testing.

Behavioral Health Disparities

Wyoming decided to fund all 23 counties as PFS sub-recipients due to two basic health disparities. The first is the disparity among youth and young adults in Wyoming. These two populations have disproportionate substance abuse rates. The second is rural and frontier populations themselves which have higher rates of substance abuse and associated consequences than the national average. Each sub-recipient will also be required to complete a local needs assessment and encouraged to explore local behavioral health disparities.

This makes adherence to culturally appropriate services and National CLAS standards easy to measure at a population level for funded communities. Data used to determine this will be collected during the assessment phase as well as at the end of the project to assess changes in the targeted subpopulations. This means adherence to culturally appropriate services and National CLAS standards will be dependent upon youth and young adult data as well as local assessments.

Adherence, then, will be accurately measured in two places. First, a number of questions exist on the CLI to measure these efforts. Second, evaluators are conducting a rigorous capacity evaluation based on a number of capacity domains. Cultural competency is one of these domains.

Moreover, all 23 counties were funded because their community populations have a health disparity related to youth, young adults, and the rural/frontier nature of Wyoming. In many situations, an entire county's population of youth or young adults are vulnerable to the targeted problems. In larger counties, smaller subpopulations may be identified. For example, Albany County (home to the University of Wyoming) may identify college students or even subpopulations of college students as most vulnerable. Outcomes for each identified and targeted subpopulation will match the above, local level outcome indicators. But this is a new effort in Wyoming, and evaluators will work with the SEOW to ensure appropriate assessment of behavioral health disparity work as part of the PFS.

All of Wyoming is classified by the Federal census as frontier except two communities that are classified as rural – Cheyenne and Casper. This means that all of our outcome measures specifically allow for calculations for this subpopulation. It is one of the challenges of doing prevention evaluation in Wyoming to work with such small populations. We have to work very hard on sample sizes in surveys and analysis of other types of data. However, the SEOW has spent years discussing, finding creative solutions to, and overcoming these issues. Much of what we know from research (ours and others) is that rural/frontier culture contributes to substance use and related issues. For example, that lack of mental health services and the long

distances people must travel to receive these services is a contributing factor for addiction, suicide, and more.”

Analysis Plan

As with Wyoming's SPF SIG and PFS II that came before it, the units of analyses for the PFS project are the state and community. In general, this means tracking trends over time for outcomes and a pre/post design for process and capacity change related to the project itself. For example, outcome data using the NSDUH and PNA provide decade long trends, and communities can follow trends using the PNA or other unique data sources as well. For example, Albany County has both PNA data providing underage drinking measures over time and National College Health Assessment data providing young adult drinking measures over time. When possible, evaluators will look for statistically significant changes in data trends using t-tests, repeated measures regression, and other appropriate statistical tests.

More rigorously, the survey of Wyoming 18 to 29 year olds will provide data on changes at the state level, and the PNA can be used to analyze data at the state and community levels. Again, the sample for each iteration of the young adult survey will be 1000; and, the PNA is a census survey. The trending of youth data also allows evaluators to look comprehensively across the SPF SIG, PFS II, and PFS projects to better understand the full impact of these important discretionary grants. The researcher who implements the PNA is an important member of Wyoming's SEOW and has committed his energies to analyzing county and state level student survey data to assess the impact of the PFS on specific underage drinking and prescription drug abuse measures.

A pre/post-test comparison will be used to evaluate the impact of local PFS efforts on targeted populations and, especially, where new local data is used. As part of this effort, evaluators have created a strategy evaluation workbook that helps communities identify and measure impacts of major strategies on local conditions. Unfortunately, evaluators cannot use a comparison group analysis because every county will be funded as part of the PFS project.

Finally, Wyoming's current prevention system focuses upon environmental strategies, but PFS funded communities will implement a more comprehensive approach that may include individual level strategies. Sub-recipients will describe implementation of their project as part of the CLI, and they will also report fidelity to and dosage of strategies on their CLI.

Participation in the National Cross-Site Evaluation

Wyoming plans to fully participate in the national cross-site evaluation – working with the State and sub-recipients to collect and report on required measures through the MRT. This includes training communities to enter data into the CLI and the collection of all appropriate data as described in Tables 1 through 4 above. Evaluators at WYSAC have years of experience participating in national cross-site evaluations for the original State Incentive Grant (SIG), the SPF SIG, the PFS II, and now the PFS in numerous western states.

Reporting Plan

PFS evaluators will create annual reports that include up-to-date process and outcome data in September 2017 through September 2019. In September 2020 evaluators will complete a final Wyoming PFS evaluation report that includes analysis of performance and outcome data. The report will also present changes in capacity and draw conclusions about the overall impact of the PFS project in Wyoming. Evaluators will also complete annual community evaluation reports that summarize changes in capacity, performance, and outcomes in each sub-recipient community. Other reporting efforts include individual reports for specific research efforts like the survey of 18 to 29 year olds, and, most importantly, attendance and participation in SAC, SEOW, and local coalition meetings as requested. This participation involves presenting evaluation findings to the SAC, SEOW, and to coalitions in sub-recipient communities. This is a practice that carries over from the SIG, SPF SIG, and other grants, where evaluators have always been common presenters across the state and completed annual site visits in each community. Evaluators will also attend and present at annual state prevention conferences.

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Available community services to support those in functioning outside of inpatient or residential institutions include mental health and co-occurring outpatient treatment services provided by CMHCs.. Services include individual, group and family therapy, case management, wrap around services, rehabilitation services, housing, medication management and recovery supports such as Wellness Recovery Action Planning and, in some areas of the state, peer specialists. . CMHCs link individuals to various other community resources such as , primary health care, educational, and other resources.

Gatekeeper and Diversionary Grants

The Division has recently provided gatekeeper and Diversionary grant awards to various providers in the state (See Gatekeeper Activities Attachment A). These services are designed to ensure individuals are receiving the least restrictive services based on their needs.

Assisted Outpatient Treatment

The Assisted Outpatient Treatment (AOT) Grant was awarded by SAMHSA to the Wyoming Department of Health in October 2016. The purpose of the AOT grant is to implement and evaluate programs which aim to reduce the incidence and/or duration of psychiatric hospitalization, homelessness, unemployment, incarceration, and interactions with the criminal justice system, while also improving the overall health and social outcomes for individuals living with SMI.

Convalescent Leave

An individual who has shown marked improvement in the Wyoming State Hospital may be considered for convalescent leave. This leave is contingent on the individual having a plan of treatment on an outpatient, or non-hospital basis.

Discharge Planning

The Division hosts monthly discharge planning calls with providers. The purpose of these meetings is to identify transition opportunities for individuals at the state hospital. The Division reviews regional bed availability in the crisis centers and attempts to identify Wyoming State Hospital clients who are appropriate to step-down to those open beds.

Memorandum of Understanding

Hospitals and community mental health centers are required in contracts to have a memorandum of understanding. This MOU lists expectations for coordination of care and communication regarding discharge plans of individuals receiving services.

Title 25

The number of involuntary hospitalizations in Wyoming under Title 25 has increased over the last several years. The Division coordinates many activities to address the high number of involuntary hospitalization in the state. The Wyoming Department of Health, Director's Unit for Policy Research and Evaluation (DUPRE) has hired a Title 25 coordinator. This coordinator is responsible for collecting and analyzing the data related to hospitalizations and individuals receiving care. Data can be evaluated to determine what changes are needed with regards to appropriate placement of individuals.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a) Physical Health ☒ Yes ☒ No

b) Mental Health ☒ Yes ☒ No

c) Rehabilitation services ☒ Yes ☒ No

- | | | | |
|----|--|---|--|
| d) | Employment services | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| e) | Housing services | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| f) | Educational Services | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| g) | Substance misuse prevention and SUD treatment services | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| h) | Medical and dental services | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| i) | Support services | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| j) | Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| k) | Services for persons with co-occurring M/SUDs | <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

Each state funded community mental health center provides case management services when needed. The services include components such as advocacy, linkage, monitoring, and follow up. Case managers serve as the primary link between community resources, basic needs, family, primary care services, legal, and recovery supports access.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Please see the above mentioned activities related to Assisted Outpatient Treatment and gatekeeper activities.

WYSUP project

The Wyoming Super-Utilizer Program (WySUP) is one component of a group of initiatives within the WDH intended to improve the health outcomes of adults with complex care needs while decreasing State costs. The project is underway and the first phases of the program have launched. The WDH plans to have the WySUP fully implemented by December of 2018.

This program focuses on high-risk adults with multiple comorbidities. In many cases, these individuals have chronic conditions and co-occurring behavioral health conditions, so the program must be tightly integrated with the mental health and substance use disorder system in Wyoming. In-person (not telephonic) care management will be accomplished by a cross-functional team to address medical, mental health, substance use treatment, and basic/social needs.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	<input type="text"/>	<input type="text"/>
2.Children with SED	<input type="text"/>	<input type="text"/>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Division utilizes SAMHSA's published prevalence and incidence rates in planning purposes. When considering which provider agencies are awarded state funds, the Division considers national data and evidence based practices for mental health treatment.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- | | | |
|----|--|---|
| a) | Social Services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| b) | Educational services, including services provided under IDE | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| c) | Juvenile justice services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| d) | Substance misuse preventiion and SUD treatment services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| e) | Health and mental health services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| f) | Establishes defined geographic area for the provision of services of such system | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

PATH Grant

The state applies for this grant each year. This grant allows the state to provide outreach and PATH case management services for adults who are or at risk of homelessness in Wyoming's four largest counties. The MHBG is utilized to supplement these four PATH contracts to advance the Housing First process; these funds provide additional staffing funds and direct rent costs while people in PATH are waiting for more secure ways of paying for rent. The BHD utilizes in-kind personnel and resources to support training and support for community providers (including PATH, CMHC's, disability providers, and others) to utilize the SOAR process for people who are literally or at risk of homelessness to apply for SSI and/or SSDI.

CMHC's/SAC's work to preempt unnecessary crisis/emergency detention of persons with SMI who are homeless. Further, CMHC's provide community based services in each county to adults and children.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Division utilizes the following management systems

The Division utilizes the Wyoming Client Information System (WCIS) to collect client level data by age, gender, race, diagnostic category, and agency code. WCIS also collects client services, client outcome, and performance data for each provider.

The Wyoming Online Financial System (WOLF's) provides agencies the means to process all payments made by the state and assist agencies in accounting for public money. The system also processes paychecks for state employees each month, including patient and inmate workers in the State's institutions, legislators, judges, board members and members of the Wyoming National Guard.

The Division Access Contract Tracking Database provides tracking for all contracts within the Division as each contract moves through the steps of being approved by the Department of Health.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i) Screening ☐ Yes ☒ No

ii) Education ☐ Yes ☒ No

iii) Brief Intervention ☐ Yes ☒ No

iv) Assessment ☐ Yes ☒ No

v) Detox (inpatient/social) ☐ Yes ☒ No

vi) Outpatient ☐ Yes ☒ No

vii) Intensive Outpatient ☐ Yes ☒ No

viii) Inpatient/Residential ☐ Yes ☒ No

ix) Aftercare; Recovery support ☐ Yes ☒ No

b) Are you considering any of the following:

Targeted services for veterans ☐ Yes ☒ No

Expansion of services for:

(1) Adolescents ☐ Yes ☒ No

(2) Other Adults ☐ Yes ☒ No

(3) Medication-Assisted Treatment (MAT) ☐ Yes ☒ No

Criterion 2

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? j n Yes j n No
2. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? j n Yes j n No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? j n Yes j n No
4. Does your state have an arrangement for ensuring the provision of required supportive services? j n Yes j n No
5. Are you considering any of the following:
 - a) Open assessment and intake scheduling j n Yes j n No
 - b) Establishment of an electronic system to identify available treatment slots j n Yes j n No
 - c) Expanded community network for supportive services and healthcare j n Yes j n No
 - d) Inclusion of recovery support services j n Yes j n No
 - e) Health navigators to assist clients with community linkages j n Yes j n No
 - f) Expanded capability for family services, relationship restoration, custody issue j n Yes j n No
 - g) Providing employment assistance j n Yes j n No
 - h) Providing transportation to and from services j n Yes j n No
 - i) Educational assistance j n Yes j n No
6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

 The PWWDC is monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the PWWDC requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The state has ability to pull individual client records and determine if the clients are receiving PWWDC services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding PWWDC.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	j n Yes j n No
b)	14-120 day performance requirement with provision of interim services	j n Yes j n No
c)	Outreach activities	j n Yes j n No
d)	Syringe services programs	j n Yes j n No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	j n Yes j n No
2. Are you considering any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	j n Yes j n No
b)	Automatic reminder system associated with 14-120 day performance requirement	j n Yes j n No
c)	Use of peer recovery supports to maintain contact and support	j n Yes j n No
d)	Service expansion to specific populations (military families, veterans, adolescents, older adults)	j n Yes j n No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 The PWID is monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the PWID requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The state has ability to pull individual client records and determine if the clients are receiving PWID services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding PWID.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

		j n Yes j n No
--	--	----------------
2. Are you considering any of the following:

a)	Business agreement/MOU with primary healthcare providers	j n Yes j n No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	j n Yes j n No
c)	Established co-located SUD professionals within FOHCs	j n Yes j n No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 All patients in Wyoming are eligible to receive financial assistance for TB medications through the Wyoming Department of Health (WDH) TB program. Treatment completion of latent TB and active treatment are monitored. The TB services are monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the TB requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The state has ability to pull individual client records and determine if the clients are receiving TB services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding TB. If agencies identify a client who needs TB services, they refer them to the WDH TB program.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery?

		j n Yes j n No
--	--	----------------

2. Are you considering any of the following:
- a) Establishment of EIS-HIV service hubs in rural areas ☐ Yes ☒ No
- b) Establishment or expansion of tele-health and social media support services ☐ Yes ☒ No
- c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ☐ Yes ☒ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? ☐ Yes ☒ No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ☐ Yes ☒ No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ☐ Yes ☒ No

If yes, please provide a brief description of the elements and the arrangement
Wyoming is not an HIV designated state.

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement j n Yes j n No
2. Are you considering any of the following:
 - a) Workforce development efforts to expand service access j n Yes j n No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services j n Yes j n No
 - c) Establish a peer recovery support network to assist in filling the gaps j n Yes j n No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) j n Yes j n No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations j n Yes j n No
 - f) Explore expansion of service for:
 - i) MAT j n Yes j n No
 - ii) Tele-Health j n Yes j n No
 - iii) Social Media Outreach j n Yes j n No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? j n Yes j n No
2. Are you considering any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services j n Yes j n No
 - b) Establish a program to provide trauma-informed care j n Yes j n No
 - c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education j n Yes j n No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) j n Yes j n No
2. Are you considering any of the following:
 - a) Notice to Program Beneficiaries j n Yes j n No
 - b) Develop an organized referral system to identify alternative providers j n Yes j n No
 - a) Develop a system to maintain a list of referrals made by religious organizations j n Yes j n No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? j n Yes j n No
2. Are you considering any of the following:
 - a) Review and update of screening and assessment instruments j n Yes j n No
 - b) Review of current levels of care to determine changes or additions j n Yes j n No

- c) Identify workforce needs to expand service capabilities j n Yes j n No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background j n Yes j n No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? j n Yes j n No
2. Are you considering any of the following:
- a) Training staff and community partners on confidentiality requirements j n Yes j n No
- b) Training on responding to requests asking for acknowledgement of the presence of clients j n Yes j n No
- c) Updating written procedures which regulate and control access to records j n Yes j n No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure j n Yes j n No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? j n Yes j n No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

In FY 16, there were seven (7) block grant sub-recipients identified to undergo the peer review.
In FY 15, there were 9 nine (9) block grant sub-recipients identified to undergo the peer review.

3. Are you considering any of the following:
- a) Development of a quality improvement plan j n Yes j n No
- b) Establishment of policies and procedures related to independent peer review j n Yes j n No
- c) Develop long-term planning for service revision and expansion to meet the needs of specific populations j n Yes j n No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? j n Yes j n No

If YES, please identify the accreditation organization(s)

- i) ☒ Commission on the Accreditation of Rehabilitation Facilities
- ii) ☒ The Joint Commission
- iii) ☒ Other (please specify)

The Division requires a national accreditation. All state funded providers have either Commission on Accreditation of Rehabilitation Facilities or Joint Commission.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? j n Yes j n No
2. Are you considering any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service j n Yes j n No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing j n Yes j n No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state j n Yes j n No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services j n Yes j n No
 - c) Performance-based accountability j n Yes j n No
 - d) Data collection and reporting requirements j n Yes j n No
2. Are you considering any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs j n Yes j n No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services j n Yes j n No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services j n Yes j n No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort j n Yes j n No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women j n Yes j n No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis j n Yes j n No
 - b) Early Intervention Services Regarding HIV j n Yes j n No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment j n Yes j n No
 - b) Professional Development j n Yes j n No
 - c) Coordination of Various Activities and Services j n Yes j n No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Below are the links to these regulations:

<https://health.wyo.gov/behavioralhealth/mhsa/rules-and-regulations/>

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked 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, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

☒ Yes ☐ No

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

[Trauma](#)⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? jn Yes jn No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? jn Yes jn No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? jn Yes jn No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? jn Yes jn No
5. Does the state have any activities related to this section that you would like to highlight.

Wyoming does take an active approach to addressing trauma. While some providers do a specific trauma screening upon intake into treatment, it is standard protocol during the psychosocial assessment for all providers to ask questions regarding past trauma/abuse experiences. As part of the Substance Abuse Rules, treatment providers are required to provide training to employees on trauma assessment and management and women's specific providers must include services as needed for individuals who have experienced trauma. Further, providers use trauma-specific therapies ranging from trauma focused cognitive behavioral approaches, exposure therapy, dialectical behavioral therapy, and other approaches to meet the needs of the persons served.

State funded providers are required through national accreditation to implement policies and procedures for providing comprehensive assessments upon admission to their program. The Substance Abuse Rules also require providers to utilize assessment tools that address prior trauma history. The written assessments contain information on client behavioral health

history including trauma. Wyoming also promotes the provision of trauma informed care through sharing information about professional trainings for providers. The BHD utilizes SAMHSA's Treatment Improvement Protocol 57 to promote trauma informed care. Trauma informed care principles have been adopted by the BHD for its operations.

The BHD has offered multiple webinars, resources, and materials to providers to promote trauma informed care including evidence based trauma specific interventions for children, families, and adolescents. State technical assistance is always available for providers who need it. The Covington Curriculum includes effective, practical, and theoretically based information for professionals. Many providers also utilize the Seeking Safety and Living in Balance curriculums as well.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. [QJDP Model Programs Guide](#)

⁶³ <http://csqjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? j n Yes j n No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? j n Yes j n No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? j n Yes j n No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? j n Yes j n No
5. Does the state have any activities related to this section that you would like to highlight?
No
Please indicate areas of technical assistance needed related to this section.
None

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? jn Yes jn No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? jn Yes jn No
3. Does the state purchase any of the following medication with block grant funds? jn Yes jn No
 - a) € Methadone
 - b) € Buprenorphine, Buprenorphine/naloxone
 - c) € Disulfiram
 - d) € Acamprosate
 - e) € Naltrexone (oral, IM)
 - f) € Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? jn Yes jn No
5. Does the state have any activities related to this section that you would like to highlight?

The Division has received a federal Medication Assisted Treatment (MAT) grant to implement specialized programs with services such as behavioral therapy, medication, and recovery support services for individuals opioid use disorder. Two provider agencies were awarded MAT funding in Natrona County and Sweetwater County. Both providers are in the second year of the grant and have served approximately 200 clients over the entire grant period. The expectations of these providers are to serve a specified number of clients according to their state contracts in addition to reporting various data sets and outcomes. The federal State Targeted Response to Opioid Crisis (STR) grant was also awarded to the Division. These funds serve multiple purposes including addressing the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder. The Division is in the startup process of executing contracts with provider agencies throughout other areas of the state.

Please indicate areas of technical assistance needed to this section.

None

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) ☒ Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) ☒ Psychiatric Advance Directives
- c) ☒ Family Engagement
- d) ☒ Safety Planning
- e) ☐ Peer-Operated Warm Lines
- f) ☐ Peer-Run Crisis Respite Programs
- g) ☒ Suicide Prevention

2. Crisis Intervention/Stabilization

- a) ☐ Assessment/Triage (Living Room Model)
- b) ☐ Open Dialogue
- c) ☐ Crisis Residential/Respite
- d) ☒ Crisis Intervention Team/Law Enforcement
- e) ☒ Mobile Crisis Outreach
- f) ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) ☒ WRAP Post-Crisis
- b) ☒ Peer Support/Peer Bridges

- c) ☒ Follow-up Outreach and Support
- d) ☐ Family to Family Engagement
- e) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
- f) ☐ Follow-up crisis engagement with families and involved community members
- g) ☒ Recovery community coaches/peer recovery coaches
- h) ☒ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed to this section.

None

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery. SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders: Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1.

Does the state support recovery through any of the following:

a)

Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

j

n

Yes

j

n

No

b)

Required peer accreditation or certification?

j

n

Yes

j

n

No

c)

Block grant funding of recovery support services.

j

n

Yes

j

n

No

d)

Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Yes

2.

Does the state measure the impact of your consumer and recovery community outreach activity?

j

n

Yes

j

n

No

3.

Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

State funded Community Mental Health Centers provide recovery services to these populations. Services include peer support through peer specialists, case management, life skills, housing, and group home services. Quality of Life funding is provided to community mental health centers for purposes of providing basic needs such as medication.

4.

Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

State funded Community Mental Health Centers provide recovery services to these populations. Services include peer support through peer specialists, case management, life skills, housing, and group home services. Quality of Life funding is provided to community mental health centers for purposes of providing basic needs such as medication.

5.

Does the state have any activities that it would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Printed: 8/28/2017 5:20 PM - Wyoming - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

Page 134 of 242

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided.	<input checked="" type="radio"/> Yes <input checked="" type="radio"/> No
home and community based services.	<input checked="" type="radio"/> Yes <input checked="" type="radio"/> No
peer support services.	<input checked="" type="radio"/> Yes <input checked="" type="radio"/> No
employment services.	<input checked="" type="radio"/> Yes <input checked="" type="radio"/> No
2. Does the state have a plan to transition individuals from hospital to community settings? ☒ Yes ☒ No
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Wyoming Department of Health is in the process updating the Olmstead plan.

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

WYOMING AND *OLMSTEAD*

A PRIMER ON DEPARTMENT OF HEALTH INITIATIVES AND POLICIES



Wyoming Department of Health

Updated July, 2017

TABLE OF CONTENTS

Executive Summary	3
Purpose.....	3
WDH Structure [pending DFS integration decisions].....	Error! Bookmark not defined.
Background	4
The Olmstead decision	4
Olmstead requirements	4
What is an Olmstead Plan?	5
Wyoming’s Progress on <i>Olmstead</i>.....	6
<i>Olmstead</i> Priorities, 2017-2021	14
Behavioral Health Division	14
Division of Health Care Financing (Medicaid).....	20
Aging Division.....	23
Challenges	25
Wyoming <i>Olmstead</i> Goals, 2017-2021	27

EXECUTIVE SUMMARY

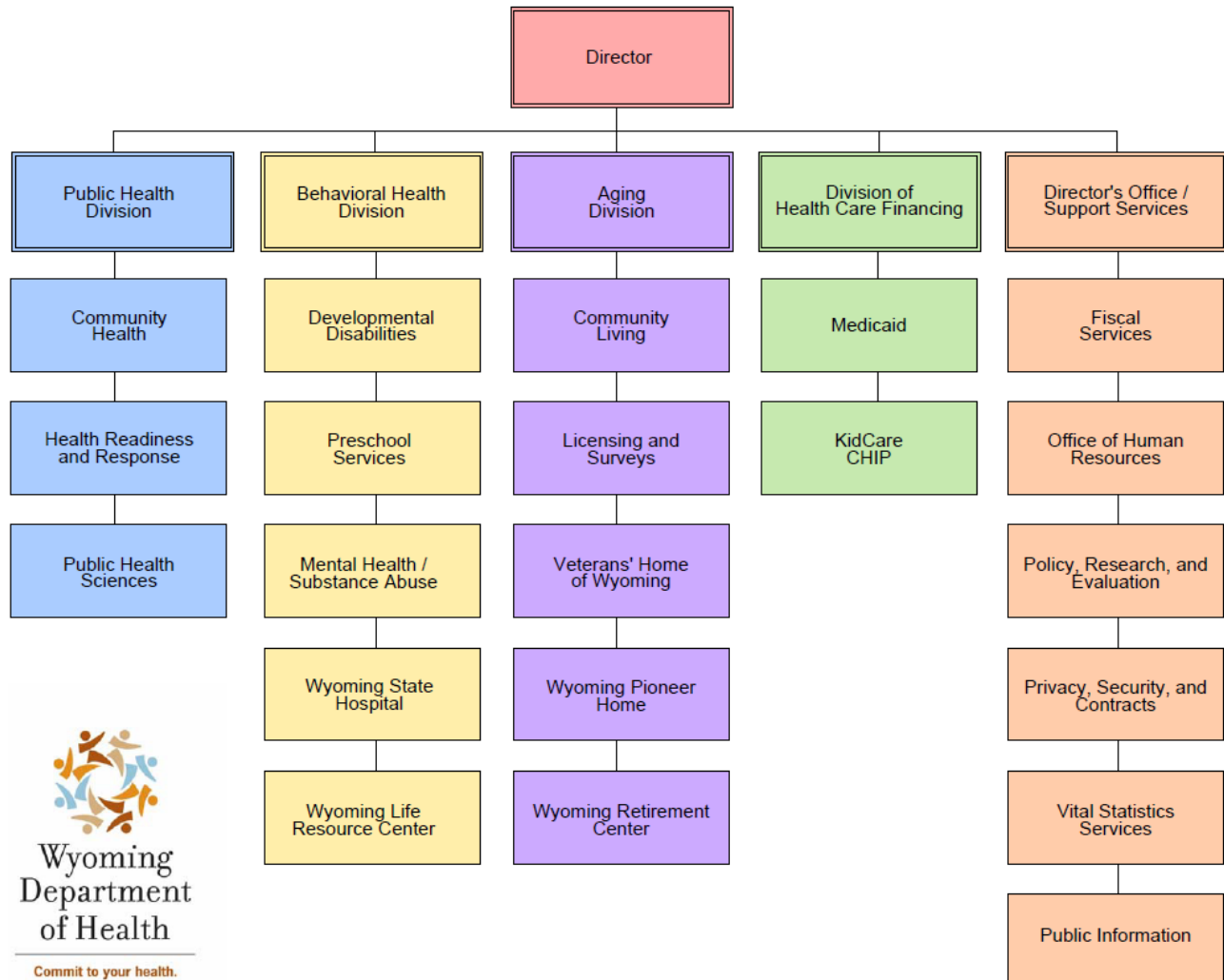
Purpose

The State of Wyoming developed its *Olmstead* plan in June, 2000 and subsequently updated the plan in 2002, and 2013. Since 2013, Wyoming has worked to improve the availability and quality of community services for those with mental illness, physical and intellectual disabilities, and aging issues to help enable those residents of our state to live productive lives in the least-restrictive, most-integrated community settings.

This document serves as a further update to Wyoming's *Olmstead* plan. The pages that follow provide background on the Wyoming Department of Health (WDH), background on the *Olmstead* decision, as well as Wyoming's progress toward its goals related to *Olmstead*, and the continued challenges faced by the state.

Moving forward, this plan will be reviewed and updated (as necessary) every quarter of each fiscal year.

Wyoming Department of Health Structure



BACKGROUND

The Olmstead decision

In 1995, the Atlanta Legal Aid society filed suit against the State of Georgia on behalf of two women with developmental disabilities -- Lois Curtis and Elaine Wilson -- who had been repeatedly institutionalized at Georgia Regional Hospital. Tommy Olmstead, the Commissioner of the Georgia Department of Human Resources, and the State of Georgia were named as defendants.

The plaintiffs contended that by failing to provide adequate support in the community -- despite assurances from treatment providers that that such placement was appropriate -- the State was violating Title II of the Americans with Disabilities Act, which guarantees non-discrimination based on disability for the services, programs or activities of a public entity.

In 1999, the Supreme Court released its decision in *Olmstead v. L.C.* The Court found that ‘unjustified institutional isolation’ is indeed a form of discrimination, based on two judgments:

- First, that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life”, and;
- Second, that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

Olmstead requirements

In its decision, the Court developed a three-part test for evaluating the qualified right of individuals with disabilities to receive funded support in the community:

- The person’s treatment professional determine that community supports are appropriate;
- The transfer from institutional care to a less-restrictive setting is not opposed by the affected individual; and,
- The provision of services in the community can be reasonably accommodated, taking into account the resources available to the State and the needs of other similarly-situated individuals with disabilities.

Further, the Court ruled that a State can meet its Olmstead responsibilities only if it has:

- A “comprehensive, effectively working plan for evaluating and placing people with disabilities in less restrictive settings”¹ and,
- A “waiting list that moves at a reasonable pace and is not controlled by the State’s endeavors to keep its institutions fully populated.”

The Court did note that institutions have their place. “We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit

¹ U.S. Department of Justice. Civil Rights Division. “Statement of the Department of Justice on Application of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* to State and Local Governments’ Employment Service Systems for Individuals with Disabilities.” 31 October 2016. Retrieved from: https://www.ada.gov/olmstead/olmstead_guidance_employment.htm

from community settings ... Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.”

However, the Court did not find -- and other courts have generally agreed -- that there is a “right” to care in an institution. States “may” keep institutions open without violating the ADA, but the decision did not rule that they “must.”²

What is an Olmstead Plan?

As previously noted, the Department of Justice requires that an Olmstead Plan be “comprehensive and effectively working” to be considered legally sufficient. An adequate plan “must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities.”³ In particular, the plan must cover several basic topics:

- **Data collection, tracking and analysis.**
 - The State should specify yearly and long-term goals for increasing utilization of home- and community based services;
 - Demonstrate progress toward those goals; and
 - Closely monitor the time individuals spend waiting for these services.
- **Access to services**
 - The State must identify and address barriers to accessing community services;
 - Develop a uniform assessment for eligibility for and appropriateness of community services;
 - Establish a “No Wrong Door” policy for accessing service to maximize efficiency and minimize eligible people being denied services⁴
 - Funding cuts can violate *Olmstead* if a reduction in community-based service provision places people at risk of institutionalization.⁵
- **Community integration**
 - The State should encourage employment and economic independence;
 - Allow for education and cultural enrichment;
 - Foster family ties and social interaction; and,
 - Establish processes to transition willing individuals from more to less restrictive environments

² Deinstitutionalization Toolkit - Legal inBrief. National Council on Disability. www.ncd.gov/rawmedia_repository/Legal%20inBrief.

³ U.S. Department of Justice. Civil Rights Division. “Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*” 22 June 2011. Retrieved from: https://www.ada.gov/olmstead/q&a_olmstead.htm

⁴ Medicaid. “No Wrong Door System and Medicaid Administrative Claiming Reimbursement Guide.” Retrieved from: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/admin-claiming/no-wrong-door/index.html>

⁵ U.S. Department of Justice. Civil Rights Division. “Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*” 22 June 2011. Retrieved from: https://www.ada.gov/olmstead/q&a_olmstead.htm

WYOMING'S PROGRESS ON *OLMSTEAD*

Despite the challenges of being a frontier State, Wyoming has made great strides in complying with the ADA and *Olmstead*.

Behavioral Health Division

Individuals with Developmental Disabilities (I/DD) and Acquired Brain Injuries

As with other States, Wyoming has its own institution for serving individuals with intellectual and developmental disabilities -- the Wyoming Life Resource Center (WLRC). And the evolution of both this institution and its home- and community-based alternatives traces a similar path.

The WLRC was established in 1907 as “an institution for the custody, care, education, proper treatment and discipline of the feeble-minded and epileptic persons.”⁶ The facility opened its doors to three children in June of 1912.⁷ By the end of that year, 23 individuals were enrolled and the facility had been named the “Wyoming State School for Defectives.” In 1921, the name was changed to the “Wyoming State Training School,” by which it was known until 2008 when the Legislature changed the name to the current “Wyoming Life Resource Center” (WLRC).

At its peak in the 1960s, the WLRC served more than 700 clients. In the 1960s and 1970s, following the revelation of appalling conditions and poor treatment of patients in many public institutions around the country, de-institutionalization became a national movement, and home- and community-based settings began to grow.

In 1989, the WLRC first began participating in Medicaid after receiving “Intermediate Care Facility for the Mentally Retarded” (ICF-MR) designation. All units at the WLRC were certified by 1993. In addition to the federal oversight demanded by this licensure standard, significant changes were also made due to a lawsuit -- *Weston et al. v. Wyoming State Training School, et al.*, Civil Action no. C90-0004 -- filed with an intent to “...improve services to people with intellectual disabilities”⁸ both at the facility and across the State.

Specifically, the Weston lawsuit, filed in January 1990, sought “improvement of conditions at [the Wyoming Life Resource Center], expansion of community resources and support services and transfer of class members to community programs.”⁹ As a result of the lawsuit, approximately 200 clients transitioned out of the WLRC into community settings, and attention greatly increased to the services provided to persons with intellectual disabilities in Wyoming.

The lawsuit was settled by the parties. The Settlement Agreement formally recognized ongoing obligations of the State with respect to services and supports for people with developmental disabilities.¹⁰ The Settlement Agreement is no longer in effect; it terminated December 31, 1996.¹¹ However, the State remains committed to upholding the spirit of the obligations set out by Weston. Since the Weston Settlement, additional protections have come about with regard to the institutionalization of individuals with intellectual disabilities.

⁶ Session Laws of Wyoming, 1907, Chapter 104.

⁷ A Century of Empowerment, Past, Present and Future, a handbook

⁸ A Century of Empowerment, Past, Present and Future, a handbook

⁹ *Weston et al. v. Wyoming State Training School, et al.*, Civil Action No. C90-0004, Consent Decree, Stipulated Agreement, March 13, 1991.

¹⁰ *Weston et al. v. Wyoming State Training School, et al.* Civil Action No. C90-0004, Annotated Settlement Agreement including the Order Approving Settlement Agreement and Dismissing Action, signed December 5, 1994.

¹¹ *Weston et al. v. Wyoming State Training School et al.*, Civil Action No. C90-0004, Annotated Settlement Agreement at pg. 16.

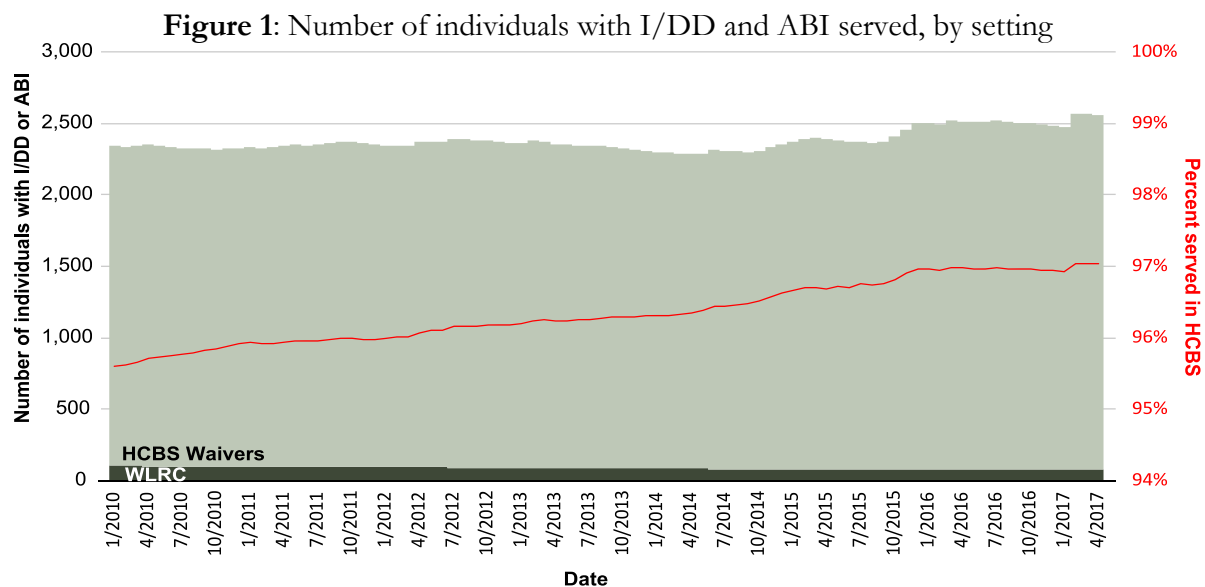
The State, as well as the WLRC, must comply with many federal and state codes, statutes and regulations, as well as the interpretations of these laws by U.S. courts.

In the same time period, the census at the WLRC has dropped significantly, as home- and community-based setting options grew. Note, in Table 1, below, that the WLRC currently serves approximately half as many people as it did in the late 1990s.

Table 1: WLRC Census and cost since SFY 1999

SFY	Avg. Census	Total Cost
1999	132	\$17,886,885
2000	119	\$17,910,225
2001	118	\$18,554,833
2002	113	\$19,083,418
2003	106	\$20,558,372
2004	107	\$20,343,767
2005	98	\$21,136,896
2006	101	\$21,379,873
2007	124	\$22,711,431
2008	109	\$25,566,162
2009	101	\$26,264,407
2010	103	\$25,039,562
2011	95	\$26,722,068
2012	94	\$28,757,686
2013	90	\$27,547,048
2014	85	\$25,927,457
2015	79	\$23,902,690
2016	76	\$22,811,745

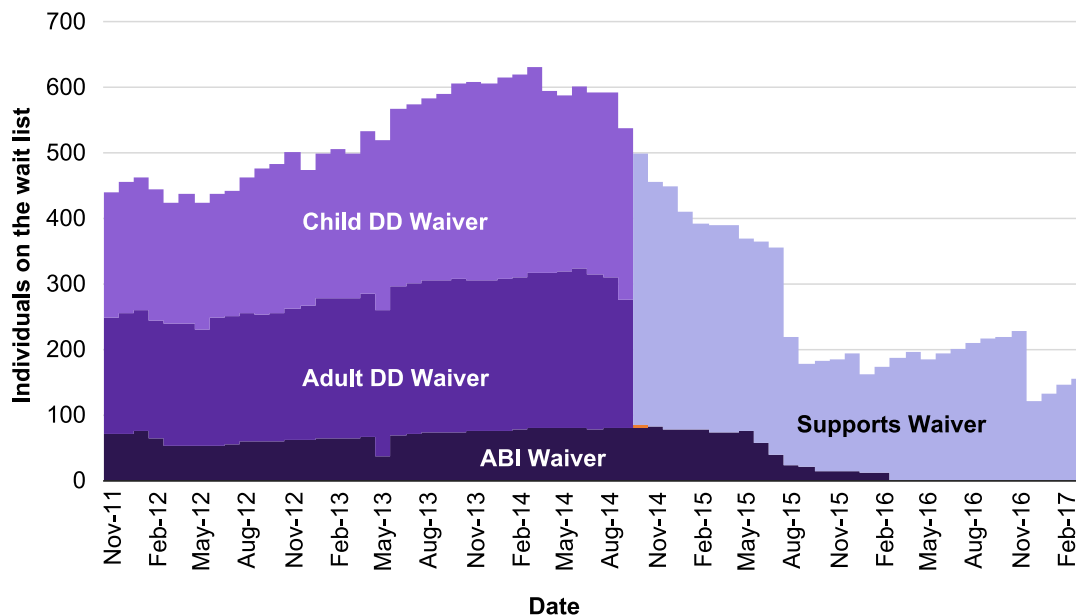
When compared with the significantly higher number of people served in home- and community-based settings, the fraction of individuals with I/DD or ABI in an institution has declined as well. This is illustrated in Figure 1, below. Note that the percent served in HCBS has increased from approximately 95.5% to 97% since 2010.



In addition to a gradually shrinking percentage of individuals served in an institutional setting, the wait list for the I/DD and ABI waivers has been significantly cut since the waiver redesign of 2013 (mandated by Senate Enrolled Act 82).

Figure 2, below, illustrates the wait list since November of 2011. The wait list in April of 2017 was 167 people, with no one on the wait list more than 18 months. By contrast, the national wait time average for HCBS services was 43 months in 2013.¹²

Figure 2: DD/ABI Waiver wait list



Despite this progress, however, significant challenges remain in better integrating individuals with I/DD and ABI into community settings.

The United Cerebral Palsy (UCP) organization, for example, has produced the “Case for Inclusion” report annually since 2006. The most recent report (2016) ranks Wyoming #43 based on 2014 data. In the first report ever produced by UCP in 2006, Wyoming ranked #10. Wyoming has fallen from 10th place to 43rd place between 2006 and 2016, according to the UCP metrics.

The rubric used by the UCP to rank States has changed over the years, but important criteria in the rankings have stayed relatively consistent. These criteria include:

- The percent of expenditures going to individuals on waivers vs. ICF (institutional) settings,
- The percent of recipients in small-group (6 or fewer) settings, and the percent living with family,
- The amount of self-directed services,
- Quality metrics from the National Core Indicators (NCI),
- The percent in competitive employment, and
- The length of the waiver waiting list.

¹² Ng, T., Harrington, C., et al. *Medicaid Home and Community Based Services Programs: 2013 Data Update*. Kasier Family Foundation. 18 October 2016. Retrieved from: <http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/>

There are three primary reasons behind the drop in Wyoming's rankings between the 2006 report and the 2016 report, which rely on data from 2004 and 2014, respectively. In order of likely importance, they are:

- The percent of Adult DD recipients with competitive and integrated employment in Wyoming has fallen from 25% in 2004 to 9% in 2014, though it has recently been increasing per State efforts (e.g. the "Employment First" initiative).
- The waitlist for DD waivers grew from 0 to 597 people between 2004 and 2014. While the waitlist decreased to fewer than 200 people in 2016, this improvement will not show up until the next two UCP reports.
- Wyoming has only recently begun participating in the National Core Indicators (NCI) survey. The 2016 UCP methodology automatically penalizes the State by 14 points (out of 100 total) for this lack of data.

Table 2, below, summarizes the UCP rankings since 2006, and compares the rankings and scores with relevant metrics from Department of Health data.

Table 2: The United Cerebral Palsy (UCP) organization "Case for Inclusion" ranking data

UCP Data				Wyoming Department of Health Data					
Report	Data from	Rank	Score	Waiver wait list	Clients		Annual per-person cost		Competitive Employment ¹³
					Waiver	WLRC	Waiver	WLRC	
2006	2004	10	"B"	n/a	n/a	n/a	n/a	n/a	25%
2007	2005	17	70.9	0	1,943	98	\$40,201*	\$215,682	22%
2008	2006	25	68.3	0	2,173	101	\$36,646*	\$211,681	21%
2009	2007	28	68.7	113	2,277	124	\$41,680*	\$183,156	19%
2010	2008	29	68.9	234	2,306	109	\$52,319	\$234,551	19%
2011	2009	21	71.6	284	2,305	101	\$52,417	\$260,043	18%
2012	2010	35	67.3	316	2,368	103	\$51,503	\$243,102	22%
2013	2011	34	66.3	383	2,398	95	\$53,542	\$281,284	13%
2014	2012	41	57.8	462	2,338	94	\$54,426	\$305,932	13%
2015	2013	45	58.9	498	2,342	90	\$54,010	\$303,071	12%
2016	2014	43	59.3	597	2,115	85	\$53,189	\$289,304	9%
2017	2015			219	2,211	79	\$53,495	\$288,599	17%

¹³ Reported by the DD Section of the Behavioral Health Division to the Department of Health Strategic Plan.

Division of Healthcare Financing (Medicaid)

Elderly and Physically-Disabled

Wyoming has also shown positive trends towards home- and community-based settings when it comes to serving the elderly and physically disabled. Wyoming Medicaid serves elderly and disabled members in need of nursing-facility level of care in four programs. These include the:

- Long Term Care (LTC) Waiver¹⁴;
- Assisted Living Facility (ALF) Waiver⁶;
- Program of All-Inclusive Care of the Elderly (PACE); and
- Skilled Nursing Facilities (SNFs) throughout the State.

Generally speaking, the first three programs are considered home- and community-based services (HCBS), while SNF services are considered institutional settings. Trends in expenditures and enrollments for the largest HCBS programs (LTC and ALF waivers) vs. SNF services are shown in Tables 3 and 4, below.

Table 3: Long-term Care and Assisted Living Facility Waivers⁶

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	\$31,663,825	19,203	1,600	\$1,649
2012	\$33,821,599	18,812	1,568	\$1,798
2013	\$30,383,671	18,152	1,513	\$1,674
2014	\$30,236,004	18,369	1,531	\$1,646
2015	\$32,719,341	19,776	1,648	\$1,654
2016	\$37,126,339	21,642	1,804	\$1,715

Table 4: Nursing Facility

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	\$79,967,179	20,307	1,692	\$3,938
2012	\$79,243,110	20,569	1,714	\$3,853
2013	\$77,134,902	20,232	1,686	\$3,813
2014	\$75,382,096	20,092	1,674	\$3,752
2015	\$74,242,244	19,667	1,639	\$3,775
2016	\$88,192,883	20,250	1,688	\$4,355

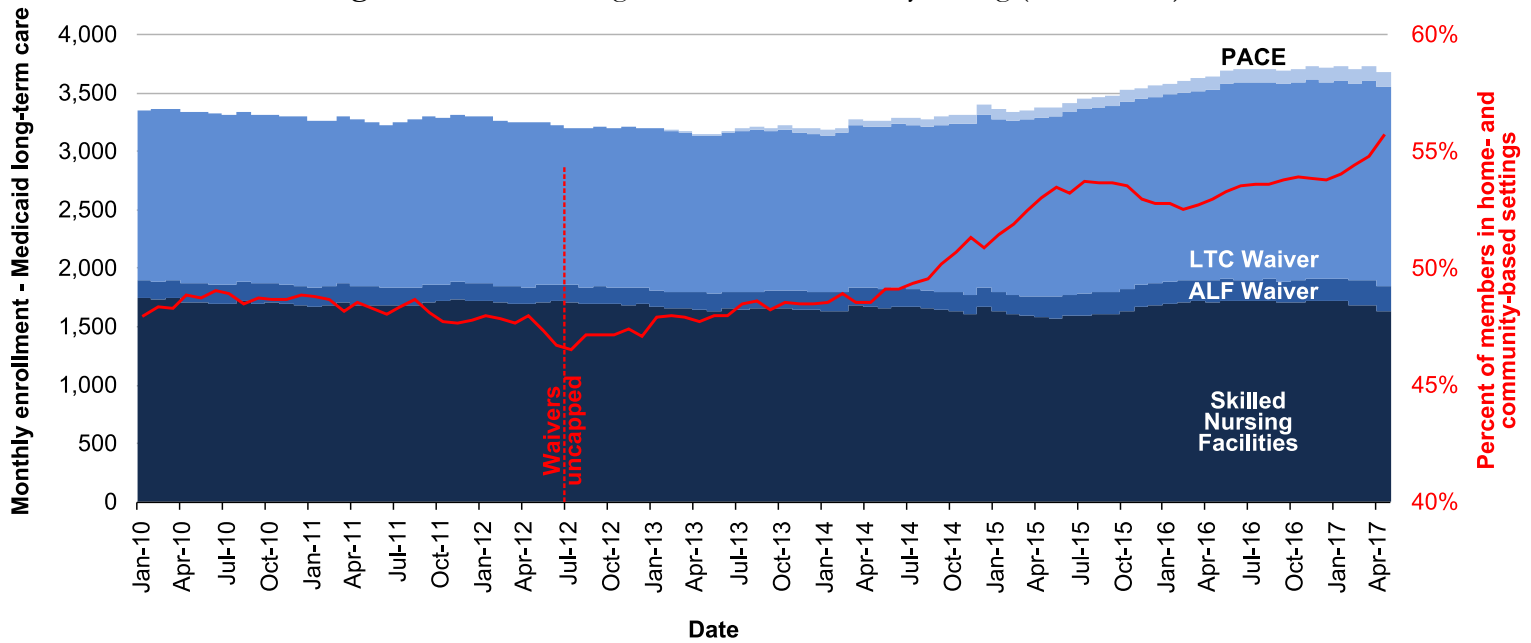
Of note in the tables:

- Per-member per-month costs for HCBS settings are approximately 40% of SNF settings.
- Enrollment growth in long-term care has largely been in HCBS settings. There are actually fewer Medicaid members in nursing homes today than there were in 2010.

Figure 3, on the next page, shows how the use of home- and community-based alternatives to institutional care has increased by almost 10 percentage points since those waivers were uncapped in 2013.

¹⁴ Note that, due to similarities in member costs and acuity, the LTC and ALF Waivers will soon be combined into the “Community Choices” Waiver.

Figure 3: Medicaid long-term care members, by setting (2010 - 2017)

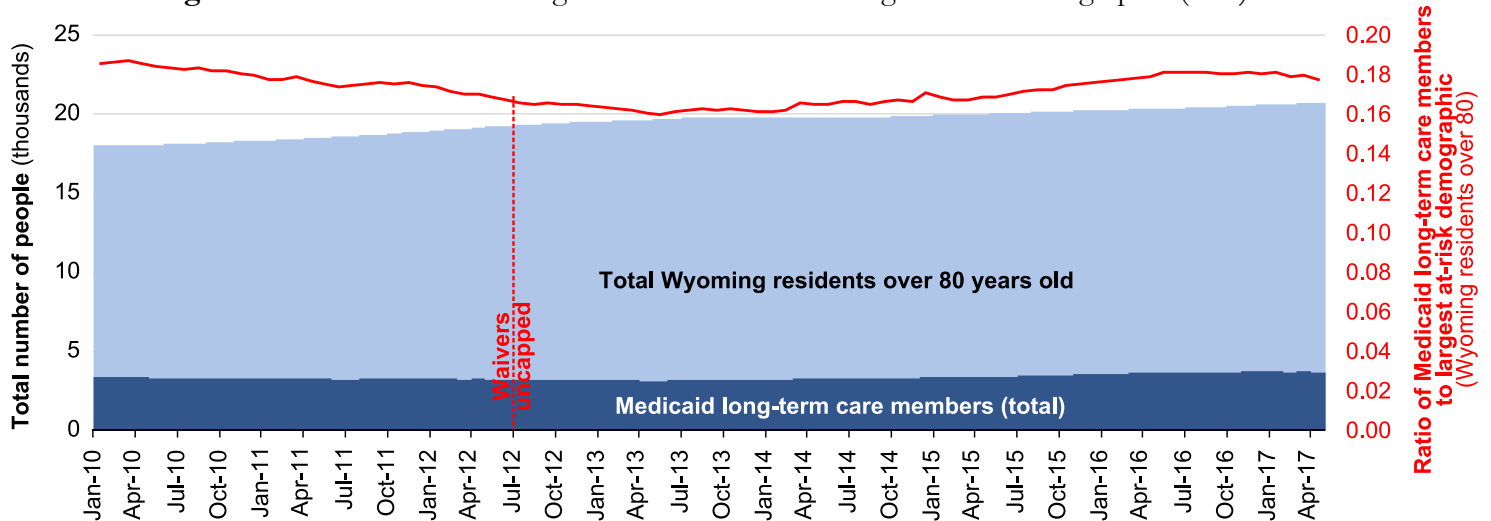


Note on Figure 3, above, the legislative decision to “uncap” the LTC and ALF waivers in SFY 2013. This has led to a gradual increase in the percentage of individuals served in HCBS settings, from approximately 47% to over 56% today. This trend is beneficial both to members (who would much prefer to remain in their own home) and to the State (since the PMPM costs are less than half of institutional care).

Note further that the total number of individuals on Medicaid long-term care has grown slowly, from approximately 3,300 people in 2010 to approximately 3,700 today, while the number of individuals served in SNF settings has declined (see Table 4).

Figure 4, below, illustrates that the growth in long-term care enrollment is largely consistent with increasing demographics. The chart shows total long-term care enrollment compared against the highest-risk demographic (all individuals over 80), in terms of both absolute numbers (blue) and a ratio (red).

Figure 4: Ratio of Medicaid long-term care members to highest-risk demographic (80+)¹⁵



¹⁵ Medicaid enrollment data from MMIS. Population data from US Census estimates, A&I Economic Analysis Division.

Because the ratio of Medicaid long-term care members to the highest-risk demographic has remained relatively stable since 2010 (at 0.18 enrollees per individual over 80), it appears that HCBS services are **generally substituting** for institutional care, rather than contributing to overall growth.

This is further substantiated by the stable, if not increasing, average acuity level of the LTC and ALF waivers, as measured by the total number of points on the LT-101 assessment, as shown in Table 5, below.

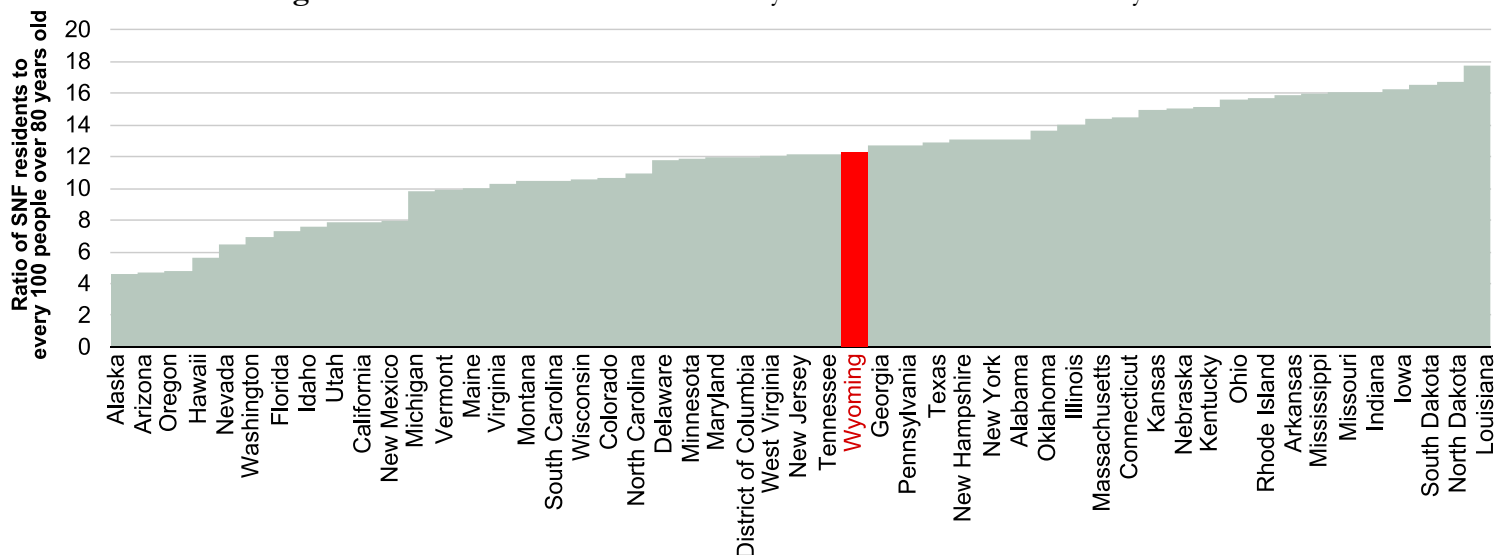
Table 5: ALF/LTC vs. SNF average number of points¹⁶

CY	LTC/ALF		SNF	
	Mean	Median	Mean	Median
2010	16.42	15	20.77	20
2011	16.53	15	20.83	21
2012	16.76	16	20.64	21
2013	16.95	16	20.75	21
2014	16.99	16	21.05	21
2015	17.11	16	21.44	21
2016	17.49	16	21.57	21

If HCBS services were entirely substituting for lower-acuity nursing home care, the relative cost savings of serving the approximately 200 additional people in HCBS in SFY 2016 would total approximately \$6.3 million per year (PMPM difference of \$2,640 * 200 individuals * 12 months).

Despite this progress, there are more challenges ahead. In terms of measuring ‘institutionalization’ among the elderly and disabled as the ratio of SNF residents to every 100 State residents who are over 80 years old (the highest-risk demographic), Wyoming ranks 28th in the nation today, as shown in Figure 5, below.

Figure 5: Ratio of SNF residents to every 100 State residents over 80 years old

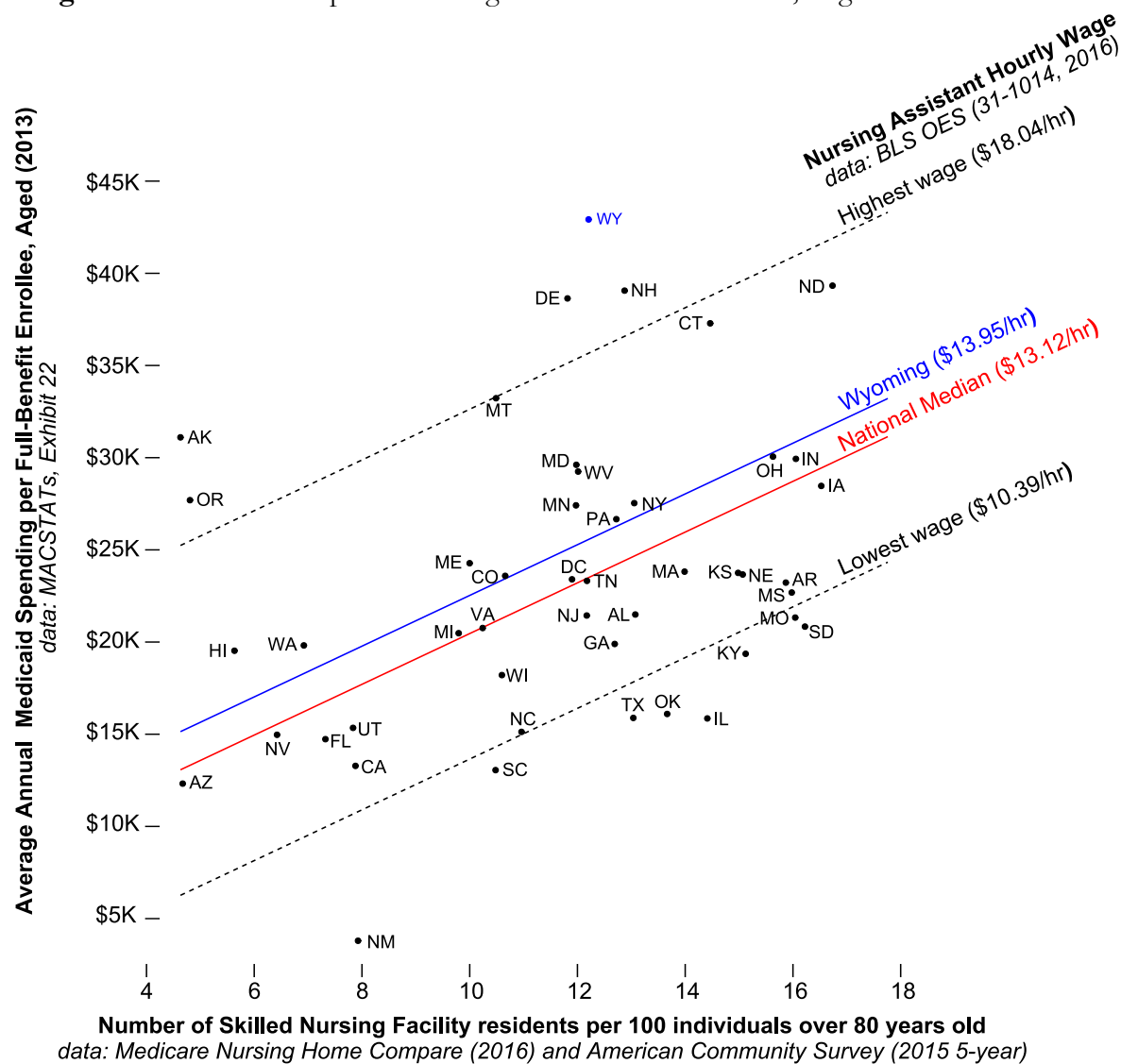


Because SNF settings are so expensive, this degree of institutionalization is partly responsible for the fact that Wyoming has the highest Medicaid cost per aged full-year equivalent enrollee. The scatterplot in Figure 6,

¹⁶ Measured for member-months with an LT-101 conducted within 400 days. Due to more frequent LT assessment requirements for LTC and ALF waivers, the average sample was 1,500 individuals for LTC/ALF and 700 for SNF.

below, shows the correlation between these two variables, controlling for labor costs, as measured by the average hourly wage for nursing assistants. These two variables are statistically-significant predictors of over 34% of the variation in Medicaid spending on the aged.

Figure 4: The relationship between degree of institutionalization, wages and Medicaid costs



OLMSTEAD PRIORITIES, 2017-2021

Behavioral Health Division

In addition to priority areas mentioned in Wyoming's 2002 *Olmstead* plan, and the subsequent 2013 update, the Behavioral Health Division will be focusing on the following areas over the next four years in relation to *Olmstead*, with the intent of serving Wyoming's neediest populations in the least-restrictive, most-integrated, and therapeutic environments.

Facilities: Wyoming Life Resource Center and Wyoming State Hospital

Facilities Redesign Project

In 2012, the Department of Health requested the commissioning of the development of a Facility Master Plan for the five (5) Department facilities. As a result, the Legislature authorized the creation of the Facilities Task Force in 2014. It includes members from the Legislature, executive branch employees and private providers. The task force was charged with reviewing the Facilities Master Plan and make any recommendations needed to address short and long-term goals and operating practices of each facility. The task force examined statutory obligations, conducted site evaluations and help public meetings at each facility. It made recommendations, which included a new vision for both the State Hospital and Life Resource Center. The Legislature and the Governor adopted the task force's findings, which are now being implemented by the Department.

The Task Force determined the role of the State should be as a "safety net" provider. The "safety net" was defined as the State's obligation to ensure access as a provider of facility-level services as a last resort for those individuals who would otherwise be critically endangered or a threat to public health and safety.

Additionally, in 2014, the Task Force set a vision for "One Campus, Long Streets". The goal is to integrate services between the State Hospital and the Life Resource Center. To do this, services were categorized into three (3) broad types of care:

- **Acute**, short-term crisis stabilization;
- **Immediate**, post-acute rehabilitation; and,
- **Long-term**, extended services to maintain functional levels.

The "One Campus, Long Streets" concept is operationalized by having the State Hospital focus on acute crisis stabilization and the Life Resource Center focus on intermediate and long-term care. The goal of acute and intermediate services is to provide care and then transition clients to the community. While long-term care means the provision of extended services, the goal includes the transition to a less-restrictive placement in the community, when possible.

The directive of the Task Force is that the State should not play a role in providing direct facility-based services to ABI, DD or dually-diagnosed individuals who do not manifest "exceptionally difficult behaviors". The State should also not provide direct facility-based services to individuals with mental illness who have not been involuntarily committed under Title 25, Title 7 or a court order. All of these populations are better served by providers in the community.

The final result of the work of the Task Force and Legislature is a realignment of the populations served and types of care provided at the State Hospital and Life Resource Center, illustrated in the figure below.

	Type of Care		
	Acute	Intermediate	Long-term
ABI/DD with exceptionally difficult behaviors	WSH	WLRC	
Title 25-Civil Commitments	WSH		
Title 7-Forensic Psych	WSH	WSH	WSH
Gero-psych	WSH	WLRC	WLRC
High Medical		WLRC	WLRC
"Hard to Place"			WLRC
"Emergency Placements"	WLRC	WLRC	WLRC

WSH	WSH
WLRC	WLRC

Wyoming statutes were codified to reflect the new missions of the State Hospital and Life Resource Center:

“Exceptionally difficult behaviors” means a high level of assaultive or self-injurious behavior in a person with an intellectual disability or organic brain syndrome. These behaviors may include aggression and violent behavior, wandering, sexually inappropriate behavior, self-endangering behaviors or medication noncompliance. (W.S. 25-5-102 (b)(xxxi))

“Hard to place” means a person who is eligible for skilled nursing facility care; does not meet the criteria for “exceptionally difficult behaviors”, “high medical need”, or “organic brain syndrome”; and for whom no community skilled nursing facility has been identified. (W.S. 25-5-102 (b)(xxxii))

“High medical needs” means a person who is eligible for skilled nursing facility services; does not meet the criteria for “exceptionally difficult behaviors”, or “organic brain syndrome”; and would qualify for the extraordinary care nursing facility reimbursement rate. (W.S. 25-5-102 (b)(xxxiii))

“Organic brain syndrome” means a decrease in mental function due to a medical disease, other than mental illness, as defined by the department. Organic brain syndrome may be the result of an acquired brain injury or the result of dementia caused by trauma, hypoxia, cardiovascular conditions including thrombotic and embolic events or degenerative, infectious, alcohol and drug related or metabolic disorders. (W.S. 25-5-102 (b)(xxxiv)).

In addition to being an Intermediate Care Facility, the Life Resource Center was authorized to provide skilled nursing services to persons with organic brain syndrome who manifest exceptionally difficult behaviors (gero-psych); persons with high medical needs; and persons who are hard to place (W.S. 25-5-103).

Wyoming State Hospital: People Empowering People (PEP) Program

People Encouraging People (PEP) is a community integration program for patients for which finding appropriate discharge options presents a challenge because of recent or historic behavioral issues or a variety of skill deficits. Individual programming emphasizes independent living skills, social interaction, personal and collaborative problem-solving and active participation in a variety of community activities. The focus is on meaningful activities aimed at decreasing isolation, helplessness, and boredom and increasing personal growth. Day programming focuses on developing and strengthening interpersonal and independent living skills required for admission into a lower level of care.

The target population for PEP are those clients whose treatment issues impair their ability to communicate and interact; who have limited experience in independent life skills; who are otherwise ready for discharge, are awaiting placement in group homes or other transitional facilities, and will benefit from additional coaching, practice and community integration opportunities.

PEP participants are discharged when conditions warranting involuntary hospitalization no longer exist and supportive services are secured in the community. Some participants who are not quite ready for community transition are served at the WLRC in the Pathways Program. They then transition into the community from Pathways.

The program philosophy encompasses the following:

- Each person arrives with an expectation of treatment, and the program assists with meeting that expectation.
- Each person has a multitude of strengths which can be used to overcome difficulties that have resulted in delayed discharge from institutional settings.
- Each person will be provided the opportunity to progress according to her capacity.
- A multidisciplinary staff supports and encourages each patient to design and participate in treatment according to individual needs and preferences. Each participant is actively engaged in planning supports needed to return successfully to the community.

Program goals include:

- Each participating individual will display an increase in independent living skills indicating readiness for discharge to a less restrictive level of care.
- Each participant will experience a better quality of life upon returning to the community.

Wyoming State Hospital: Priority Metrics and Utilization Review/Management

In recent years, Wyoming has seen growth in volume and expenditures in “Title 25,” the legal system for emergently detaining and involuntarily hospitalizing individuals who are dangerous to themselves or others. While entry into the Title 25 system is not controlled by the WDH, it is in the interest of all stakeholders to limit the use of involuntary Title 25 commitments and services to only those cases that truly require hospitalization. The WDH continues to work with local, county-based, regional, and statewide stakeholders on initiatives to improve the continuum of care for individuals with behavioral health challenges, and ensure that, to the extent possible, services are provided in the least-restrictive, most-integrated, and therapeutic environment.

Accordingly, the WSH prioritizes and tracks the following metrics, in order to improve its service delivery and facilitate appropriate discharges and community transitions for its clients:

- Average Length of Stay
- Level of care (LOCUS)
- Barriers to discharge

The Wyoming State Hospital has partnered with Optum/WYhealth to perform utilization review and utilization management for individuals committed to the WSH under Title 25 (which includes commitments in private

“designated hospitals” throughout the state). As part of that effort, the Director’s Unit for Policy, Research, and Evaluation created a management tool and database to facilitate better data collection, facility management, and discharge planning for the Title 25 system. The database will allow the following to occur, through availability of real-time data:

- Patient tracking, facility management, and improved discharge planning for the Wyoming State Hospital;
- Ease of performing utilization review (admission reviews, continued stay reviews, medical necessity, etc.) for Optum/WYhealth; and,
- Improved data analysis, analytics, and reporting for the Director’s Office with respect to Title 25.

Wyoming Life Resource Center: Pathways Program

The Pathways Program (Pathways) is a non-forensic dual diagnosis program that supports people with intellectual disabilities and mental illness. It is a safety net for people coming from the State Hospital and the community. The program is a comprehensive ICF/IID program of assessment, stabilization, treatment and transition services back to the community. It includes integrated medical, psychiatric, behavioral, and diagnostic and assessment components.

Program goals include:

- Provide a dual diagnosis program based on integrity and best practices.
- Provide outcome driven services that successfully place people back into the community.
- Develop an infrastructure and foster referral relationships to assist transition into the community.
- Provide extensive outreach and education to both intellectual disability and mental health providers throughout the state.

Person-centered planning is the foundation of Pathways. The focus is on identifying and maximizing an individual’s strengths and preferences. It is a process that focuses on the person’s preferences, talents, dreams and goals. It is a collaborative and helps people get the supports and services they need to live a quality life based on their own preferences and values. The person served drives the planning process and those who know the person best are important participants.

The principles of Person Centered Planning include:

- Identifying and incorporating what is important to, as well as what is important for, the person into all supportive interventions.
- Using information to identify outcomes the person desires.
- Respecting each person’s life journey, dignity, and cultural background.
- Supporting the person’s self-determination.
- Providing the most integrated setting and inclusive service deliveries that support, promote and allow for inclusion and self-sufficiency.

Intellectual and Developmental Disabilities (DD) Waivers

Rate Rebasing

At the direction of the Wyoming State Legislature, WDH is undertaking a rate analysis and setting project for the Comprehensive and Supports waiver programs. The purpose of this initiative is to provide the State of Wyoming with an accurate and objective portrait of the cost to deliver Medicaid waiver services. This study will inform the State's ability to maintain and expand an adequate provider network for community based services.

Individualized Budget Amounts (IBA) and Service Cap Reviews

In conjunction with the above-mentioned rate rebasing project, WDH will re-examine the current methodology for individualized budget amounts, including the use of caps on specific waiver services. Eliminating or easing service caps will allow for greater individual choice for the services and the ability to increase or decrease specific services through the course of the individual's plan of care. Any changes resulting from this project would be intended to maximize individual control and autonomy over the services that can best serve the person in their community setting and, in times of crisis, keep services in place in the community rather than a more restrictive setting.

Waitlist Policy

It is the policy of the WDH that no individual shall wait longer than 18 months for DD waiver services. This policy will continue as long as funding and program enrollment trends allow. Reducing wait times for services is a key objective of the DD Section and the WDH. Continuing to reduce waitlists will provide needed community services and reduce the possibility of services being delivered to the same population in a more restrictive setting.

Community Mental Health and Substance Use Disorder Treatment Services

Ombudsman

The Behavioral Health Division contracts with Wyoming Guardianship Corporation to provide the Substance Abuse and Mental Health Ombudsman program (SAMHOP). Ombudsman services are delivered in Wyoming, without interference from the WDH, as part of the *Chris S. Stipulated Agreement*. Ombudsman services entail advocacy and support to help individuals resolve issues related to accessing mental health and substance use treatment and recovery. More than half (52%) of individuals that seek Ombudsman services in Wyoming live in a restrictive, but non-jail, environment. Financial need and lack of appropriate housing have been identified through the Ombudsman program as systemic barriers to community integration.

The contract requires SAMHOP to provide Ombudsman services to at least eighty (80) individuals served per quarter. In recent years, the number of persons served has exceeded those expectations

Assisted Outpatient Treatment (AOT) Grant

The Assisted Outpatient Treatment (AOT) Grant was awarded by SAMHSA to the Wyoming Department of Health in October 2016. The purpose of the AOT grant is to implement and evaluate programs which aim to reduce the incidence and/or duration of psychiatric hospitalization, homelessness, unemployment, incarceration, and interactions with the criminal justice system, while also improving the overall health and social outcomes for individuals living with serious mental illness (SMI). The AOT grant was first implemented at Central Wyoming Counseling Center in Natrona County. Emphasis in the first year of the grant was placed

on developing treatment infrastructure to support the utilization of directed outpatient commitment, as per Wyo. Stat. Ann. § 25-10-110.1, in lieu of state hospital commitment for at-risk individuals. The Wyoming Department of Health plans to expand the AOT Grant to other areas of the state in the second year of the grant. AOT Expansion sites will be selected in Summer 2017 on the basis of demonstrable regional need and a competitive grant application process. As part of the AOT grant, the Department will contract with the GAINS Center, a SAMHSA contractor, to provide training to current and potential AOT providers in Wyoming.

Title 25 “Gatekeeper” Designations

The Wyoming State Legislature amended Title 25 during the 2016 budget session to allow the Wyoming Department of Health, in consultation with local County Commissioners, to designate county gatekeepers. Designated gatekeepers serve as the single point of responsibility for the Title 25 emergency detention and involuntary hospitalization process. Designated gatekeepers are expected to provide guidance to courts, healthcare providers, and other stakeholders on the detention and hospitalization process, and to provide intensive care coordination for individuals before, during, and after the involuntary hospitalization process. The Wyoming Department of Health has received requests for gatekeeper designation from 12 community mental health providers representing 20 counties since the legislation took effect. The Wyoming Department of Health has received support from local boards of county commissions thus far in designating 8 community mental health providers representing 13 counties as official Title 25 gatekeepers. The Wyoming Department of Health continues to strive toward its goal of achieving gatekeeper designation in all 23 counties of the state.

The Department offered one-time funding in Fiscal Year 2017 to community entities interested in designating a gatekeeper for their county and establishing infrastructure to increase the effectiveness of the community response to Title 25, lower costs associated with emergency detentions and involuntary hospitalizations, and improve the continuity of care for individuals living with mental illness. The Wyoming Department of Health awarded 10 grants totaling \$623,925.

PATH Grant

The Behavioral Health Division uses federal Projects for Assistance in Transition from Homelessness (PATH) funds to provide outreach and case management services for people with serious mental illness (SMI) experiencing homelessness. Wyoming receives approximately \$300,000 each year, the majority of which goes to non-profit providers in Wyoming’s four largest counties. The focus is on helping PATH participants gain permanent sources of funding for their housing expenses. Up to 20% of PATH funds are limited to rental deposits, necessary move in costs and other necessary expenses (i.e. birth certificates, clothes for a job interview, beds) and, on occasion, for one-time rent payments when there is a risk of eviction and no other way to pay. An emphasis is placed on helping community partners increase their contributions to reducing homelessness.

Division of Health Care Financing (Medicaid)

Community Choice Waiver

The Medicaid Home and Community-Based Services (HCBS) Community Choices Waiver (CCW) program is authorized in 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state, and local public programs as well as the supports that families and communities provide.

CCW serves people who are 19 years old and older who meet the functional and financial criteria for Medicaid nursing home care. Services include case management, personal care attendant, respite care, skilled nursing, adult day care, home delivered meals, non-medical transportation, assisted living facility (ALF), and personal emergency response system. Participant directed service delivery option services include Direct Service Worker (which replaces the personal care attendant), and fiscal management. The goal of the waiver is to provide access to safe and appropriate services for Medicaid-eligible, functionally impaired elderly and physically disabled residents of Wyoming.

The objectives of the CCW program include:

1. Minimizing admissions to long-term care institutions for people who can be safely served at home or in an assisted living facility in the community;
2. Providing a transition option for eligible nursing facility residents to move from a nursing facility to a residential home or an assisted living facility;
3. Providing this population with access to appropriate health and social services to help them maintain independent living;
4. Providing for the most efficient and effective use of public funds in the provision of needed services which promote and maintain the health and welfare of waiver participants;
5. Allowing communities flexibility in development of those services; and
6. Assuring service quality is maintained for participants receiving services through this waiver.

The Waiver is housed in and administered by the Division of Healthcare Financing. Services are provided by entities within the communities that meet established provider qualification for each service they provide and have executed a Medicaid Provider Agreement. Participants are offered a choice of settings to receive their services identified on their individual Plans of Care (POC). In addition the CCW does not have a waitlist. Participants who are eligible and meet all of the program criteria are able to join the waiver program and receive services in the community in a timely manner. It is our goal to maintain a zero waitlist policy.

In addition to the CCW Program, Wyoming also provides services to the elderly and disabled population through two other programs: Program of All-Inclusive Care for the Elderly (PACE) and Project Out, described further below.

PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a program which provides an option for individuals who need nursing home level of care but wish to remain in their home. The mission of the Wyoming PACE is to enable the aging population to live with dignity within their communities.

Through the PACE Center, older adults and people over the age of 55 living with disabilities can receive medical care and supportive services. Not only does PACE allow participants to stay within their own homes, but it

also provides family members and care givers with needed professional guidance, physical relief, and emotional support. Services provided through PACE include:

- On-site physician access with personalized care tailored to participant needs;
- Primary and specialty medical care including dental, audiology, optometry and podiatry;
- Nursing and social work;
- Physical, occupational and speech therapy;
- Hospital and emergency care;
- Prescription drug coverage and management;
- Lab tests and diagnostic procedures;
- Meals and nutritional counseling;
- Personal care;
- Home care;
- Adult day care; and,
- Transportation services.

PACE is currently only available in Laramie County.

Project Out

Project Out is a temporary short-term program that is designed to assist individuals who are currently residing in a nursing facility and wish to return to independent living safely within the community. This program also assists individuals – who are at imminent risk of going to a nursing facility – remain in their community and out of an institution. Project Out ensures that services and supports are provided to maintain the highest quality of life for individuals returning to the community, or individuals who wish to remain in the community.

The Division of Healthcare Financing currently partners with two provider agencies to administer this program. Transition Specialists within these agencies work with the individuals to assess eligibility and safely transition them out of, or keep them living independently, in the community. Some of the services provided through Project Out include: application assistance, first and last month's rent payments, utility deposits, transportation assistance, acquiring furniture, and accessibility and adaptive equipment.

Project Out is a key component within the Olmstead plan to safely transition and keep the elderly and disabled population out of institutions and remain in the communities they prefer.

Wyoming Super-utilizer Program (WySUP)

The Wyoming Super-Utilizer Program (WySUP) is one component of a group of initiatives within the WDH intended to improve the health outcomes of adults with complex care needs while decreasing State costs. The WDH plans to have the WySUP fully implemented by December of 2018.

This program will focus on adults with multiple comorbidities. In many cases, these individuals will have co-occurring behavioral health conditions, so the program must be tightly integrated with the mental health and substance abuse system in Wyoming.

- Adults with complex healthcare conditions are the focus of this initiative. Large coordination efforts already exist for children, to include:
 - The Care Management Entity (CME) for high-risk (SED) youth;
 - The Children's Mental Health Waiver;
 - Department of Family Services and Wyoming Department of Education services; and,
 - Medicaid coverage of Psychiatric Residential Treatment Facilities (PRTFs) and Early Prevention, Screening, Detection and Treatment (EPSDT).

- Those targeted in this project do not include individuals that are high cost simply based on their long-term care costs (e.g., nursing home residents, ID/DD waiver clients, and Long-Term Care waiver clients). Program and care management reforms are already underway to improve care and lower costs for these populations.
- Instead, the program will be targeted towards the top 5% of the remaining Medicaid population (largely SSI and Family Care Adults), using an open-source, prospective, additive risk scoring algorithm calibrated with Wyoming Medicaid claims data.

In its current phase, this project relies on a contract with a health management vendor to provide in-person care coordination for Wyoming Medicaid members selected as potential participants in the program. As mentioned above, members in this program often have co-occurring behavioral health challenges in addition to their medical conditions. The state hopes that, through more targeted care coordination, health outcomes for these clients will improve, including reduced reliance on higher levels of care (e.g., inpatient and/or involuntary hospitalization).

Upon assessment of success of the early phases of the WySUP, the state hopes to potentially expand the program to non-Medicaid populations, including those going through the Title 25 (emergency detention and involuntary hospitalization) system.

Additionally, a primary focus of this program is facilitating enrollment in, and use of, Patient-centered Medical Homes (PCMHs) for high-need, high-cost clients. As part of the project, the state will assess the feasibility of program expansion through regional or local care coordination entities, and potentially implement “Health Homes” in certain areas, under Section 2703 of the Affordable Care Act.

Aging Division

State Plan on Aging Summary

As part of its State Plan on Aging, the Community Living Section within the Aging Division of the WDH has set forth the following goals for the 2017-2021 time period:

1. Strengthen and expand programs that delay or prevent the need for long-term care services.
2. Improve awareness of and access to services.
3. Ensure the rights and safety of older adults.
4. Enhance the quality of existing programs.

These goals are rooted in the Community Living Section's primary mission to help in preventing premature institutionalization for older adults in Wyoming. Further, the goals are based on the following four components:

- Anticipating increased needs and financial restraints, improving the health of older adults in order to delay the need for services must be a priority. Improved health also increases the likelihood of aging in place, which is the preference of most older adults and a priority for the State of Wyoming.
- Without awareness and access, quality services offer little benefit to older adults. Wyoming is rural in nature, and lacks robust public transportation services; thus, access to services is a primary barrier for people who cannot drive, do not own a car, or live long distances from available services.
- Preventing abuse and exploitation of older adults is important. Increased awareness of elder abuse and exploitation helps maintain the mental and physical safety of older adults in the full range of living arrangements. The safety of older adults also needs to be considered more broadly in the context of the community. For example, older adults living alone could face additional challenges in the event of an emergency, such as a natural disaster.
- Increased access to services is less meaningful if those services are not of a high quality; thus, quality improvement and performance improvement are an important part of our mission.

Preventing Premature Institutionalization

The Aging Division is implementing three objectives within its current State Plan on Aging aimed at preventing premature institutionalization for older adults and severely disabled individuals in Wyoming. They are outlined below.

- **Objective:** Using the Ombudsman Program as an avenue to identify inappropriate institutional placements.
 - **Strategy:** The State Ombudsman will educate the regional ombudsmen to promote an *Olmstead* informed program in addressing resident rights.
 - **Performance measure:** Number of P128 (Request for less-restrictive placement) complaints to those with dispositions of "Resolved to the satisfaction of the resident or complainant."
- **Objective:** Promoting services offered through the Wyoming Home Services program.
 - **Strategy:** Improve coordination of care and other services to older adults in community-based settings.
 - **Performance measure:** Increase enrollment in the Wyoming Home Services program.

- **Objective:** Improve awareness of and access to Title III and VII services.
 - **Strategy:** Partner with providers to reach more eligible older adults, not yet enrolled.
 - **Performance measure:** Increase Title III and VII enrollment.

CHALLENGES

Statewide Coordination on *Olmstead* Plan and Initiatives

The *Olmstead* plan outlined in this document is specific only to the Wyoming Department of Health. While collaboration within various initiatives (some related to *Olmstead*) exists between state agencies and external stakeholders, there is currently no single entity (e.g., state agency, commission, or task force) that would be responsible for ensuring elements of a statewide *Olmstead* plan are executed in a comprehensive manner. The Department will continue to make progress on its *Olmstead* goals and initiatives, but the lack of statewide coordination may present a challenge going forward.

Housing

Housing availability and affordability – especially for high-need individuals at risk of institutionalization – is a challenge for all states, including Wyoming. Regular reviews of patients committed to the Wyoming State Hospital through the Title 25 system indicate that housing is a primary barrier to discharge for patients no longer meeting medical necessity for inpatient psychiatric care. While the Department has programs dedicated to assisting high-need individuals with access to housing (e.g., emergency funds or quality of life funds for first/last months rent), the supply of affordable housing in Wyoming communities is often limited.

Compounding this problem is the fact that the State of Wyoming does not have a dedicated housing authority, or state agency responsible for housing and development.

Provider Availability

Wyoming is a rural and frontier state, and has Health Provider Shortage Areas (HPSAs) in every county, for every provider type. Accordingly, access – namely the availability of some providers and services – is a continuing struggle for the state's fragile healthcare system. Appropriate healthcare services, levels of care, and infrastructure are not available in every Wyoming community, resulting in higher demand in more populous areas and thus increasing challenges in physical access to care (travel times, limited supply, etc.).

Economic Fluctuation and Budget Reductions

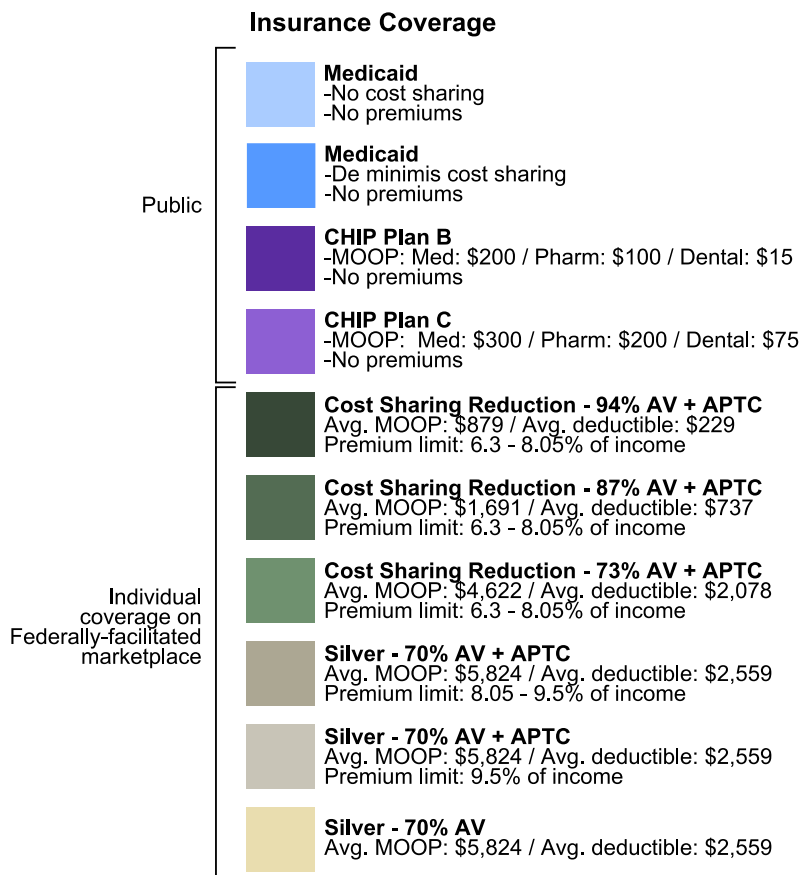
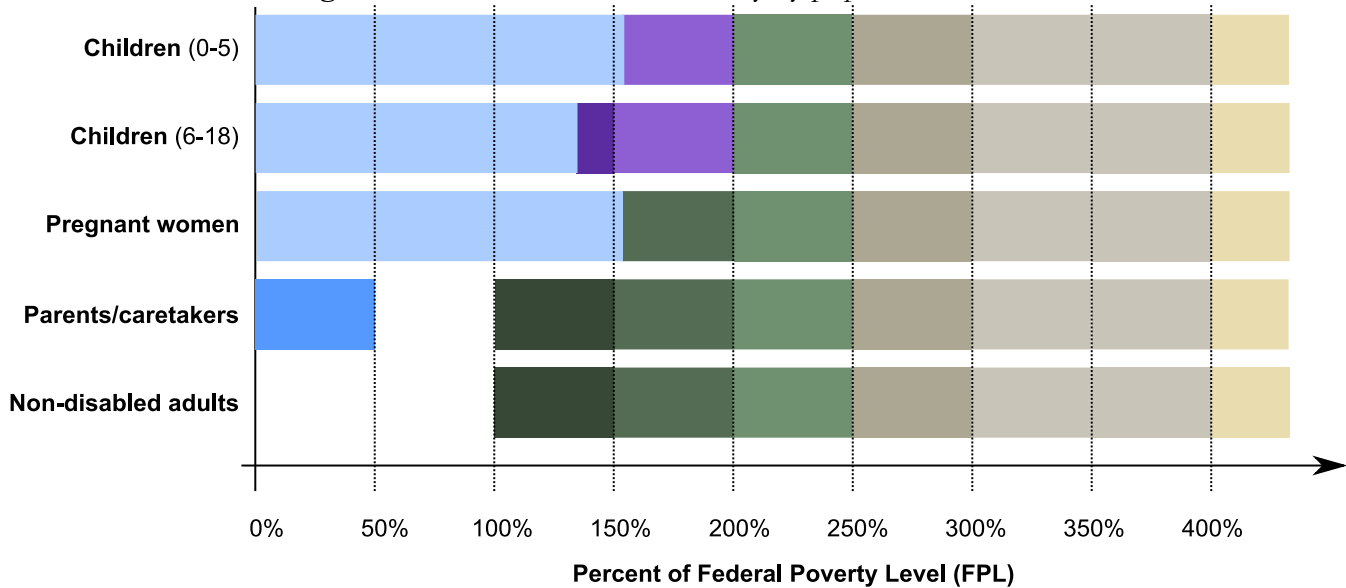
Wyoming's economy depends heavily on mineral extraction and tourism. Low prices for oil and gas, along with decreasing demand for coal have depressed output, increased unemployment, and reduced State government revenues by an estimated 23 percent for 2017-18. The Governor and Legislature have, accordingly, required state agencies to do more with less. For example, the Wyoming Department of Health operating budget was reduced by over \$150 million for the 2017-18 biennium.

Healthcare Coverage

Wyoming did not elect to expand Medicaid to all low-income adults, per the Affordable Care Act. Accordingly, Wyoming has a higher rate of uninsured individuals than some of our neighboring states, primarily around low-income adults who do not currently qualify for health insurance subsidies on the Marketplace. Access to healthcare coverage is often determined to be a primary barrier to discharge for some patients at the Wyoming State Hospital and other designated hospitals in Wyoming.

Figure 5, on the next page, shows what kind of health insurance coverage is available for various categories of people and income ranges. The color key below the figure describes the premiums and member cost sharing for that particular coverage option.

Figure 5: Health insurance availability by population and income level



Notes:

(1) Maximum out-of-pocket (MOOP) and deductible data are national averages from the Kaiser Family Foundation (2014), but are similar to WY BCBS offerings.

(2) Actuarial value (AV) refers to the expected average percent of medical costs borne by the insurer (vs. the insured)

(3) Advance Premium Tax Credits (APTC) are refundable tax credits that lower the cost of an individual's premium. The amount is based on:

- The individual's income
- The cost of the second-lowest Silver-level plan
- The sliding percent of income schedule noted to the left.

WYOMING *OLMSTEAD* GOALS, 2017-2021

The Wyoming Department of Health sets forth the following *Olmstead*-informed goals for the 2017-2021 period:

1. Complete the redesign of the Behavioral Health Division facilities, and implement and operationalize the new missions.
2. Continue to implement, and expand, the PEP and Pathways programs at the Wyoming State Hospital and Wyoming Life Resource Center.
3. Reduce volume and demand in Wyoming's "Title 25" system for involuntary commitments.
4. Decrease the average length of stay at the Wyoming State Hospital and Title 25 "designated hospitals."
5. Continue to manage the wait list for Wyoming's Comprehensive and Supports (DD/ID) waivers, and reduce the percent of individuals waiting 18 months or more (currently 1.2%).
6. Continue to increase the percentage of Medicaid long-term care recipients served in home and community-based settings, as opposed to institutional settings.
7. Continue to maintain a "zero waitlist" policy for Medicaid Long-term Care Waivers (Community Choice Waiver).
8. Expand healthcare coverage options for Wyoming's uninsured population experiencing, or at-risk of institutionalization.

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁸Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ☐ Yes ☐ No

b) The recovery and resilience of children and youth with SUD? ☐ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

a) Child welfare? ☐ Yes ☐ No

b) Juvenile justice? ☐ Yes ☐ No

c) Education? ☐ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ☐ Yes ☐ No

b) Costs? ☐ Yes ☐ No

c) Outcomes for children and youth services? ☐ Yes ☐ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☐ Yes ☐ No

b) Mental health treatment and recovery services for children/adolescents and their families? ☐ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system? ☐ Yes ☐ No

b) for youth in foster care? ☐ Yes ☐ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Community Mental Health Centers receive funding from the Division to provide mental health and substance use services to children. The Division works collaboratively with other agencies throughout the state such as the Department of Family Services who is responsible for social and welfare services, and juvenile justice/law enforcement. Wyoming Department of Education is responsible for the education services.

7. Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☒ Yes ☐ No
2. Describe activities intended to reduce incidents of suicide in your state.
Wyoming updated the state suicide prevention plan at the beginning of 2017. The goals and objectives have been closely aligned with the 2012 National Strategy for Suicide Prevention, a report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. Activities intended to reduce incidents of suicide in Wyoming include: developing broad-based support for suicide prevention by increasing support for suicide efforts; develop and implement community-based suicide prevention programs and activities through support and development of community-based coalitions for suicide prevention and increasing capacity for suicide prevention in school districts; promote awareness that suicide is a public health problem that is preventable by developing media campaigns to raise awareness about suicide prevention and coordinating with other suicide prevention organizations to enhance outreach; reduce stigma associated with mental health including education of media on appropriate reporting; reduce access to lethal means by working with stakeholders including local gun shop owners and prescription drug abuse stakeholder groups; implement suicide prevention training to increase recognition of at-risk behavior and delivery of effective treatment, to include implementation of Zero Suicide; increase key services for individuals at risk for suicide and suicide survivors by establishing a statewide network of suicide survivors and support group leaders and collaborating with primary care facilities to incorporate suicide prevention appropriate responses to individuals at risk for suicide; build capacity for Lifeline services in Wyoming to increase the number of lifeline calls answered within the state from 0% to 70%; and finally we are working to improve and expand surveillance systems to collect suicide-related data.
3. Have you incorporated any strategies supportive of Zero Suicide? ☒ Yes ☐ No
4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☒ Yes ☐ No
5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ☒ Yes ☐ No

If so, please describe the population targeted.

WDH collaborates with and provides multiple resources (i.e., funding and technical assistance) to suicide prevention efforts across the state through community-based coalitions. Coalitions in all 23 Wyoming counties have a primary focus of suicide prevention. Each coalition works with local stakeholders and decision makers to impact identified disparate populations through the implementation of a community level strategic plan reflective of the 2017-2021 State Suicide Prevention Plan.

Does the state have any activities related to this section that you would like to highlight?

Until recently, suicide prevention was administratively housed with substance abuse prevention under the Substance Abuse and Suicide Prevention Program. At this time, the Injury Prevention Program is expanding to include both unintentional and intentional injury, therefore including suicide prevention services. The expanded Injury Prevention Program, Substance Abuse Prevention Program, and Tobacco Prevention and Control Program will work as a unified team to coordinate efforts to enhance community outcomes. The Injury Prevention Program also works collaboratively with the Behavioral Health Division which operates programs to maintain the mental health and reduce substance abuse primarily through the application of treatment services through community mental health centers.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? jn Yes jn No
2. Has your state identified the need to develop new partnerships that you did not have in place? jn Yes jn No
If yes, with whom?
3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Division coordinates with community mental health centers to produce the best possible outcomes and to enable consumers to function outside of inpatient and residential programs.
Service contracts outline deliverables and expectations of these centers in order to allow the Division to maximize efficiency, effectiveness, quality and cost-effectiveness of the services and programs.

a. Title 25 Coordinator hired
b. Memorandum of Understanding between hospitals and community mental health centers.
c. Behavioral Health Advisory Council
d. Gatekeeping and Diversion grants
e. Assisted Outpatient Treatment
f. Early Intervention and Education Program- Ensures that services are provided to eligible children birth through 5 with Developmental Delays and disabilities in accordance with the IDEA and Wyoming state laws.

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Governor's Behavioral Health Advisory Council

Robert Johnston, Chair

Governor Matthew H. Mead

August 23, 2017

Ref: GB-2016-001

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention, Division of State Programs
Center for Substance Abuse Treatment, Division of State and Community Assistance
Center for Mental Health Services, Division of State and Community Systems Development
1 Choke Cherry Road
Rockville, MD 20857

To Whom It May Concern:

The Wyoming Governor's Behavioral Health Advisory Council reviewed the Uniform Application FY 2018/2019 State Behavioral Health Assessment and Plan for the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant via email and supports this application.

The Behavioral Health Advisory Council members represent advocates, consumers, family members, providers, legislators, and other designees representing various state and regional offices.

This letter of support/concurrence serves to fulfill the state of Wyoming's requirement for support from state partners.

We look forward to continuing our work to provide a voice for consumers in the planning and implementation of mental health and substance abuse treatment and prevention services in Wyoming.

If you have any questions, you may contact me at 307-259-5026 or via e-mail at rjohnston@pmowyo.org.

Sincerely,



Rob Johnston
Chair

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

- a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The Wyoming Behavioral Health Advisory Council (BHAC) is a majority Consumer and Family member advisory body to state and local government, the Legislature, and residents of Wyoming on mental health and substance abuse services in Wyoming. The vision and mission of the BHAC guides its ability to review, and recommend evidence based approaches to be supported with the federal SAMHSA Mental Health and Substance Abuse Block Grant. The Council wants to assure that our state's system of care for behavioral health addresses necessary modifications for health care reform, and that our strategic plan allows us the flexibility to not only provide input into these changes, but also to modify the Council's processes as necessary to accommodate and support the behavioral health system.

The BHAC informs the Administration and the Legislature on priority issues and provides feedback on behavioral health policy and regulations. In addition the council monitors and evaluates the allocation and adequacy of behavioral health services in the state.

Further, the BHAC participates in the development of the block grant plan through a review and comment process. The Block Grant State Planner presents a draft copy of the Plan to the Council and invites comments and feedback from the Council. A new process was created in 2017 in which the State Planner drafted an outline of the block grant application presented it in a two part series Webinar to the council. The council Chair co-facilitated the presentation and addressed any questions on the review of the draft outline of the state plan. The council plays an integral role in the pre-submission activities relating to the Block Grant Plan. Comments are recorded and addressed within the plan whenever possible prior to submission. The council meets on a quarterly basis to monitor, review, and evaluate the allocation and adequacy of behavioral health services within the State and to provide direction to the BHD in its functioning and allocation of resources.

What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

A robust planning process is utilized each year which includes alignment with the Division's strategic plan and funding decisions. This process involves Division staff, provider staff, and other key stakeholders. Once group decisions are made regarding the specific service needs and funds available, the Division contracts with provider agencies to carry out the services. The state provides data to the Council to help prioritize the delivery of substance abuse services. The WAMSAC representatives on the Council provide input based upon the experiences/services of their member organizations for substance abuse and mental health. Many of those agencies provide services to both populations with an emphasis on co-occurring disorders.

- b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i

☒ Yes ☐ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ☒ Yes ☒ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council is responsible for the following three areas:

- To review the block grant and make recommendations;
- To monitor, review, and evaluate the allocation and adequacy of behavioral health services; and
- To advocate for people with behavioral health needs

The Council currently meets four (4) times a year. These meetings focus on addressing concerns identified by the membership. For the past two years the Council has received targeted technical assistance from SAMHSA to develop mission and vision statements and to develop a 3 year strategic plan. The strategic plan is now in a draft form and is to be finalized at the August 2015 meeting. Our membership reflects the populations identified as critical for our work: LGBTQ, persons recovering from substance abuse, persons experiencing mental health issues, and family members affected by behavioral health concerns. Members and others are encouraged to share "what is happening in their community or with the group they represent" at the beginning of each meeting. These discussions then drive the agenda for future meetings. Other agencies are also asked to provide information on data that they collect to help the Council understand behavioral health issues in a broader perspective.

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Karen Aurand	State Employees	Department of Family Services, Social Services	WY, PH: 307-777-5357	
Trisha Bannon	Family Members of Individuals in Recovery (to include family members of adults with SMI)		4800 E. 13th St Cheyenne WY, 82001	
Sam Borbely	State Employees	Criminal Justice	1609 Monroe Ave Cheyenne WY, 82001 PH: 307-777-6301	sam.borbely@wyo.gov
Lori Burns	Others (Not State employees or providers)		PH: 307-266-1388	
Karl Cline	Providers	Peak Wellness Center	PH: 307-632-9362	
Tammy Cooley	Others (Not State employees or providers)		PH: 307-286-6367	
Carol Day	State Employees	Wyoming Department of Health, Behavioral Health Division	6101 Yellowstone Rd Cheyenne WY, 82002 PH: 307-777-3365 FX: 307-777-5849	carol.day3@wyo.gov
Paul Demple	Providers	Mental Health	909 Long Drive, Suite C Sheridan WY, 82801 PH: 307-655-5013	pauldemple@nwymhc.org
Scott Erickson	Others (Not State employees or providers)		PH: 307-708-2967	
Kyle Gamroth	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 307-267-6801	
Sunny Goggles	Federally Recognized Tribe Representatives		1715 Ashley ave Riverton WY, 82501 PH: 307-851-3386	
Laura Griffith	Providers	Recover Wyoming	512 Killarney Drive Cheyenne WY, 82001 PH: 307-421-7261	
Kim Hair	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4940 East 13th Street Cheyenne WY, 82007 PH: 307-514-4612	teamyellow1@hotmail.com
Nicky Harper	State Employees	Vocational Rehab	PO Box 185 Glenrock WY, 82637 PH: 307-259-9718	nicky.harper@wyo.gov
Kathy Herdenreich	Others (Not State employees or providers)		PH: 307-413-5263	

Robert Johnston	Others (Not State employees or providers)	Wyoming Prevention Management Organization	503 Beech Street Casper WY, 82601 PH: 307-577-6482	roberthaysjohnston@gmail.com
Cheri Kreitzmann	Others (Not State employees or providers)		WY, PH: 307-250-1338	
Martin Kury	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4940 E. 13th St Cheyenne WY, 82001 PH: 307-214-5001	
Sheri Mercer	Family Members of Individuals in Recovery (to include family members of adults with SMI)		736 Florence Sheridan WY, 82801 PH: 307-672-0885	sherry@fiberpipe.net
Christy Misplay	Family Members of Individuals in Recovery (to include family members of adults with SMI)		WY, PH: 307-677-4888	
Jo Ann Numoto	State Employees	Wyoming Department of Education	2300 Capitol Avenue Cheyenne WY, 82008 -2060 PH: 307-777-7675	jo-annnumoto@wyo.gov
Elizabeth Parker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO BOX 2512 Rock Springs WY, 82902 PH: 307-352-6689	
Tracy Ritchey	Others (Not State employees or providers)		PH: 307-682-7970	
Donna Sedey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 307-727-8926	
Brenda Stout	State Employees	Medicaid	6101 Yellowstone Rd Suite 210 PH: 307- 777-7326	brenda.stout1@wyo.gov
Jeff Wasserburger	Others (Not State employees or providers)		4300 Longhorn Avenue Gillette WY, 82716 PH: 307-682-0936	
Kellie Webb	Federally Recognized Tribe Representatives	Eastern Shoshone Tribe	PO Box 638 Fort Washakie WY, 82514 PH: 307-438-0955	
Jessi Westling	Providers	WAMHSAC	PO Box 2778 Cheyenne WY, 82001 PH: 307-632-5519	
Susan Wilson	Others (Not State employees or providers)	Wyoming Legislature	1207 Crestview Dr Cheyenne WY, 82001 PH: 307-638-6473	
Carolyn Yeaman	Others (Not State employees or providers)		PH: 307-632-3496	

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	32	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	10	
Total Individuals in Recovery, Family Members & Others	19	59.38%
State Employees	6	
Providers	4	
Federally Recognized Tribe Representatives	2	
Vacancies	1	
Total State Employees & Providers	13	40.62%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	10	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Wyoming Behavioral Health Advisory Council (BHAC) is a majority Consumer and Family member advisory body to state and local government, the Legislature, and residents of Wyoming on mental health and substance abuse services in Wyoming. The vision and mission of the BHAC guides its ability to review, and recommend evidence based approaches to be supported with the federal SAMHSA Mental Health and Substance Abuse Block Grant. The Council wants to assure that our state's system of care for behavioral health addresses necessary modifications for health care reform, and that our strategic plan allows us the flexibility to not only provide input into these changes, but also to modify the Council's processes as necessary to accommodate and support the behavioral health system.

The BHAC informs the Administration and the Legislature on priority issues and provides feedback on behavioral health policy and regulations. In addition the council monitors and evaluates the allocation and adequacy of behavioral health services in the state.

Further, the BHAC participates in the development of the block grant plan through a review and comment process. The Block Grant State Planner

presents a draft copy of the Plan to the Council and invites comments and feedback from the Council. A new process was created in 2017 in which the State Planner drafted an outline of the block grant application presented it in a two part series Webinar to the council. The council Chair co-facilitated the presentation and addressed any questions on the review of the draft outline of the state plan. The council plays an integral role in the pre-submission activities relating to the Block Grant Plan. Comments are recorded and addressed within the plan whenever possible prior to submission. The council meets on a quarterly basis to monitor, review, and evaluate the allocation and adequacy of behavioral health services within the State and to provide direction to the BHD in its functioning and allocation of resources.

The council did make recommendations to the plan and outline.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

- | | | |
|----|--|---|
| a) | Public meetings or hearings? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) | Posting of the plan on the web for public comment? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) | Other (e.g. public service announcements, print media) | <input checked="" type="radio"/> Yes <input type="radio"/> No |

If yes, provide URL:

<https://health.wyo.gov/behavioralhealth/mhsa/grants/>

The block grant link above was also posted in both the Cheyenne, Wyoming Tribune Eagle and the Casper Wyoming Star Tribune Newspapers.

Footnotes:

COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT PLAN AND REPORT

Behavioral Health Division
September 2017

State of Wyoming
FFY 2018-2019

Wyoming has selected the option of submitting a combined mental health and substance abuse prevention and treatment block grant application. The following pages detail said plan based on the most current Substance Abuse and Mental Health Services Administration (SAMHSA) guidance.

TABLE OF CONTENTS

Section A: Executive Summary	3
Section B: Planning Step 1	4
Substance Use Description of Service System	6
Mental Health Description of Service System	7
Behavioral Health-Primary Care Integration.....	11
Recovery Support.....	11
Individuals with Co-occurring Disorders.....	12
Children/Adolescents.....	12
Prevention.....	14
Diverse Racial, Ethnic and Sexual Gender Minorities	16
Challenges and Limitations.....	17
Section B: Planning Step 2	17
Section B: Planning Step Quality and Data Collection Readiness.....	22
Section C-1: The Health Care System and Integration.....	23
Section C-2: Health Disparities	25
Section C-3: Innovation in Purchasing Decisions	26
Section C-4 Evidence-Based Practices for Early Intervention	27
Section C-6 Person Centered Planning	32
Section C-6 Self Direction.....	32
Section C-7 Program Integrity.....	33
Section C-8 Tribes	34
Section C-9 Substance Abuse Block Grant Primary Prevention.....	34
Section C-10 Statutory Mental Health Block Grant.....	40
Section C-11 Substance Use Disorders.....	44
Section C-13: Trauma.....	55
Section C-14: Criminal and Juvenile Justice	56
Section C-15 Medication Assisted Treatment	57
C-16 Crisis Services	58
Section C-17 Recovery	59
C-18 Community Living and the Implementation of Olmstead.....	60
Section C-19 Children and Adolescents Behavioral Health Services	61

C-20 Suicide Prevention	62
Section C-21 Support of State Partners	63
Section C-22: State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application.....	64
Section C-23: Public Comment on the State Plan	65

Section A: Executive Summary

The Wyoming Community Mental Health and Substance Abuse Prevention and Treatment Block Grant allows the state to give maximum flexibility in addressing the unique behavioral health needs of priority populations such as individuals with serious mental illness, serious emotional disturbance, early intervention, and individuals with substance use disorders. Funds are utilized for mental health and substance use treatment services and supports and also provides for training, technical assistance, administration, prevention, and tuberculosis services for priority populations. The funds are provided to various agencies across the state as they carry out direct services to individuals in need. Wyoming follows all statutory requirements under the federal block grant program and highly values the planning, implementation and delivery of quality of services throughout the state and community levels.

The sections in this application include planning and discussion around the following policy topics: health care system, parity and integration; health disparities; innovations in purchasing decisions; evidence-based practices for early intervention (e.g., serious mental illness); person centered planning and self-direction; program integrity; tribes; primary substance use disorder prevention, statutory criteria for the Mental Health Block Grant; substance use disorder treatment; quality improvement; trauma informed care; criminal and juvenile justice; medication-assisted treatment; crisis services; recovery; community living and Olmstead; children and adolescents behavioral health services; suicide prevention; support of state partners; state behavioral health planning/advisory council; and public comment.

Section B: Planning Step 1

Assess the strengths and organizational capacity of the service system to address the specific populations.

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the five criteria that must be addressed in state mental health plans. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services.

States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

As the least populous state in the nation, Wyoming contains 586,107 people in its 97,093 square miles (U.S. Census Bureau, 2015). Wyoming is a rural and frontier state. The two most populous towns are Cheyenne and Casper, which collectively account for about one-fifth of the state's population. The remaining residents live in small towns, rural communities, and frontier settings scattered throughout the state. Wyoming has six (6) persons per square mile, as compared with the national average of ninety-one (91) persons per square mile (U.S. Census Bureau, 2015).

The role of the Wyoming Department of Health (WDH), Behavioral Health Division (Division) is to develop and oversee the behavioral health service system in Wyoming. The Division includes four (4) major sections called Developmental Disabilities (DD), Mental Health and Substance Abuse (MHSA), Wyoming State Hospital, and Wyoming Life Resource Center. The MHSA section has various tasks such as quality management, contracts and monitoring, and substance use provider certification. The DD section oversees home and community based waiver services for people with developmental disabilities and acquired brain injuries. The Wyoming State Hospital provides acute psychiatric and forensic care to adults. The Wyoming Life Resource Center is a residential community with therapeutic and medical support services for adults. MHSA services in Wyoming are funded through the Division. The Division is the single state authority for the delivery of State funded mental health and substance abuse services.

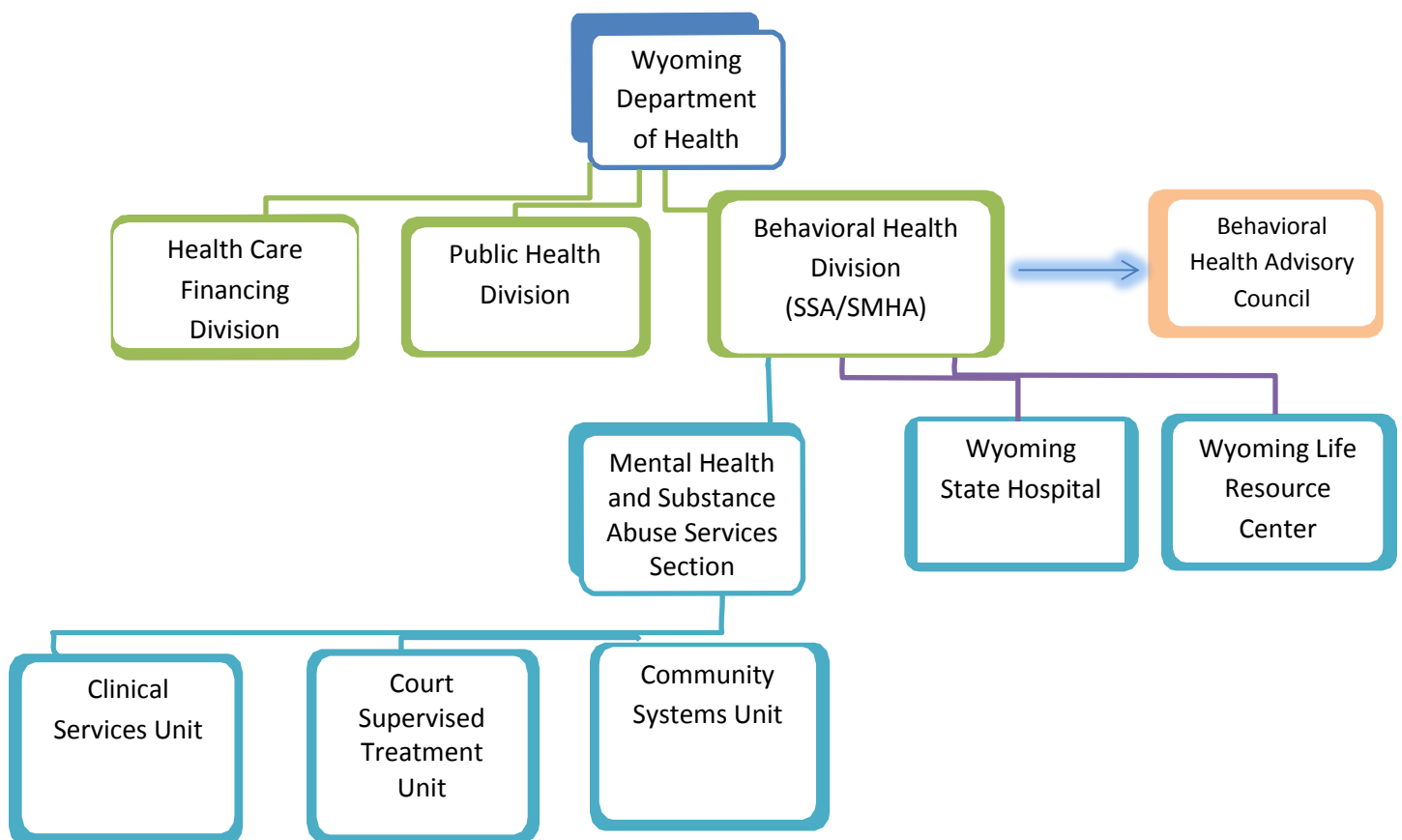
The Division contracts for outpatient and residential mental health and substance abuse services through contracts with eighteen (18) separate providers statewide. There are twelve (12) agencies that provide both mental health and substance abuse services, four (4) provide only substance abuse services, and two (2) provide mental health services only. Community Mental Health and Substance Abuse Centers (CMHCs) and (SACs) are obligated by contract to provide services and supports as indicated by individual treatment plans to all population groups even after State funding has been exhausted. The Drug Court program is also housed in the MHSA section and it includes adult, juvenile, tribal and DUI categories within twelve counties in Wyoming and nineteen state funded courts. Drug Court programs provide sentencing alternatives for the judicial system in cases stemming from substance abuse.

The WDH has five (5) divisions which include Administration and Support, Health Care Financing (Medicaid), Aging, Behavioral Health, and Public Health. The Public Health Division includes many units that are relevant to

behavioral health such as Substance Abuse and Suicide Prevention, Communicable Diseases, and Tobacco Prevention and Control. The Division works closely with the Public Health Division as it relates to the block grant services. The Healthcare Financing Division oversees public healthcare programs such as Medicaid and Kid Care CHIP. The Aging Division provides care and services to older adults in Wyoming.

The Department of Family Services is currently being administered by the WDH. Analysis is underway to determine if the Department can be added to the WDH structure on a permanent basis. The Department of Family Services assists in the delivery of services and the welfare needs of individuals with mental health and substance use disorders. The Wyoming Department of Corrections oversees the criminal justice and legal involvement of those in the criminal justice system who may also have mental health and substance use disorders.

Wyoming Behavioral Health System Organization



Substance Use Description of Service System

The MHSA section has recognized an increase in treatment demand for opioid and methamphetamine use both of which can be fatal. The Division's Wyoming Client Information System (WCIS) reports a fifty-four percent (54%) increase of clients with an opiate drug problem at admission. Likewise, methamphetamine as the first or second drug problem for clients in substance use treatment is on the rise with a seventy-six (76%) increase over the past three (3) years. The data collection period spans from 2014 to 2017.

Specialized programs for intravenous drug users including individuals with opioid use disorders are in the implementation stage in Wyoming. The Division has received a federal Medication Assisted Treatment Prescription Drug Opioid Addiction (MAT-PDOA) grant to implement specialized programs with services such as behavioral therapy, medication, and recovery support services for individuals opioid use disorder. The federal State Targeted Response to Opioid Crisis (STR) grant was also awarded to the Division. These funds serve multiple purposes including addressing the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder. As a priority population, substance abuse providers are required by contract to provide treatment to this population according to the priority population hierarchy that is outlined in the provider contracts, i.e., pregnant Intravenous Drug User (IVDU) first, followed by pregnant women, then women with dependent children, and finally, IVDU.

The Division promotes the use of standardized screening and assessment tools and placement criteria to improve patient retention and treatment outcomes. The State of Wyoming Substance Abuse Rules and Regulations requires certified providers to utilize the American Medicine Patient Placement Criteria (ASAM) Criteria as well as the Addiction Severity Index (ASI).

The independent Peer Review occurs annually with both mental health and substance use providers. The Division randomly selects a percentage of providers to participate in the peer review. Selections are chosen based on provider performance, data, and relevant initiatives within the state. Providers visit other agencies and look at program areas such as clinical documentation, client satisfaction, and treatment. Providers are required to submit a report with their findings of the peer review to the Division by August of each year.

The Division collaborates with the Addiction Technology Transfer Center (ATTC) for all statewide provider trainings related to substance use. Prevention, treatment and recovery personnel within the state attended the 2016 SAMHSA National Block Grant Conference. In 2015, the Division hosted a Wyoming Medication Assisted Treatment conference and approximately one hundred (100) individuals attended including providers. In 2015, selected state staff also attended a training on government performance accountability with senior lecturer Dr. Bob Behn of Harvard University's John F. Kennedy School of Government.

According to State contract requirements, substance abuse services are to be prioritized to those persons who meet the special populations identified by SAMHSA Substance Abuse Prevention and Treatment (SAPT) grant requirements for admission preference. The SAPT block grant will be utilized to directly fund community substance use centers for outpatient and residential treatment services. A portion of the grant is utilized for women's outpatient services. The Public Health Division also utilizes a portion of the grant for community level

prevention efforts. Although there is a low incidence of tuberculosis (TB) cases in Wyoming, the Public Health Division also funds treatment services for TB. Mental health and substance use providers are able to refer clients to the state TB program as needed.

The Division continues to ensure that treatment for women and women with dependent children comply with Wyoming State Treatment Standards and federal block grant requirements, e.g., primary medical care for women and dependent children, prenatal care, therapeutic child care, drug free housing, and education and employment training programs. The Division has implemented more specialized curriculum and evidence-based practicing programs for women with substance use issues.

Wyoming currently has several specific programs that meet federal requirements for priority populations. Not only are all funded providers required to meet the priority population guidelines, there are several programs that are specific to various populations. One main service area considered a strength for Wyoming is its Women's Treatment programs. The Division continues to provide technical assistance and federal funding to Pathfinder Women's Intensive Outpatient Program, Central Wyoming Counseling Center, Volunteers of America and the programs at Southwest Counseling Center for women and children's treatment. The Division also provides funding for substance abuse residential treatment for women and day treatment programs for women.

Mental Health Description of Service System

CMHC's and SAC's are private non-profit organizations with local volunteer governing boards. The citizen-board concept facilitates a natural attachment to the communities served. Citizen boards allow CMHC/SAC to be more responsive to local needs and provide advocacy and accountability at the local level. Local control is enhanced by the politically active Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC), which includes mental health and substance abuse center executive directors and board members.

The Wyoming State Hospital (WSH) is a part of the Division and works to coordinate continuity of care for those with serious mental illness (SMI). The WSH is located in the southwest corner of the state on 175 acres, encompassing 35 buildings and 475,000 square feet. The WSH provides inpatient care for the state's most severely mentally ill clients.

The foundation of Wyoming's mental health system is the philosophy that services should be available in all counties and/or regions, and that everyone, regardless of the severity of their need or ability to pay, should have access to these services. Historical funding has targeted adults with SMI and children with serious emotional disturbance (SED). While the majority of states have shifted public funding to only those persons who are the most severely ill, Wyoming has chosen to maintain the original focus of community mental health and substance abuse treatment by providing a range of services to broad populations throughout the state, with an access priority given to persons with SMI, SED and specified substance abuse populations.

The MHSA section has targeted several initiatives to increase access to the least restrictive environment for individuals who have been involuntarily hospitalized or who are at risk of hospitalization. Wyoming's involuntary hospitalization statute (Wyo. Stat. Ann. 25-10-101 - 128) (Title 25) allows individuals to be detained against their will if they are deemed to be a danger to self or others or have the inability to care for oneself because of mental illness. Engagement and cooperation between state staff, providers, and other agencies strengthens partnerships by creating teams that work more closely together to implement initiatives and projects.

Adults with SMI are the primary clients served in the Title 25 system. MHSA assists the mental health system by focusing on clients with high needs through contracting strategies and conducting projects such as analyzing utilization and reducing the length of stay in mental health community housing options. Reducing the length of stay will assist in providing an increased number of available beds for individuals discharged from Title 25.

There are limited options for diversion from involuntary hospitalizations in areas of the state where the CMHC has limited or no involvement in Title 25 processes. To increase CMHC involvement in the Title 25 process, in April 2017, the Division executed ten contracts with agencies to begin implementing gatekeeper programs and processes. The gatekeeper role includes duties such as providing guidance to courts, healthcare providers, and other stakeholders on the detention and hospitalization process. Furthermore, gatekeepers are designed to monitor and facilitate effective client treatment prior to, during, and after any emergency detention or involuntary hospitalization. Gatekeepers also provide intensive case management to clients. A separate memorandum of understanding was created with CMHCs for purposes of outlining each center's role in the Title 25 process relevant to each county, and to formally "designate" the entity as the gatekeeper for the service area. Additional funding has also been made available to CMHCs for the development of diversionary services, such as gatekeeping and crisis stabilization. Through the gatekeeper grants and gatekeeper designations, providers can play a vital role in diverting individuals from the Title 25 system, including providing services under directed outpatient commitment. Directed outpatient commitment allows individuals to stay in the community under a required treatment plan as providers work together with other agencies to assist the individual in obtaining needed supports and services. The Division has received a federal Assisted Outpatient Treatment (AOT) grant to implement directed outpatient commitment in Wyoming. The AOT model is designed to work with families and courts, to allow individuals with SMI to obtain treatment while continuing to live in the community and their homes.

Emergency health service training also known as Crisis Intervention Team (CIT) is currently utilized to help provide law enforcement the tools to identify someone who is in a mental health crisis, to de-escalate a situation and possibly get the person to the right services instead of taking them to jail. This intensive training has gained increased recognition and support, as officers have experienced the positive benefits of early intervention with someone in crisis and the ability to immediately transfer the individual to mental health services for further care. Seven Wyoming communities have established CIT programs (Cheyenne, Laramie, Casper, Cody, Powell, Torrington, Gillette), two more are actively planning their CIT training program, and five locales have expressed high interest in starting a program. To support this growth, the Prevention Management Organization (PMO) has developed a CIT Quickstart Toolkit, which includes tools and sample documents from CIT programs and tools to assist communities in establishing their own CIT program without needing to reinvent forms, strategies, and protocols.

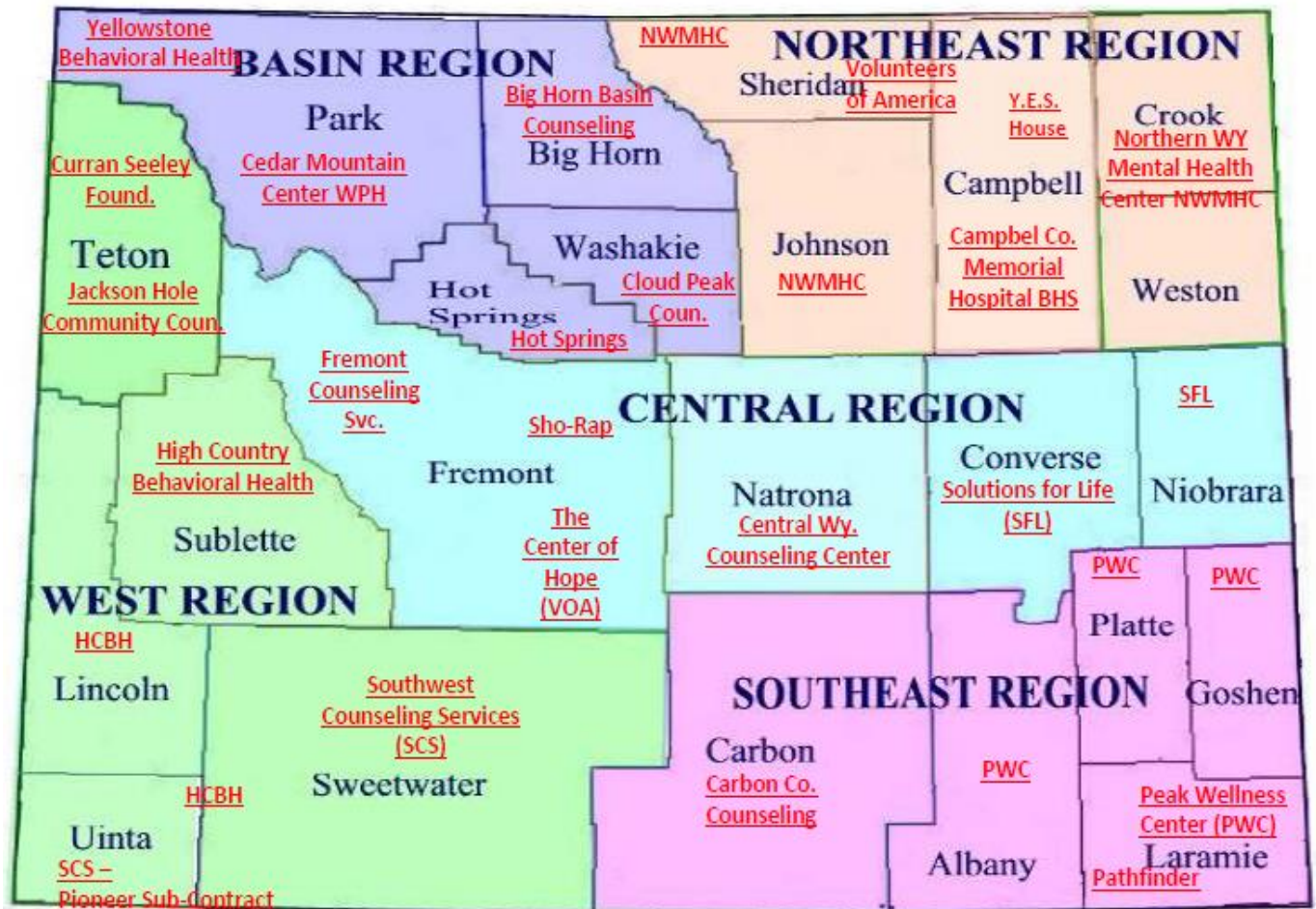
The Mental Health Block grant will be utilized to directly fund mental health providers for outpatient treatment services. Additional initiatives such as Housing First are also funded through the mental health block grant. Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible and then providing voluntary supportive services as needed. The Division will utilize mental health block grant funds to continue a contract with a mental health Ombudsman through Wyoming Guardianship Corporation to advocate on behalf of individuals with mental health or substance use issues. First Episode Psychosis (FEP) services are also a priority and funded through the block

grant to Southwest Counseling Services and Yellowstone Behavioral Health Center. Peak Wellness Center has chosen to utilize state funds to develop a FEP program in FY 18.

The following map portrays the comprehensive care regions in the state.

Comprehensive Care Regions

FY17 Wyoming Treatment Providers by Location (State Funded)



Wyoming is a rural/frontier state with limited access to specialized services for priority populations. The population density in Wyoming ranges from .92 persons per square mile to 6.1 persons per square mile. Travel in winter months is often restricted due to weather related conditions. Funding for specialized services was secured in 2007 under a regionalization framework, which allowed some services to be available in each region but not throughout all communities. Regional funding availability led the Division to require all CMHC/SACs to submit a regional service delivery plan in order to advance the goals of regionalization. These plans describe how regional services will be delivered to priority populations within Wyoming. Although much of the funding awarded in 2007 has since been lost due to budget reductions, the Division continues to support the regional concept of service delivery, specifically for high-cost services such as residential care.

In the application, Wyoming was asked to provide a summary of activities or programs that exist, are planned for, or that are needed to address three common areas: behavioral health primary care integration, recovery support, and individuals with co-occurring disorders.

Behavioral Health-Primary Care Integration

The Division, in collaboration with other departments and the Director's office within the WDH, completed phase one of a mental health and substance abuse modernization project in which system gaps, best practices, the Affordable Care Act, and maximizing Medicaid reimbursements were investigated and recommendations were made. Integrated care was one recommendation. The Division postponed the modernization project until further resources are available. Other efforts towards primary care integration include the Division's recent application for the SAMHSA grant Promoting Integration of Primary Care and Behavioral Health Care. If awarded, this grant will support providers in the implementation of the integration and collaboration in clinical practice between primary and behavioral healthcare. Additionally the grant would provide support in the improvement of integrated care models for primary and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness and individuals with substance use disorders.

Recovery Support

Wyoming has one Recovery Community Organization (RCO), Recover Wyoming, located in Cheyenne, Wyoming, and provides services only in the southeast region. RCOs are independent, non-profit entities governed and run by people in recovery which work to bridge the gap between treatment and long-term recovery. Recover Wyoming is closely connected to the national RCO network, allowing Wyoming to learn from the experience of others and gain access to tools and techniques proven effective in sustaining long-term recovery. Recover Wyoming is a community-based organization dedicated to advancing advocacy and involvement for persons in recovery from substance and alcohol addiction. Recover Wyoming conducts training for persons in recovery aiming to "equip people in recovery, their families, and friends to change how health, public safety, workplace, and criminal justice systems deal with alcohol and drug problems." The 12-24 Club, a 12-step and recovery organization, is located in Casper, Wyoming. 12-24 is recognized as the hub of recovery in Casper but it is not an RCO.

The Behavioral Health Division supports recovery coaches and peer specialists through four mechanisms:

- Peer specialist certification for persons with their own recovery history who have completed a 40-hour Division approved peer specialist training course or recovery coach course
- Funding from federal grants to support a Wyoming developed annual 40-hour peer specialist training course that is taught by experienced Wyoming peer specialists and recovery coaches
- Inclusion of optional peer support services in community mental health and substance use treatment contracts
- Inclusion of peer support services in federally funded special grant contracts

Wyoming recognizes recovery coaches as peer specialists. Both persons with mental health and substance use recovery may qualify as a peer specialist. Wyoming Medicaid includes peer support as a billable service.

From 2005-2016 the BHD provided small optional funding that supported the hiring of fourteen peer specialists in CMHC/SAC's in 2016. In 2017, those funds were removed but nine of these peer specialists were retained as a part of their agency's staff. Peer specialists are also employed through

the substance use treatment contractor for the Wyoming Department of Corrections, at the Wyoming State Hospital, the veteran's hospitals, tribal and reservation providers, and private providers. The number of persons certified to provide peer support has increased over time:

Number of Certified Wyoming Peer Specialists				
2013	2014	2015	2016	2017
18	18	23	22	44

Thirty-five of the 44 persons with peer specialist certification in 2017 are employed in peer support roles.

Individuals and family members are frequently presented with opportunities to proactively engage and participate in treatment planning, shared decision-making, and the behavioral health services delivery system. The Consumer Survey project is a way to collect the overall satisfaction of consumers as it pertains to services. Consumers may also participate on agency level advisory boards. The Behavioral Health Advisory Council has consumer representation.

The Division wishes to continue to broaden current recovery initiatives, which provide care coordination and support for individuals with and family members of persons with SMI and SED, as well as those with substance use disorders.

The Division would like to see a broader use of peer specialist in Wyoming. Peer specialists may be utilized in many settings, including physical healthcare. We are working on a long term plan to sustain peer specialist credentialing which may lead to this broader use.

Individuals with Co-occurring Disorders

A majority of providers in Wyoming provide integrated mental health and substance abuse services. Integrated mental health and substance abuse services are delivered in both residential and outpatient programs. It is considered a standard of care to serve all of the needs of an individual, including those with co-occurring disorders.

Peak Wellness Center, located in southeast Wyoming, operated a residential service for persons with co-occurring disorders. Due to budget reductions, this program ended July 31, 2016. Central Wyoming Counseling Center and Southwest Counseling Center provide co-occurring services through their outpatient and residential programming.

Children/Adolescents

Substance Use Services. Intensive outpatient substance use treatment programs for adolescents have been developed in some of the more populated areas of the state. Substance abuse residential services are available through Division funding at one location, in Casper, Wyoming through Central Wyoming Counseling Center. All SAC provide outpatient services for adolescents.

Mental Health Services. The mental health system of care for children and adolescents in Wyoming is the shared responsibility of several systems and the local providers with which they contract. CMHC provide a full

range of mental health services for children/adolescents and their families. However, accessing these specialty services is more challenging in the more rural regions of the state.

The Wyoming Department of Education (WDE) oversees forty-eight (48) school districts, which are administered with considerable local autonomy. The WDE and local school districts are responsible for implementing PL 101-476 and its amendments. This law is the Education of the Handicapped Act Amendments of 1990 and also known as the Individuals with Disabilities Education Act (IDEA). This federal law amended and expanded The Education for All Handicapped Children Act of 1975. The act uses “people-first” language, replacing “handicapped children” with “individuals with disabilities” and the definition of those with disabilities was expanded. The law mandates special education services for children ages three to twenty-one and extends services for infants from birth to age two. School districts are responsible for providing or purchasing services to meet the needs of children with SED, including arranging for residential placement if needed. To be eligible for these services, a child’s serious emotional disturbance must adversely affect their educational performance. In some school districts, this is a fairly subjective decision and appropriate services for these children are difficult to access without intense advocacy.

The Children’s Mental Health Waiver (CMHW) is a Medicaid program for children with SED. The goal of the program is to keep youth with SED in their home communities with their parents/families involved in all aspects of their treatment, preventing custody relinquishment. The program works to strengthen families’ skills to support the physical, emotional, social, and educational needs of their children. The CMHW provides non-clinical mental health support services as a part of the overall children’s mental health system of care. The program seeks to reduce or prevent children from needing placement in psychiatric hospitals.

The CMHW serves children/youth ages 4-20. Participants must meet the definition of serious emotional disturbance, have a Diagnostic and Statistical Manual (DSM) Axis I or ICD diagnosis, meet at least one Medicaid criteria for inpatient psychiatric hospitalization, have a Child and Adolescent Service Intensity Instrument (CASII) composite score of 20-27 (ages 6-20) or Social/Emotional Assessment (ages 4-5). Participants must also be financially eligible for Medicaid based on their own resources and must receive services provided by certified waiver providers available in all counties in Wyoming. Through the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) grant program and statewide implementation, Wyoming seeks to improve clinical, functional, and cost outcomes, access to home and community-based services, and youth and family resiliency of Medicaid children and youth with serious behavioral health challenges and historically high costs or at risk of high cost through implementation of a CME pilot in Wyoming. The care management entity for the CMHW is Magellan.

The Division has, in the past, invested extensive resources to train public and private community providers across the state in the implementation of the high fidelity wraparound model. Through contractual agreements the Division has fostered use of wraparound with children, youth, and their families in addition to those families served through the Children's Mental Health Waiver program. Successful implementation of a wraparound individual service plan will increase a child's opportunities for successful outcomes and enhance a family's potential for safely caring for their child through natural supports and community-based services. The Division piloted two programs in the state to demonstrate HFWA. The pilot programs were intended to advance the CMHW and CHIPRA efforts. Services provided through the CMHW include Family Care Coordination, Youth and

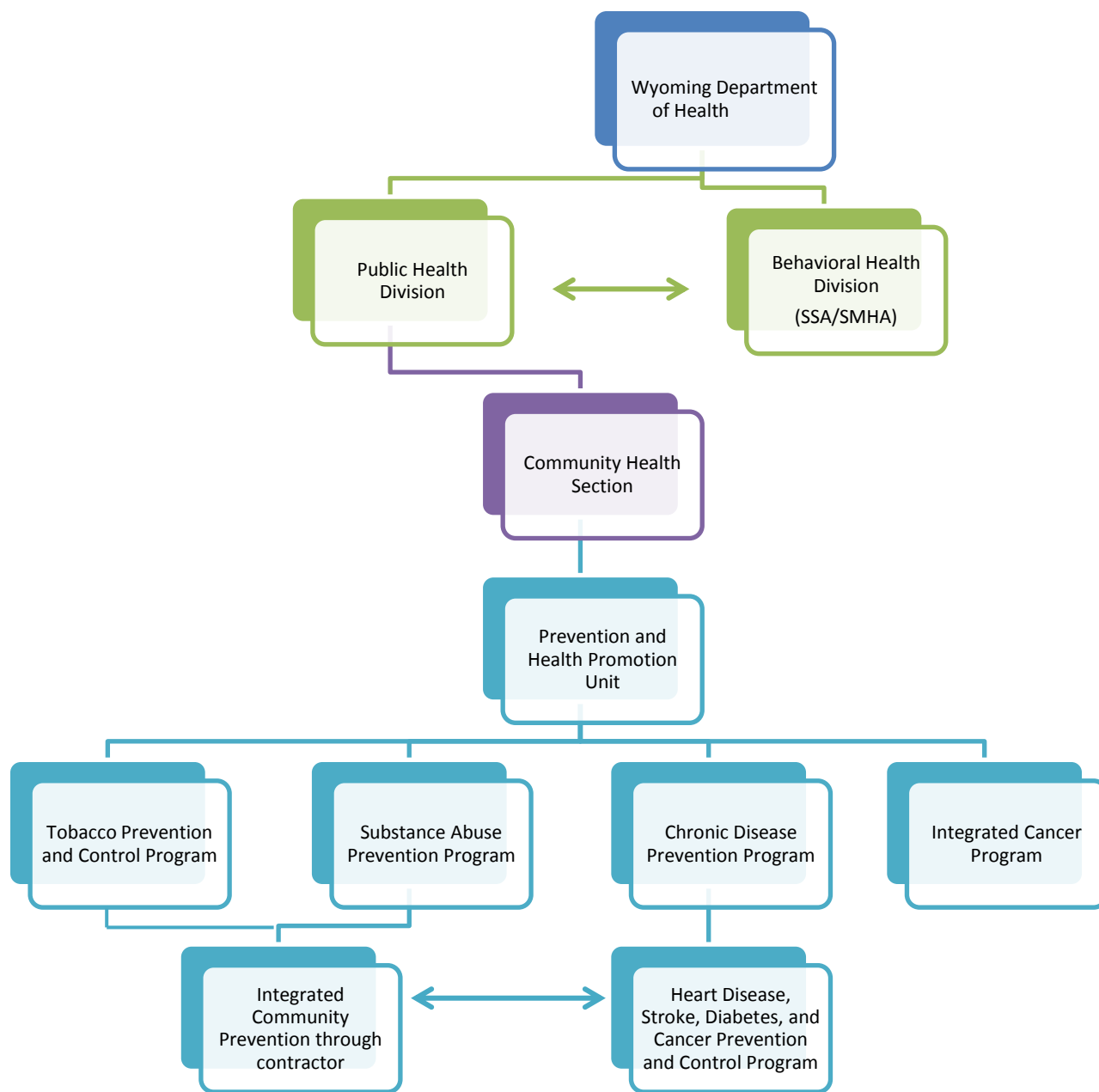
Family Training and Support, and Respite care. The Division has made a concerted effort towards HFWA but with the budget restrictions, most of the projects were eliminated.

In FY2015, the Division retained Western Interstate Commission for Higher Education (WICHE) to facilitate a First Episode Psychosis training program for Wyoming provider agencies. These services were funded using the five percent (5%) set aside in the mental health block grant. Through WICHE, experts from Yale University and Early Assessment and Support Alliance (EASA) presented webcast trainings in February of 2016 covering the most important aspects of first episode psychosis and the day to day treatment of clients. The goal of this training was to increase provider agency's interest and competency in these areas. Overall, the outcome of the training was helpful to providers and the trainings are now posted on the Division's website at <https://health.wyo.gov/behavioralhealth/mhsa/initiatives/fep/>.

Prevention

Since 2012, the Substance Abuse Prevention Program and the Tobacco Prevention and Control Program have been a part of the Prevention and Health Promotion Unit in the Public Health Division, increasing collaboration with the Chronic Disease Prevention Program, as well as the Integrated Cancer Program. This has strengthened programs at the State and community level because of the shared populations and risk factors. The chart below depicts the current organization of primary prevention services in Wyoming.

Wyoming Substance Abuse Prevention Program Organization



The Substance Abuse Prevention Program works closely with the Tobacco Prevention and Control Program to provide prevention services. The integrated community prevention model includes funding to all 23 counties in Wyoming, including the Wind River Indian Reservation (WRIR), through the use of a single fiscal agent, currently the Prevention Management Organization of Wyoming (PMO). This model creates several strengths such as coordinated training efforts, an active network of prevention coalitions, strategic planning at the community level guided by the state, and long-standing relationships. The funding is a combination of the 20 percent set-aside from the SAPT, State General Funds, and State Tobacco Settlement Funds, which is contractually obligated to the single fiscal agent.

At both State and local levels, Wyoming employs a data-driven decision-making process. Both the Substance Abuse Prevention Program and the Tobacco Prevention and Control Program require all funded communities to implement the Strategic Prevention Framework (SPF) public health model in their prevention efforts, which obligates the community coalitions to engage in data-driven strategic planning. In the State Fiscal Year (SFY) 2013, each community was required to undertake a comprehensive alcohol, tobacco, and other drug (ATOD) needs assessment. In SFY 2016, communities updated their needs assessments and the associated strategic plans that identify best-practice environmental strategies and evidence-based programs designed to appropriately meet their identified needs. This approach allows the prevention efforts to have greater reach across the lifespan of Wyoming residents. Communities also have access to Insight Vision this year, a new strategy management system based on best practices that the PMO will be using to manage ATODS prevention activities in communities. The system imports data from sources to provide a centralized location where community prevention specialists can access and manage strategies.

All funded communities are required to participate in evaluation of prevention efforts at the community level. Both the Substance Abuse Prevention and Tobacco Prevention and Control Program evaluations are currently administered by the Wyoming Survey and Analysis Center (WYSAC). Though the evaluations are contractually separate, WYSAC researchers collaborate on the development and maintenance of the Prevention Evaluation and Reporting for Communities (PERC) data collection system. WYSAC works closely with the communities to collect and analyze data while also utilizing user-friendly reporting for both state and local prevention stakeholders. The Substance Abuse Prevention evaluation data is also reported annually to the SAMHSA with regards to the National Outcome Measures.

The Substance Abuse Prevention Program currently contracts with the PMO to provide technical assistance and training for all funded communities. The technical assistance team provides ongoing expert and tailored technical assistance to communities including strategic planning and implementation support, quality prevention workforce training and resources, and facilitation of community coalition meetings when requested. Additionally, the Substance Abuse Prevention Program works with the technical assistance contractor to identify strengths and weaknesses within the prevention infrastructure and is a key partner in prevention planning aimed at enhancing strengths and rectifying weaknesses.

The Substance Abuse Prevention Program strongly believes that Wyoming communities must strive for population-level change in order to create healthier community outcomes. By endeavoring for community-level change, disparate populations will be afforded the same health opportunities and benefits as the rest of the population. Wyoming's environmental approach creates healthier environments for people in recovery who are reentering the larger community. This approach is also flexible enough to target our disparate populations when necessary.

Diverse Racial, Ethnic and Sexual Gender Minorities

Wyoming's demographic and cultural characteristics are not highly diverse but recent data shows an increase in the minority population. According to the Wyoming Division of Economic Analysis, Hispanics in particular have

diversified the state's population, increasing their numbers at a faster rate than the state overall¹. There are very few specialty programs that address minorities. The Division is partnered with the Office of Multi-cultural Health to address cultural health disparities. The Division has conversed with all provider agencies and reviewed their Commission on Accreditation for Rehabilitation Facilities (CARF) "Cultural Competency and Diversity Plan." The provider agencies address many areas of diversity including race, ethnicity, sexual orientation, gender, age, and socioeconomic backgrounds. Funded providers update and review their cultural competency plans for relevancy on an annual basis and provide diversity training to their staff as required in their CARF standards.

Fremont County Counseling is a contracted outpatient mental health and substance abuse treatment provider who serves clients in Fremont County including Native Americans. Sho-Rap Lodge provides housing and employment services, funded by the Division, on the Wind River Indian Reservation.

Challenges and Limitations

Some of the challenges and limitations of the state include continued economic downfall and budget restrictions. As a result Wyoming has reduced budgets for mental health and substance use services. In 2017, Wyoming qualified for a waiver of the maintenance of effort (MOE) requirement due to the fact that the state met criteria for revenue reductions and unemployment increases. The following program areas were impacted due to budget reductions: : children and adolescent services, Recovery Support Services, , residential treatment and housing, and the outreach and advocacy program for veterans. In addition, the state is experiencing prescriber and clinical staff shortages. The Division also works with the Behavioral Health Advisory Council on strategies to address these areas and limitations. Wyoming has applied for and received federal grants which augment current efforts and enable the Division to focus on specific areas of need such as opioids, and the implementation of directed outpatient commitment. In addition, Wyoming has worked collaboratively within each grant program to seek technical assistance when barriers arise.

Section B: Planning Step 2

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

Description of Behavioral Health Needs in Wyoming

The Division has taken several progressive steps to begin analyzing the behavioral health needs of the citizens of Wyoming to determine the unmet service need. Individuals who are defined as "most in need" of services are considered the first priority for Wyoming's public mental health system. The Division has identified a number of sources that help identify the needs and gaps of the populations relevant to determining priorities.

1. Wyoming Division of Economic Analysis, (2015). *Wyoming's Minority Population Increases: 2015 Casper Star Tribune* by W. Liu Principal Economist, Casper, WY: Wyoming Division of Economic Analysis, Wyoming Department of Administration and Information.

HealthStat

Development of the WDH performance management system, HealthStat, began in 2011 with the arrival of Director Thomas O. Forslund. Director Forslund had used a similar system as City Manager for the City of Casper and recognized the potential for change at the WDH. The process includes the identification, by program managers, of specific areas of challenge within their program areas and the identification of metrics through which improvements can be measured. Strategies are then developed to address the challenges, data is routinely monitored, regular updates are provided to Division staff, and an annual report is provided to the Director's office. HealthStat efforts have bolstered the WDH's reputation as a responsive agency committed to improvement and accountability, such that Governor Matt Mead adopted a similar system, WyoStat, in 2013 across all health and human service agencies in Wyoming. In the fall of 2014, Senior Leadership at the WDH met in a series of intensive workshops to analyze the overall performance of HealthStat and identified several areas for improvement. It was determined that the system had greatly enhanced reporting within the WDH, but lacked the follow-up needed for a true performance management system. In 2015, several changes under "HealthStat 2.0" are under way to increase follow-up and accountability, allowing the WDH to pursue its mission to promote, protect, and enhance the health of all Wyoming citizens, to the fullest extent and with the highest level of excellence that our stakeholders have come to expect.

The HealthStat process ultimately helps the Division identify deficit areas that need improvement. The Division has utilized HealthStat along with contract requirements, and monitoring through the Division's quality management process to enhance the accountability of the public behavioral health care system.

Statewide Data as of July 5, 2017

FY 17 reporting to date indicates 6,749 persons were served in substance abuse outpatient treatment. The average number of substance use service hours provided per client was 24.47. There were a total of 7,576 clients with SMI who received an average of 22.17 hours of mental health services. There were 2,205 children diagnosed as SED in FY 17. These children received an average of 22.63 hours per child. Many of these high need individuals benefit from additional services to help them achieve treatment and recovery goals. The mandate of Wyoming's publicly funded mental health and substance abuse system is to provide services to anyone who requests them. While this policy has a positive effect on the greater population, it can have significant impacts on the higher need populations in Wyoming. There is a limited amount of funding and ability to provide services and that must be spread among all who have no pay source. The Division is currently in the process of evaluating our system for gaps and deficiencies regarding services to persons with SMI and SED. .

Although the data pulled at the time of this application submission was not yet final, the numbers have remained consistent over the years. The statewide penetration rate for substance abuse outpatient in FY 16 is 1.11% compared to FY 15 which was 1.07%. The statewide penetration rate for mental health outpatient services in FY 16 is 3.01% compared to FY 15 which was 2.91%.

The Division funds four Regional Crisis Stabilization programs and related facilities. These programs are intended to function as a process for which individuals experiencing an acute mental health crisis may receive short term (1-30 days) intensive evaluation and treatment. Further, they provide support to stabilize the crisis in a safe

environment as an intercept from higher levels of care such as hospitalization. These funds supported a total of 23 crisis beds.

Title 25, as described earlier in this application, provides a foundation and structure under which persons who are a danger to themselves or others or who are unable to satisfy their basic needs due to mental illness can be evaluated, detained and hospitalized if needed. The detention and hospitalization processes defined in the statute require the collaboration of several different community and state level organizations and services. Each county is empowered to determine the specific process, in keeping with the broad parameters outlined in statute. Given the state's disparate distribution of community resources the process varies by county. The State's sole state hospital, located in Evanston is at times, at capacity. In the absence of bed availability at the state hospital, persons involuntarily hospitalized are served at local and regional hospitals until they can be transferred to the state hospital. Costs associated with care at local and regional hospitals have prompted the Wyoming Department of Health to examine Title 25 processes, including the role of CMHCs prior to and after a detention or hospitalization. This focus on community systems has prompted the Division to enter into a number of Title 25 initiatives mentioned earlier, including gatekeeping, implementation of directed outpatient commitment, and development of diversion services.

Transition age youth continue to be a group that is severely underserved in Wyoming. This population is high need, as evidenced by the growing substance abuse population, escalating youth crime rates, increasing jail populations and a high suicide rate among youth ages 16-24. Age appropriate services are needed for youth to develop independent living skills, acquire jobs, and avoid substances. Another way to provide better service to this population is to work on developing peer supports within the CMHCs and SAC in Wyoming. This would help develop youth-oriented services to improve access and retain youth in services as they develop skills to become functional adults within the communities.

Employment has been recognized nationally and through the literature as being an important part of recovery and community integration for persons with serious mental illness. Approximately 60 – 70% of persons with SMI express a desire to work in competitive employment, however the employment rate of this population nationally remains at about 15%.¹ According to recent data for FY17 YTD (year-end data not yet available) 4307.25 hours of supported employment activity was reported for 7525 identified individuals as seriously mentally ill, and 141 hours for 8008 non-seriously mentally ill individuals. As of July 2017, 30.66% of clients with SMI who were unemployed at admission were employed upon discharge. The strategy is to utilize Supported Employment, evidence based practice, to increase the number of persons with SMI receiving treatment in CMHC/SACs who obtain competitive employment to 40%. It is expected that the substance abuse population will mirror this strategy.

The National Council for Behavioral Health, a longtime leader in the mental health and substance use treatment field has established that the sooner an individual can get into, and engage in treatment services the greater likelihood of a positive treatment outcome. Recent information indicates the national benchmark for wait time has now moved to 5 days or less. For FY17, the Division has required that individuals are given a treatment appointment in 7 days or less. The Wyoming statewide average wait time for FY 17 YTD for Substance Abuse is 2.74 days. For mental health the data indicates an average wait time of 2.18 days. The strategy taken by the BHD

is for 100% of community mental health centers to show wait times for SMI/SED clients as less than or equal to the wait times of other populations.

¹Substance Abuse and Mental Health Services Administration, *Supported Employment: The Evidence*. DHHS Pub. No. SMA-0804364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009

Wyoming Consumer Survey

According to the 2016 Wyoming Consumer Survey results for mental health, 86% of clients are generally satisfied with the services they received in 2016 compared to 2015 which was 88.3%. For substance abuse, the consumer survey general satisfaction in 2016 was 82% compared to 2015 which was 82.2%. The Consumer Survey is used by CMHCs and SACs to evaluate their programming and make qualitative changes in service provision.

Wyoming Survey and Analysis Center (WYSAC)

The Division is currently under contract with the University of Wyoming to prepare a treatment needs assessment for clients with opioid use disorder. This assessment is funded through the State Targeted Response to the Opioid Crisis grant. Key findings will be summarized and utilized in future funding and strategic planning decisions.

2015 Wyoming Behavioral Health Barometer

The 2015 Wyoming Behavioral Health Barometer report presents a set of substance use and mental health indicators as measured through data collection efforts sponsored by SAMHSA, including the National Survey on Drug Use and Health and the Uniform Reporting System. This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking change and trends over time. As new data become available, indicators highlighted in these reports will be updated to reflect the current state of the science and incorporate new measures of interest. The Behavioral Health Barometers will provide critical information to a variety of audiences in support of SAMHSA's mission of reducing the impact of substance abuse and mental illness on America's communities. Overall, the barometer places Wyoming close to the national averages. Some metrics such as binge alcohol use for youth are higher than the national percentage. To view the full 2015 Wyoming Behavioral Health Barometer report, the publication may be downloaded at: <https://www.samhsa.gov/data/browse-report-document-type?tab=46>

(Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Wyoming, 2015. HHS Publication No. SMA-16-Baro-2015-WY. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.)

Prevention

Wyoming continually collects data to address unmet service needs and critical gaps within the current prevention system in order to reach individuals in need of primary substance abuse prevention. Data sources used to identify primary prevention needs include the National Survey on Drug Use and Health, the Behavioral Risk Factor Surveillance System, the Wyoming Prevention Needs Assessment, American Communities Survey,

Adult Criminal Investigation, Fatal Accident Reporting System, Hospital Discharge Database, Pregnancy Risk Assessment Monitoring System, Synar, Uniform Crime Reports, United States Census, WASCOP-Compliance Checks, Web-based Injury Statistics Query and Reporting System, Wyoming Vital Statistics, and Wyoming Department of Transportation Crash Reports.

The Statewide Epidemiological Outcomes Workgroup (SEOW) continues to be one of the most valuable aspects of the prevention system. The SEOW has a wide range of membership including representation from the WDH, the Wyoming Survey Analysis Center (who serves as the evaluator), the Prevention Management Organization of Wyoming, the Wyoming Pharmacy Board, Department of Corrections, Department of Family Services, Department of Transportation, and Wyoming community members. The WDH works with the SEOW to review consequences, consumption, and risk/protective factor data. The SEOW contributes to prevention planning by providing state and community profiles on alcohol, tobacco, and other drugs as well as mental health for state and community use and providing guidance to numerous data collection efforts around the state.

The SEOW focuses on six areas including alcohol, tobacco, illicit drug use, prescription drug abuse, mental health, and general related factors, with subcommittees focusing on a particular area when necessary. The SEOW guides many efforts to address data gaps. Currently, the group is addressing the prescription drug data gaps by completing a prescription drug data report that will detail what information currently exists and what information would be helpful moving forward.

Conclusion

By knowing how many individuals in Wyoming need public behavioral health services and how many are currently accessing these services, the Division can estimate how many people would benefit from services, and have not yet accessed them. The evidence from the various sources enables the state and its behavioral health stakeholders to create positive change within the statewide system of care, develop targeted plans for individuals to receive services, better advocate for the needs of high risk populations, improve access to services by underserved populations, analyze outcomes of services, and contract and finance services based on individual need, capacity, and performance. The data sources provide an excellent foundation for fulfilling the mission of responding to behavioral health needs of Wyoming residents. Although the Division has not formally embarked on a formal needs assessment since 2011, the Division has identified some trends for unmet needs to include

1. Need for co-occurring youth services
2. Need for recovery support services
3. Need for behavioral health professionals including prescribers
4. Need for increased access to least restrictive levels of care

Wyoming is confident that despite recent budget reductions the state can address some the above mentioned gaps. The American Health Care Act of 2017 will impact the state's behavioral health system in a number of ways which are being considered by the Division in relation to the planning and utilization of the block grant funds. The Behavioral Health Advisory Council will play a critical role in the assistance of how to best dedicate the block grant funds to prevention, treatment, early intervention, and recovery efforts.

Co-occurring Youth Services

Wyoming will continue to collaborate with other state agencies, providers and the Behavioral Health Advisory Council to determine additional needs for this population. Wyoming will continue to purchase outpatient behavioral health services from community based agencies. Early intervention services for first episode psychosis will be replicated in counties around the state.

Recovery Support Services

Wyoming will continue to provide opportunities for training of peer specialists in the state. The Division will collaborate with Recovery Community Organizations in the state such as Recover Wyoming to support individuals in recovery.

Behavioral Health Workforce

Currently there is a gap in the behavioral health workforce in Wyoming. The Division has a partnership with the University of Wyoming Echo program which is planning to host a learning community that consists of experts and various technologies to assist in obtaining resources for the behavioral health field. This partnership could be utilized as a resource for new graduates looking to work in the field. However, more effort is needed to explore this gap.

Least Restrictive Levels of Care

The Division has made several efforts towards increasing access to the least restrictive levels of care. These activities include the implementation of Directed Outpatient Commitment, gatekeeping pilot program development, and various trainings and monitoring efforts.

Section B: Planning Step Quality and Data Collection Readiness

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Wyoming has a history of successfully collecting and reporting required data and performance measures. The Division currently collects, analyzes, and reports client level and service level data submitted by provider agencies into the Wyoming Client Information System (WCIS). Wyoming community based grantees successfully fulfill the data reporting requirements of the block grant as part of local prevention, treatment, and recovery support efforts. The Division has also used the data to improve efforts and make decisions at the state and local level. This system collects client and service data at the program and provider levels only. Funded CMHCs/SAC's are required by contract to collect and report client demographic, clinical, and key indicator data. Some of the performance indicator data collected and reported include the following:

- Treatment completion rate
 - GAF improvement rate
 - Unemployment improvement rate
 - Homelessness improvement rate
 - Treatment service wait time
 - Treatment length of stay
 - Mental health and/or substance use disorder diagnoses
 - Client demographics
 - Service type/duration/frequency data
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

The WCIS is not part of a larger data system and it is specific to substance abuse and mental health services.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Yes the state is able to collect and report measures at the individual client level.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Not applicable.

Please indicate areas of technical assistance needed related to this section.

There are no areas of technical assistance needed related to this section.

Section C-1: The Health Care System and Integration

Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

Although the state has not formally integrated mental health and primary health care including co-occurring mental and substance use disorders, the Division contracts with community mental health and substance use centers who are working towards becoming Federally Qualified Health Centers. There are also some community mental health and substance use centers with nursing and primary care services available on site. Each agency arranges for primary care and specialty services based on individual client need. The Division has applied for the Promoting Integration of Primary Care and Behavioral Health Care (PIPBHC) Grant. This grant is designed to support providers in the implementation of integration and collaboration in clinical practice between primary and behavioral healthcare. If awarded, the grant will provide support in the improvement of integrated care models for primary care and behavioral health care to improve overall wellness and physical health stats of adults with serious mental illness and invidiously with substance use disorders. Funding under this grant will be

provided to community mental health centers in order to develop state capacity; provide primary care services for the populations of focus and improve health outcomes for individuals in need.

Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The state does not currently provide services and supports towards integrated systems of care however, if the Division is awarded the PIPBHC federal grant opportunity these services can begin implementation.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs

Yes ☐

No ☒

and Medicaid

Yes ☐

No ☒

2. Who is responsible for monitoring access to M/SUD services by the QHPs?

If a client is covered by Wyoming Medicaid, the Behavioral Health Program Manager and the Program Integrity Unit of the Healthcare Financing Division are responsible for monitoring access to M/SUD services.

3. Is the SSA/SMHA involved in any coordinated care initiatives in the state?

Yes ☐

No ☒

4. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education

Yes ☒

No ☐

b) Health risks such as

i) heart disease,

Yes ☒

No ☐

ii) hypertension,

Yes ☒

No ☐

iii) high cholesterol

Yes ☒

No ☐

iv) diabetes

Yes ☒

No ☐

c) Recovery supports

Yes ☒

No ☐

5. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

Yes ☐

No ☒

6. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

Yes ☐

No ☒

The Division and stakeholders were involved in a payment reform effort which would have included a risk-based contract and incentivized providers to serve persons most in need of services. The effort was not supported by the Wyoming State Legislature and has been tabled.

7. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The Division is not aware of any issues related to the implementation and enforcement of parity provisions.

8. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

There are no areas of technical assistance needed related to this section.

Section C-2: Health Disparities

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

a) race

Yes ☒

No ☐

b) Ethnicity

Yes ☒

No ☐

c) gender

Yes ☒

No ☐

d) sexual orientation

Yes ☒

No ☐

e) gender identity,

Yes ☒

No ☐

f) Age?

Yes ☒

No ☐

2. Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?

Yes ☐

No ☒

3. Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?

Yes ☐

No ☒

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

Yes ☐

No ☒

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

Yes ☐

No ☒

6. Does the state have a budget item allocated to identifying and remediating disparities in behavioral health care?

Yes ☐

No ☒

7. Does the state have any activities related to this section that you would like to highlight?

No

Section C-3: Innovation in Purchasing Decisions

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

Yes ☒

No ☐

2. Which value based purchasing strategies do you use in your state (check all that apply):

☒ Leadership support, including investment of human and financial resources.

- ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- ☒ Use of financial and non-financial incentives for providers or consumers.
- ☐ Provider involvement in planning value-based purchasing.
- ☐ Use of accurate and reliable measures of quality in payment arrangements.
- ☒ Quality measures focus on consumer outcomes rather than care processes.
- ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- ☒ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

No

Section C-4 Evidence-Based Practices for Early Intervention

1. Does the state have policies for addressing early serious mental illness (ESMI)?

Yes ☒

No ☐

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI

Yes ☒

No ☐

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI

Two providers implementing First Episode Psychosis (FEP) treatment programs have utilized EBP's and are exploring how to best implement the EBP's in a rural and frontier state. Providers have experienced challenges with some of the models including how to tailor the models to fit the frontier nature of the state. Fidelity to an FEP model is difficult in a rural setting due to limited community resources and geography challenges. Also, family education and involvement in treatment is critical to helping clients develop resiliency to psychotic triggers and symptoms. When there is no family, natural supports are a viable alternative, but limited community and social resources in a rural environment can be an impediment to adequate treatment. Yellowstone Behavioral Health Center (YBHC) in Cody, WY has utilized the group home for one adult client to simulate a 'family type' environment. It has provided some, but limited benefit, mainly in structured social activities

A third provider, Peak Wellness Center, in the Southeast region of the state will be funded for an FEP program with state general funds in fiscal year 2018. This provider is in the exploration stage of implementing an FEP program.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The state requires through a services contract for the funded FEP providers to utilize EBP's but does not specify which EBP's should be used. A webinar series was presented to Wyoming providers regarding the use of EBP's

for early psychosis programs. The state encourages providers to engage with other state's FEP programs to explore different EBP's and learn the successes.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a FEP ESMI?

Yes ☐

No ☒

5. Does the state collect data specifically related to FEP ESMI?

Yes ☒

No ☐

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

Yes ☒

No ☐

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Although Wyoming has explored utilizing Coordinated Specialty Care (CSC) model, the state has not prescribed a specific EBP for providers to use. The providers are required through a services contract to utilize an EBP and report quarterly. Currently, Southwest Counseling Services has been following the RAISE Model but is also interested in utilizing components of the On Track New York Model. In addition to these models, Southwest Counseling Services also utilizes Cognitive Behavioral Therapy, Psychiatric Medication Assessment and Management, wrap around services including peer specialist services and case management. Current evidenced based models such as PIER, Navigate and OnTrack have some components that are useful in a rural environment, but fidelity to each of these models is virtually impossible to achieve. YBHC would like to pull some of these components together and develop a model that is usable and tailored to the unique attributes of a frontier environment.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

The planned activities for 2018 and 2019 include that the project will fully implement services in 2018. In 2018 and 2019 providers will continue to provide outreach to various primary care, schools, and other agencies and disseminate outcome information. Priorities include engaging the Behavioral Health Advisory Council and promoting awareness and support towards potential growth and sustainability.

The proposed activities for FFY 2018 and FFY2019 are:

- a. Continue first episode psychosis treatment implementation with Yellowstone Behavioral Health Center and Southwest Counseling Services
- b. Identify any areas of technical assistance and training needs
- c. Provide state funding to Peak Wellness Center to replicate FEP treatment.
- d. Evaluate client outcomes for FEP treatment
- e. Present client outcomes to Behavioral Health Advisory Council
- f. Collect and report data and other information to Substance Abuse and Mental Health Services Administration and state stakeholders.

- g. Utilize outcome data to inform providers of FEP treatment should they choose to use state funds towards the services. Continue to link providers together to replicate programs. This includes provider peer reviews.

h. Develop sustainability plan.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

At this time the Division utilizes the Wyoming Client Information System (WCIS) to collect data by age, gender, race, diagnostic category, and agency code. Therefore, the Division collects data to demonstrate the impact of the set aside for first episode psychosis. Further evaluation of data is needed and has been described in the future activities section above. Both FEP agencies are currently reporting into the WCIS. Providers have submitted four quarterly reports to the Division. These reports list critical details such as the number of outreach activities conducted over the quarter.

10. Please list the diagnostic categories identified for your state's ESMI programs

The diagnostic categories in the programs are:

- a. Schizophrenia
- b. Bi-Polar Disorder
- c. Schizoaffective Disorder
- d. Borderline Personality Disorder
- e. Schizoaffective Disorder Bipolar Type, and other Unspecified Stimulant Use Disorder, and Cannabis Use Disorder, and Alcohol Use Disorder
- f. Major Depressive Disorder, Severe with Psychotic Features
- g. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, and Generalized Anxiety Disorder and Nightmare Disorder
- h. Major Depressive Disorder with Mood Congruent Psychotic Features
- i. Bipolar Disorder with Psychotic Features, and Gender Identity Dysphoria, ADHD combined type
- j. Major Depressive Disorder with Anxious Distress and Mood Congruent Psychotic features.

Please indicate area of technical assistance needed related to this section.

1. Training specific to psychosis has been requested by the FEP providers and team members. The clinicians on the teams are licensed family and child therapists and have significant training and experience in engaging families and providing systemic family treatment. However, they would benefit from training and education specific to the pathology of psychosis, as well as any unique impact of psychosis on family systems. This training was anticipated but not received at the recent PIER workshop in Utah.
2. It continues to be difficult, if not impossible, to meet fidelity of current evidenced based practices for FEP, in a rural frontier environment. Multifamily groups are challenging to provide when often there are not enough families in treatment at one time, or families are dispersed around the county and transportation and/or family schedules make it difficult to bring families together. Further, clients of adult age may not have families in the area, or refuse to include family in treatment. The inclusion of natural supports can be a beneficial substitute in these cases, but can also be challenging in environments with limited community resources. Provider agencies believe it is necessary to be proactive in developing an effective FEP model for rural environments that pull effective components from such models as PIER, Navigate, and OnTrack, and modifying them as necessary to support effective FEP treatment in frontier communities. Assistance from

SAMHSA would be appreciated to allow Wyoming this upcoming year to pursue a modification of FEP treatment components into a more effective rural program.

Section C-6 Person Centered Planning

1. Does your state have policies related to person centered planning?

Yes ☒

No ☐

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Division contracts with provider agencies who are responsible for engaging consumers through surveys, consumer driven boards, and other methods of care coordination including primary care. The state can provide ongoing technical assistance to providers who may need assistance with health care decisions.

4. Describe the person-centered planning process in your state.

The process for person centered planning at the state level includes contracting with nationally accredited provider agencies who can involve the client in the planning of services and care. Provider agencies are required through national accreditation to provide person centered services. Wyoming Community Mental Health and Substance Abuse Rules and Regulations also require that clients have an individualized treatment plan which means an action plan based on initial and ongoing assessment information identifying the client's needs, strategy for providing services to meet those needs, measurable treatment goals and objectives and criteria for discharge. Initial treatment plans are developed with the client. The treatment planning process can involve other collateral entities working with the client. In most agencies a clinical team can help integrate the assessment with the treatment plan while also involving the family and any necessary medical liaisons.

Section C-6 Self Direction

1. Does your state have policies related to self-direction?

Yes ☐

No ☒

2. Are there any concretely planned initiatives in your state specific to self-direction?

Yes ☐

No ☒

If yes, describe the current or planned initiative. In particular, please answer the following questions:

a. How is the initiative financed?

b. What are the eligibility criteria?

c. How are budgets set, and what is the scope of the budget?

d. What role, if any, do peers with lived experience of the mental health system play in the initiative?

e. What, if any, research and evaluation activities are connected to the initiative?

f. If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

The state does not currently have any action steps planned to develop self-directed initiatives.

Section C-7 Program Integrity

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

Yes ☒

No ☐

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Yes ☒

No ☐

3. Does the state have any activities related to this section that you would like to highlight?

The rigorous contract performance management process begins with the separation of duties to maximize validity and accountability. The Knowledge-Management, Analysis, and Technology (KMAT) unit maintains the Wyoming Client Information System (WCIS) which collects and records the data directly from the providers. This system contains numerous data validation sequences to ensure the input of high quality and reliable data. Next, the Quality Program Manager places a data request to KMAT with various parameters such as timelines, performance indicators, and number of clients. KMAT will then generate a data report which includes a peer validation process to ensure the accuracy of the report. These reports are then used by the Division to analyze contract performance and set future target goals. Underperforming providers will go through a progressive process of improvement planning and corrective action. These reports are reviewed on a monthly basis to identify problematic trends as soon as possible. This comprehensive contract management process allows providers the opportunity to compare their outcomes with other providers across the state. In turn, providers are able to network with high performers and learn new strategies.

Provider on site visits are typically planned every other year unless there is an investigation or complaint prompting the Division's response. The purpose of these visits are to monitor block grant and contract requirements.

The Division's Substance Use Disorder Certification Program is responsible for overseeing state certification of substance use providers. State certification means the Division formally recognizes the provider's substance use disorder program as having met the requirements of the current Wyoming rules and regulations that pertain to specific substance abuse prevention, early intervention, recovery

support services and treatment services provided. Individual providers are required to be licensed by the Wyoming Mental Health Professions Licensing Board. In addition to state certification, all state funded providers are required to hold a national accreditation.

Please indicate areas of technical assistance needed related to this section.

There are no areas of technical assistance needed related to this section.

Section C-8 Tribes

1. How many consultation sessions have the state conducted with federally recognized tribes?

The Wyoming Department of Health (WDH) meets quarterly with the Tribal Leadership Advisory Council to discuss health care in Wyoming. Various individuals participate from different entities including WDH Behavioral Health Division, WDH Public Health Division, WDH Healthcare Financing, WDH Aging Division, and Vital Statistics.

2. What specific concerns were raised during the consultation session(s) noted above?

According to the most recent minutes from the meeting, there are no major concerns however, there are questions regarding service availability within the state and those questions are answered by each responsible state agency representative. The meetings focus on providing updates regarding funding for services and health care program availability. For example, the WDH Rural Health office presented an update recently on the American Indian Commercial Tobacco Program. Questions regarding alcohol prevention services contracts with WDH and the fetal alcohol syndrome program were also addressed.

3. Does the state have any activities related to this section that you would like to highlight?

Governor Mead places a high priority on establishing and maintaining a positive relationship with both the Northern Arapaho and Eastern Shoshone tribes. The Governor meets with the tribes two to four times per year, both in Cheyenne and on the reservation. In addition, both tribes have a Tribal Liaison who serves as a link to the Governor's Office. These liaisons advise the Governor's Office of matters on concern or accomplishments and also provide feedback from the Governor's Office to the tribes.

There are no areas of technical assistance requested in these areas.

Section C-9 Substance Abuse Block Grant Primary Prevention

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?

Yes ☒

No ☐

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

☒ Data on consequences of substance-using behaviors

☒ Substance-using behaviors

- ☒ Intervening variables (including risk and protective factors)
☐ Other (please list)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply): a) Children (under age 12)

- ☒ Youth (ages 12-17)
☒ Young adults/college age (ages 18-26)
☒ Adults (ages 27-54)
☒ Older adults (age 55 and above)
☐ Cultural/ethnic minorities
☐ Sexual/gender minorities
☒ Rural communities
☒ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply): a) Archival indicators (Please list :)

b) National Survey on Drug Use and Health (NSDUH)

- ☒ Behavioral Risk Factor Surveillance System (BRFSS)
☐ Youth Risk Behavior Surveillance System (YRBS)
☐ Monitoring the Future
☐ Communities that Care
☐ State-developed survey instrument)
☐ Other (please list :)

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?

Yes ☒

No ☐

i) If yes, (if yes, please explain)

Allocation of resources and Substance Abuse and Treatment Block Grant primary prevention fund is based on annual community epidemiological profiles created by the SEOW and community-level comprehensive alcohol, tobacco, and other drug (ATOD) needs assessments. As Wyoming's population density is sparse with very few populous areas, funding all twenty three (23) counties and the Wind River Indian Reservation for prevention services is a necessity. Funding levels are determined on a needs-based funding model that considers rates of abuse for targeted populations, size of target populations, and other disparities. Wyoming utilizes this calculation to rank communities of highest need and apply appropriate levels of funding to each community. This year, the results from a coalition and community capacity assessment will also be used as part of the decision-making process for resource allocation.

ii) If no, please explain how SABG funds are allocated:

Capacity Building

6. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes ☒

No ☐

(if yes, please describe)

Wyoming requires all funded prevention specialists to be trained in Substance Abuse Prevention Skills Training (SAPST) within six months of employment. Additionally the substance abuse prevention unit established an International Certification and Reciprocity Consortium (IC&RC) Prevention Specialist credential in Wyoming in the beginning of 2017. This credential helps establish standardized expectations and qualifications for the prevention workforce and other interested individuals who oversee alcohol, tobacco, other drug (ATOD) within the state. We encourage all prevention professionals who are or will be funded by the Wyoming Department of Health to be certified. This allows the prevention certification to remain voluntary, but emphasizes the importance that Wyoming places on the need for highly qualified professionals providing the service.

7. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?

Yes ☒

No ☐

(if yes, please describe mechanism used)

WDH provides state and national level support through consultation and resources to address organizational and community level technical assistance. Technical assistance through WDH is targeted and customized by professionals with subject matter expertise for the purpose of developing or strengthening process, knowledge application, or implementation of services. Strategies include development and dissemination of tools and resources to help identify and implement prevention programs and strategies using the best available evidence; identification and promotion of effective strategies in rural settings; provisions of proactive technical assistance to prevention staff to support coordination, implementation, dissemination, and evaluation of prevention efforts; and enhancement of capacity.

WDH also contracts with a technical assistance (TA) provider is responsible for providing the resources and training necessary to develop, implement, and improve strategies and programs. In coordination with WDH, the TA provider develops and implements a training plan for every community prevention specialist (CPS) on identified workforce needs to reinforce and supplement core competencies for ATOD prevention.

The TA provider, in partnership with WDH, provides prevention training opportunities. At least one Substance Abuse Prevention Skills Training is held annually. Once per quarter the TA provider hosts a multi-party trainings that are structured to address disparate populations, regional, geographical concerns, specific substance abuse prevention strategies, or integration of services. Opportunities for sustainability or capacity building within communities is enhanced through the development of training curriculums, partnerships with prevention stakeholders to provide education opportunities, and coordination or trainings or train the trainers, such as TiPS.

The TA provider also provides expert TA to both CPSs and coalitions to strengthen and enhance grassroots support, community engagement, and capacity building. This includes proactively providing TA to communities in policy development, policy changes, and the strategic use of media. The TA provider also works with coalitions to use evidence-based practices and objectives within a comprehensive, multi-year strategic plan. The TA provider supports the community prevention workforce with building capacity, engaging the community, and developing media.

The TA provider also works to support the community prevention workforce in the advancement of strategy management by implementation of the strategic performance management system, InsightVision, at the local level to streamline needs assessment data, manage and monitor strategy execution, build assets and capacity to

address prevention, and align partners around objectives and actions. InsightVision is used to incorporate key strategic prevention framework model components. The TA provider works with the community prevention workforce to make local level adjustments and modifications to strategy maps and scorecards as needed.

TA occurs on an as-needed basis with contact frequency ranging from daily to weekly. TA also occurs through peer-to-peer interaction. Each CPS is paired with a mentor partner. These partnerships are specifically designed so that each employee is paired with someone who has skills or knowledge in an area they are deficient. This allows county programs to share concerns, struggles, questions and successes. If further support is sought, a listserv designed specifically for programmatic information dissemination can be utilized to discuss issues on a wider scale with all prevention personnel in Wyoming.

8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

Yes ☒

No ☐

(if yes, please describe mechanism used :)

Capacity assessments were conducting in Wyoming, establishing a 2016 baseline of existing capacity for all 23 counties in Wyoming. The capacity assessments identified key ingredients including prevention workforce, resources, effective community, community engagement, active leadership, readiness for change, and sustainability. A rubric was then created to describe these key ingredients and rank the capacity of the community from 1 to 5. Ranking was based on interviews with the Community Prevention Specialists (CPSs), community focus groups, and results from a coalition member survey to determine readiness. Overall, Wyoming communities ranked some to most capacity in most areas. An assessment will be conducted again in 2020.

Based on individual capacity assessments, all communities have developed capacity-building strategic plans. Six communities were identified as in need for extensive Technical Assistance (TA), although all communities will be provided with TA to ensure plans include a wide range of capacity-building strategies (such as trainings, case studies, field visits, etc.) ensuring the most effective and cost-efficient approach. Evaluation will be utilized to determine success of strategies by an independent evaluator. The SEOW and WDH will make recommendations for continued and long-term capacity building with provided technical assistance to include capacity building within upcoming educational and community mobilization strategic plans.

Planning

9. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?

Yes ☒

No ☐

(If yes, please attach the plan in BGAS)

10. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?

Yes ☒

No ☐

Not applicable (no prevention strategic plan)

11. Does your state's prevention strategic plan include the following components? (check all that apply):

- ☒ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- ☒ Timelines
- ☐ Roles and responsibilities
- ☒ Process indicators
- ☒ Outcome indicators
- ☐ Cultural competence component
- ☐ Sustainability component
- ☐ Other (please list:)

i) Not applicable/no prevention strategic plan

12. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?

Yes ☒

No ☐

13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?

Yes ☒

No ☐

b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Wyoming's substance abuse treatment and prevention rules require the use of evidence-based substance abuse prevention practices and programs. The Evidence-Based Workgroup is a subcommittee of the SEOW. The group ensures that funded communities are utilizing Evidence Based Practices (EBPs) in their prevention work. This group includes WDH program managers and epidemiologists, senior leadership from the community services provider, currently the PMO, and researchers from WYSAC, our current outside evaluators for prevention efforts administered by WDH and implemented by the PMO. This group meets on an as-needed basis to discuss ongoing progress and challenges in the design and implementation of EBPs in Wyoming communities.

The determination of which programs, policies, and strategies are evidence based are guided by the National Registry of Evidence-based Programs and Practices (NREPP) and the community guide. Wyoming also uses the Catalog of Environmental Prevention Strategies, which was developed by the Wyoming Survey & Analysis Center at the University of Wyoming, under contract to the Public Health Division of the Wyoming Department of Health. This document is an inventory of environmental substance abuse prevention strategies targeting

alcohol, tobacco, and other drugs assessed to determine the evidence base and effectiveness of the evidence for each identified strategy.

In Wyoming, substance abuse prevention and tobacco prevention are fully integrated at both state and local levels. At the state level, the WDH, Substance Abuse Prevention Program (SAPP) Manager oversees the management of alcohol/drug abuse and misuse and ensures efforts are complementary and coordinated. Tobacco Prevention and Control Program (TPCP) works closely with the SAPP through shared data, resources, and other means. Within community efforts, each Wyoming county has at least one Community Prevention Specialist (CPS) whose primary responsibility is facilitating local coalitions in identifying programs, practices, and policy change in drinking, prescription drug misuse, and tobacco prevention within a single umbrella. Local coalitions work with the CPS to develop a strategic plan that outlines goals and strategies to achieve those goals. These strategic plans are reviewed by SAPP and TPCP to ensure that all strategies are evidence-based.

Implementation

14. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state: ☐ SSA staff directly implements primary prevention programs and strategies.

☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

☐ The SSA funds regional entities that provide training and technical assistance.

☐ The SSA funds regional entities to provide prevention services.

☐ The SSA funds county, city, or tribal governments to provide prevention services.

☐ The SSA funds community coalitions to provide prevention services.

☐ The SSA funds individual programs that are not part of a larger community effort.

☐ The SSA directly funds other state agency prevention programs.

☒ Other (please describe)

15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies: a) Information Dissemination:

b) Education:

c) Alternatives:

d) Problem Identification and Referral:

e) Community-Based Processes:

e) Environmental:

Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

Yes ☒

No ☐

(if so, please describe:)

Block grant dollars in Wyoming are used to supplement prevention services primarily funded through other sources. Through the Request for Proposal/Application process used for selection of vendors and the contracting process, Wyoming ensures that all SABG funded activities compliments and supplements existing substance abuse prevention services. Oversight of the SABG funding continues with the contract payment process. The

SABG funds are utilized within the single-fiscal agent community services contract with multiple funding streams for a variety of prevention services. All expenses are coded as to the prevention service, purpose, and appropriate funding stream is applied.

Evaluation

17. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?

Yes ☒

No ☐

(If yes, please attach the plan in BGAS)

18. Does your state's prevention evaluation plan include the following components? (check all that apply):

- ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- ☐ Includes evaluation information from sub-recipients
- ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- ☐ Establishes a process for providing timely evaluation information to stakeholders
- ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- ☐ Other (please describe:)
- ☐ Not applicable/no prevention evaluation plan

19. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- ☐ Numbers served
- ☐ Implementation fidelity
- ☐ Participant satisfaction
- ☒ Number of evidence based programs/practices/policies implemented
- ☐ Attendance
- ☐ Demographic information
- ☐ Other (please describe:)

20. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- ☒ 30-day use of alcohol, tobacco, prescription drugs, etc...
- ☒ Heavy use Binge use Perception of harm
- ☒ Disapproval of use
- ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- ☐ Other (please describe:)

Section C-10 Statutory Mental Health Block Grant

Criterion 1 Comprehensive Community-Based Mental Health Service Systems

Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Available community services to support those in functioning outside of inpatient or residential institutions include mental health and co-occurring outpatient treatment services provided by CMHCs.. Services include

individual, group and family therapy, case management, wrap around services, rehabilitation services, housing, medication management and recovery supports such as Wellness Recovery Action Planning and, in some areas of the state, peer specialists. . CMHCs link individuals to various other community resources such as , primary health care, educational, and other resources.

Gatekeeper and Diversionary Grants

The Division has recently provided gatekeeper and Diversionary grant awards to various providers in the state (See Gatekeeper Activities Attachment A). These services are designed to ensure individuals are receiving the least restrictive services based on their needs.

Assisted Outpatient Treatment

The Assisted Outpatient Treatment (AOT) Grant was awarded by SAMHSA to the Wyoming Department of Health in October 2016. The purpose of the AOT grant is to implement and evaluate programs which aim to reduce the incidence and/or duration of psychiatric hospitalization, homelessness, unemployment, incarceration, and interactions with the criminal justice system, while also improving the overall health and social outcomes for individuals living with SMI.

Convalescent Leave

An individual who has shown marked improvement in the Wyoming State Hospital may be considered for convalescent leave. This leave is contingent on the individual having a plan of treatment on an outpatient, or non-hospital basis.

Discharge Planning

The Division hosts monthly discharge planning calls with providers. The purpose of these meetings is to identify transition opportunities for individuals at the state hospital. The Division reviews regional bed availability in the crisis centers and attempts to identify Wyoming State Hospital clients who are appropriate to step-down to those open beds.

Memorandum of Understanding

Hospitals and community mental health centers are required in contracts to have a memorandum of understanding. This MOU lists expectations for coordination of care and communication regarding discharge plans of individuals receiving services.

Title 25

The number of involuntary hospitalizations in Wyoming under Title 25 has increased over the last several years. The Division coordinates many activities to address the high number of involuntary hospitalization in the state. The Wyoming Department of Health, Director's Unit for Policy Research and Evaluation (DUPRE) has hired a Title 25 coordinator. This coordinator is responsible for collecting and analyzing the data related to hospitalizations and individuals receiving care. Data can be evaluated to determine what changes are needed with regards to appropriate placement of individuals.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a) Physical health

Yes ☐

No ☒

b) Mental Health

Yes ☒

No ☐

c) Rehabilitation services

Yes ☒

No ☐

d) Employment services

Yes ☒

No ☐

e) Housing services

Yes ☐

No ☒

f) Educational services

Yes ☒

No ☐

g) Substance misuse prevention and SUD treatment services

Yes ☒

No ☐

h) Medical and dental services

Yes ☐

No ☒

i) Support services

Yes ☒

No ☐

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)

Yes ☐

No ☒

k) Services for persons with co-occurring M/SUDs

Yes ☒

No ☐

Please describe as needed (for example, best practices, service needs, concerns, etc.)

Describe your state's case management services

Each state funded community mental health center provides case management services when needed. The services include components such as advocacy, linkage, monitoring, and follow up. Case managers serve as the primary link between community resources, basic needs, family, primary care services, legal, and recovery supports access.

Describe activities intended to reduce hospitalizations and hospital stays.

Please see the above mentioned activities related to Assisted Outpatient Treatment and gatekeeper activities.

WYSUP project

The Wyoming Super-Utilizer Program (WySUP) is one component of a group of initiatives within the WDH intended to improve the health outcomes of adults with complex care needs while decreasing State costs. The project is underway and the first phases of the program have launched. The WDH plans to have the WySUP fully implemented by December of 2018.

This program focuses on high-risk adults with multiple comorbidities. In many cases, these individuals have chronic conditions and co-occurring behavioral health conditions, so the program must be tightly integrated with the mental health and substance use disorder system in Wyoming. In-person (not telephonic) care management will be accomplished by a cross-functional team to address medical, mental health, substance use treatment, and basic/social needs.

Criterion 2: Mental Health System Data Epidemiology

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Division utilizes SAMHSA's published prevalence and incidence rates in planning purposes. When considering which provider agencies are awarded state funds, the Division considers national data and evidence based practices for mental health treatment.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a) Social Services

Yes ☒

No ☐

b) Educational services, including services provided under IDE

Yes ☒

No ☐

c) Juvenile justice services

Yes ☒

No ☐

d) Substance misuse prevention and SUD treatment services

Yes ☒

No ☐

e) Health and mental health services

Yes ☒

No ☐

f) Establishes defined geographic area for the provision of the services of such system

Yes ☐

No ☒

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Describe your state's targeted services to rural and homeless populations and to older adults.

PATH Grant

The state applies for this grant each year. This grant allows the state to provide outreach and PATH case management services for adults who are or at risk of homelessness in Wyoming's four largest counties. The MHBG is utilized to supplement these four PATH contracts to advance the Housing First process; these funds provide additional staffing funds and direct rent costs while people in PATH are waiting for more secure ways of paying for rent. The BHD utilizes in-kind personnel and resources to support training and support for community providers (including PATH, CMHC's, disability providers, and others) to utilize the SOAR process for people who are literally or at risk of homelessness to apply for SSI and/or SSDI.

CMHC's/SAC's work to preempt unnecessary crisis/emergency detention of persons with SMI who are homeless. Further, CMHC's provide community based services in each county to adults and children.

Criterion 5: Management Systems

Describe your state's management systems.

The Division utilizes the following management systems

The Division utilizes the Wyoming Client Information System (WCIS) to collect client level data by age, gender, race, diagnostic category, and agency code. WCIS also collects client services, client outcome, and performance data for each provider.

The Wyoming Online Financial System (WOLF's) provides agencies the means to process all payments made by the state and assist agencies in accounting for public money. The system also processes paychecks for state employees each month, including patient and inmate workers in the State's institutions, legislators, judges, board members and members of the Wyoming National Guard.

The Division Access Contract Tracking Database provides tracking for all contracts within the Division as each contract moves through the steps of being approved by the Department of Health.

There are no areas of technical assistance requested in these areas.

Section C-11 Substance Use Disorders

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services:

i) Screening

Yes ☒

No ☐

ii) Education

Yes ☒

No ☐

iii) Brief intervention

Yes ☒

No ☐

iv) Assessment

Yes ☒

No ☐

v) Detox (inpatient/social)

Yes ☒

No ☐

vi) Outpatient

Yes ☒

No ☐

vii) Intensive outpatient

Yes ☒

No ☐

viii) Inpatient/residential

Yes ☒

No ☐

ix) Aftercare; recovery support

Yes ☒

No ☐

b) Are you considering any of the following:

Targeted services for veterans

Yes ☐

No ☒

c) Expansion of services for:

(1) Adolescents

Yes ☐

No ☒

(2) Older adults

Yes ☐

No ☒

(3) Medication-Assisted Treatment (MAT)

Yes ☒

No ☐

Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?

Yes ☒

No ☐

2. Either directly or through an arrangement with public or private nonprofit entities make prenatal care available to PWWDC receiving services?

Yes ☒

No ☐

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?

Yes ☒

No ☐

4. Does your state have an arrangement for ensuring the provision of required supportive services?

Yes ☒

No ☐

5. Are you considering any of the following:

a) Open assessment and intake scheduling

Yes ☒

No ☐

b) Establishment of an electronic system to identify available treatment slots

Yes ☒

No ☐

c) Expanded community network for supportive services and healthcare

Yes ☒

No ☐

d) Inclusion of recovery support services

Yes ☒

- No ☐
- e) Health navigators to assist clients with community linkages
Yes ☐
No ☒
- f) Expanded capability for family services, relationship restoration, custody issue
Yes ☐
No ☒
- g) Providing employment assistance
Yes ☒
No ☐
- h) Providing transportation to and from services
Yes ☒
No ☐
- i) Educational assistance
Yes ☐
No ☒

States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The PWWDC is monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the PWWDC requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The state has ability to pull individual client records and determine if the clients are receiving PWWDC services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding PWWDC.

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program
Persons Who Inject Drugs (PWID)

1. Does your state fulfill the
- a) 90 percent capacity reporting requirement
Yes ☒
No ☐
- b) 14-120 day performance requirement with provision of interim services
Yes ☒
No ☐
- c) Outreach activities
Yes ☒
No ☐
- d) Syringe services programs
Yes ☐
No ☒
- e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

Yes ☒

No ☐

2. Are you considering any of the following:

a) Electronic system with alert when 90 percent capacity is reached

Yes ☐

No ☒

b) Automatic reminder system associated with 14-120 day performance requirement

Yes ☐

No ☒

c) Use of peer recovery supports to maintain contact and support

Yes ☐

No ☒

d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

Yes ☐

No ☒

States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The PWID is monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the PWID requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The state has ability to pull individual client records and determine if the clients are receiving PWID services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding PWID.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

Yes ☒

No ☐

2. Are you considering any of the following:

a) Business agreement/MOU with primary healthcare providers

Yes ☐

No ☒

b) Cooperative agreement/MOU with public health entity for testing and treatment

Yes ☐

No ☒

c) Established co-located SUD professionals within FQHCs

Yes ☐

No ☒

2. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All patients in Wyoming are eligible to receive financial assistance for TB medications through the Wyoming Department of Health (WDH) TB program. Treatment completion of latent TB and active treatment are monitored. The TB services are monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the TB requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The state has ability to pull individual client records and determine if the clients are receiving TB services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding TB. If agencies identify a client who needs TB services, they refer them to the WDH TB program.

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?

Yes ☐

No ☒

3. Are you considering any of the following:

a) Workforce development efforts to expand service access

Yes ☐

No ☒

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services

Yes ☐

No ☒

c) Establish a peer recovery support network to assist in filling the gaps

Yes ☐

No ☒

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)

Yes ☐

No ☒

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations

Yes ☐

No ☒

f) Explore expansion of services for:

i) MAT

Yes ☒

No ☐

ii) Tele-health

Yes ☒

No ☐

iii) Social media outreach

Yes ☒

No ☐

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

Yes ☐

No ☒

2. Are you considering any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services

Yes ☐

No ☒

b) Establish a program to provide trauma-informed care

Yes ☐

No ☒

c) Identify current and perspective partners to be included in building a system of care, e.g., FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education

Yes ☒

No ☐

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)

Yes ☐

No ☒

Are you considering any of the following:

a) Notice to Program Beneficiaries

Yes ☐

No ☒

b) Develop an organized referral system to identify alternative providers

Yes ☐

No ☒

c) Develop a system to maintain a list of referrals made by religious organizations

Yes ☐

No ☒

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs

Yes ☐

No ☒

2. Are you considering any of the following:

a) Review and update of screening and assessment instruments

Yes ☐

No ☒

b) Review of current levels of care to determine changes or additions

Yes ☒

No ☐

c) Identify workforce needs to expand service capabilities

Yes ☐

No ☒

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Yes ☐

No ☒

Patient Records

Does your state have an agreement to ensure the protection of client records

Yes ☒

No ☐

Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements

Yes ☐

No ☒

b) Training on responding to requests asking for acknowledgement of the presence of clients

Yes ☐

No ☒

c) Updating written procedures which regulate and control access to records

Yes ☐

No ☒

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure

Yes ☐

No ☒

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers

Yes ☒

No ☐

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved

In FY 16, there were seven (7) block grant sub-recipients identified to undergo the peer review.

In FY 15, there were 9 nine (9) block grant sub-recipients identified to undergo the peer review.

3. Are you considering any of the following:

a) Development of a quality improvement plan

Yes ☒

No ☐

b) Establishment of policies and procedures related to independent peer review

Yes ☒

No ☐

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations

Yes ☐

No ☒

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

Yes ☒

No ☐

- b) **If Yes**, please identify the accreditation organization(s)
- i) Commission on the Accreditation of Rehabilitation Facilities
 - ii) The Joint Commission
 - iii) Other (please specify)

The Division requires a national accreditation. All state funded providers have either Commission on Accreditation of Rehabilitation Facilities or Joint Commission.

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?

Yes ☐

No ☒

2. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service

Yes ☐

No ☒

Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing

Yes ☐

No ☒

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

The Division does not have a formal agreement to ensure systems have opportunities for training on an ongoing basis however, the Division works closely with the Central Rockies ATTC, SAMHSA, National and Rural Frontier ATTC. Trainings are distributed via email to the providers through the SUD state certification program. Additionally, for special projects, state staff may forward various trainings regularly.

a) Recent trends in substance use disorders in the state

Yes ☒

No ☐

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services

Yes ☐

No ☒

c) Performance-based accountability

Yes ☐

No ☒

d) Data collection and reporting requirements

Yes ☐

No ☒

2. Are you considering any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs

Yes ☐

No ☒

b) Addition of training sessions designed to increase employee understanding of recovery support services

Yes ☐

No ☒

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services

Yes ☐

No ☒

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort

Yes ☒

No ☐

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations Regarding Women

Yes ☐

No ☒

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus a) Tuberculosis

Yes ☐

No ☒

Early Intervention Services Regarding HIV

Yes ☐

No ☒

3. Additional Agreements a) Improvement of Process for Appropriate Referrals for Treatment

Yes ☐

No ☒

Professional Development

Yes ☐

No ☒

Coordination of Various Activities and Services

Yes ☐

No ☒

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Below are the links to these regulations:

<https://health.wyo.gov/behavioralhealth/mhsa/rules-and-regulations/>

<https://rules.wyo.gov/>

13. Quality Improvement Plan- requested

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

Yes ☐

No ☒

Please indicate areas of technical assistance needed related to this section.

Section C-13: Trauma

Wyoming does take an active approach to addressing trauma. While some providers do a specific trauma screening upon intake into treatment, it is standard protocol during the psychosocial assessment for all providers to ask questions regarding past trauma/abuse experiences. As part of the Substance Abuse Rules, treatment providers are required to provide training to employees on trauma assessment and management and women's specific providers must include services as needed for individuals who have experienced trauma. Further, providers use trauma-specific therapies ranging from trauma focused cognitive behavioral approaches, exposure therapy, dialectical behavioral therapy, and other approaches to meet the needs of the persons served.

State funded providers are required through national accreditation to implement policies and procedures for providing comprehensive assessments upon admission to their program. The Substance Abuse Rules also require providers to utilize assessment tools that address prior trauma history. The written assessments contain information on client behavioral health history including trauma. Wyoming also promotes the provision of trauma informed care through sharing information about professional trainings for providers. The BHD utilizes

SAMHSA's Treatment Improvement Protocol 57 to promote trauma informed care. Trauma informed care principles have been adopted by the BHD for its operations.

The BHD has offered multiple webinars, resources, and materials to providers to promote trauma informed care including evidence based trauma specific interventions for children, families, and adolescents. State technical assistance is always available for providers who need it. The Covington Curriculum includes effective, practical, and theoretically based information for professionals. Many providers also utilize the Seeking Safety and Living in Balance curriculums as well.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?

Yes ☐

No ☒

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?

Yes ☐

No ☒

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?

Yes ☐

No ☒

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?

Yes ☒

No ☐

5) Does the state have any activities related to this section that you would like to highlight.
The Division does not have any activities to highlight at this time.

Please indicate areas of technical assistance needed related to this section.

The Division does not request technical assistance in this section.

Section C-14: Criminal and Juvenile Justice

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?

Yes ☐

No ☒

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

Yes ☐

No ☒

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Yes ☐

No ☒

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?

Yes ☒

No ☐

5. Does the state have any activities related to this section that you would like to highlight?

The Division does not have any activities to highlight at this time.

There are no areas of technical assistance requested in these areas.

Section C-15 Medication Assisted Treatment

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?

Yes ☐

No ☒

This plan is in process but not finished at the time of writing this application.

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?

Yes ☐

No ☒

3. Does the state purchase any of the following medication with block grant funds?

Yes ☐

No ☒

a) Methadone

b) Buprenorphine; Buprenorphine/naloxone

c) Disulfiram

d) Acamprosate

e) Naltrexone (oral, IM)

f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance use disorders are used appropriately*?

Yes ☐

No ☒

Does the state have any activities related to this section that you would like to highlight?

The Division has received a federal Medication Assisted Treatment (MAT) grant to implement specialized programs with services such as behavioral therapy, medication, and recovery support services for individuals opioid use disorder. Two provider agencies were awarded MAT funding in Natrona County and Sweetwater County. Both providers are in the second year of the grant and have served approximately 200 clients over the entire grant period. The expectations of these providers are to serve a specified number of clients according to their state contracts in addition to reporting various data sets and outcomes.

The federal State Targeted Response to Opioid Crisis (STR) grant was also awarded to the Division. These funds serve multiple purposes including addressing the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder. The Division is in the startup process of executing contracts with provider agencies throughout other areas of the state.

C-16 Crisis Services

The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- ☒ Wellness Recovery Action Plan (WRAP) Crisis Planning
- ☒ Psychiatric Advance Directives
- ☒ Family Engagement
- ☒ Safety Planning
- ☐ Peer-Operated Warm Lines
- ☐ Peer-Run Crisis Respite Programs
- ☒ Suicide Prevention

2. Crisis Intervention/Stabilization:

- ☐ Assessment/Triage (Living Room Model)
- ☐ Open Dialogue
- ☐ Crisis Residential/Respite
- ☒ Crisis Intervention Team/ Law Enforcement
- ☒ Mobile Crisis Outreach
- ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support:

- ☒ WRAP Post-Crisis
- ☒ Peer Support/Peer Bridgers

- ☒ Follow-Up Outreach and Support
- ☐ Family-to-Family engagement
- ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
- ☐ Follow-up crisis engagement with families and involved community members
- ☒ Recovery community coaches/peer recovery coaches
- ☒ Recovery community organization

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

There are no areas of technical assistance requested in these areas.

Section C-17 Recovery

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

Yes ☒

No ☐

Required peer accreditation or certification?

Yes ☒

No ☐

Block grant funding of recovery support services.

Yes ☒

No ☐

Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Yes ☒

No ☐

2. Does the state measure the impact of your consumer and recovery community outreach activity?

Yes ☐

No ☒

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

State funded Community Mental Health Centers provide recovery services to these populations. Services include peer support through peer specialists, case management, life skills, housing, and group home services. Quality of Life funding is provided to community mental health centers for purposes of providing basic needs such as medication.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

State funded Community Mental Health Centers provide recovery services to these populations. Services include peer support through peer specialists, case management, life skills, housing, and group home services. Quality of Life funding is provided to community mental health centers for purposes of providing basic needs such as medication.

5. Does the state have any activities that it would like to highlight?

There are no areas to highlight at this time.

Please indicate areas of technical assistance needed related to this section

There are no areas of technical assistance needed at this time.

C-18 Community Living and the Implementation of Olmstead

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include :

housing services provided

Yes ☒

No ☐

home and community based services

Yes ☒

No ☐

peer support services

Yes ☐

No ☒

employment services

Yes ☒

No ☐

2. Does the state have a plan to transition individuals from hospital to community settings?

Yes ☒

No ☐

What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Wyoming Department of Health is in the process updating the Olmstead plan.

Please indicate areas of technical assistance needed related to this section.

There are no areas of technical assistance needed related to this section.

Section C-19 Children and Adolescents Behavioral Health Services

1. Does the state utilize a system of care approach to support:
 - a) The recovery and resilience of children and youth with SED?
Yes ☐
No ☒
 - The recovery and resilience of children and youth with SUD?
Yes ☐
No ☒
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs
 - a) Child welfare?
Yes ☐
No ☒
 - b) Juvenile justice?
Yes ☐
No ☒
 - c) Education?
Yes ☐
No ☒
3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization?
Yes ☐
No ☒
 - b) Costs?
Yes ☐
No ☒
 - c) Outcomes for children and youth services?
Yes ☒
No ☐
4. Does the state provide training in evidence-based :
 - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families. ?
Yes ☒
No ☐

b) Mental health treatment and recovery services for children/adolescents and their families?

Yes ☒

No ☐

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system?

Yes ☐

No ☒

b) for youth in foster care?

Yes ☐

No ☒

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Community Mental Health Centers receive funding from the Division to provide mental health and substance use services to children. The Division works collaboratively with other agencies throughout the state such as the Department of Family Services who is responsible for social and welfare services, and juvenile justice/law enforcement. Wyoming Department of Education is responsible for the education services.

7. Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section

None

C-20 Suicide Prevention

1. Have you updated your state's suicide prevention plan in the last 2 years?

Yes ☒

No ☐

2. Describe activities intended to reduce incidents of suicide in your state.

Wyoming updated the state suicide prevention plan at the beginning of 2017. The goals and objectives have been closely aligned with the 2012 National Strategy for Suicide Prevention, a report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. Activities intended to reduce incidents of suicide in Wyoming include: developing broad-based support for suicide prevention by increasing support for suicide efforts; develop and implement community-based suicide prevention programs and activities through support and development of community-based coalitions for suicide prevention and increasing capacity for suicide prevention in school districts; promote awareness that suicide is a public health problem that is

preventable by developing media campaigns to raise awareness about suicide prevention and coordinating with other suicide prevention organizations to enhance outreach; reduce stigma associated with mental health including education of media on appropriate reporting; reduce access to lethal means by working with stakeholders including local gun shop owners and prescription drug abuse stakeholder groups; implement suicide prevention training to increase recognition of at-risk behavior and delivery of effective treatment, to include implementation of Zero Suicide; increase key services for individuals at risk for suicide and suicide survivors by establishing a statewide network of suicide survivors and support group leaders and collaborating with primary care facilities to incorporate suicide prevention appropriate responses to individuals at risk for suicide; build capacity for Lifeline services in Wyoming to increase the number of lifeline calls answered within the state from 0% to 70%; and finally we are working to improve and expand surveillance systems to collect suicide-related data.

3. Have you incorporated any strategies supportive of Zero Suicide?

Yes ☒

No ☐

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

Yes ☒

No ☐

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?

Yes ☐

No ☒

If so, please describe the population targeted?

Section C-21 Support of State Partners

1. Has your state added any new partners or partnerships since the last planning period?

Yes ☐

No ☒

2. Has your state identified the need to develop new partnerships that you did not have in place?

Yes ☐

No ☒

If yes, with whom? N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Division coordinates with community mental health centers to produce the best possible outcomes and to enable consumers to function outside of inpatient and residential programs.

Service contracts outline deliverables and expectations of these centers in order to allow the Division to maximize efficiency, effectiveness, quality and cost-effectiveness of the services and programs.

- a. Title 25 Coordinator hired
- b. Memorandum of Understanding between hospitals and community mental health centers.
- c. Behavioral Health Advisory Council
- d. Gatekeeping and Diversion grants
- e. Assisted Outpatient Treatment
- f. Early Intervention and Education Program- Ensures that services are provided to eligible children birth through 5 with Developmental Delays and disabilities in accordance with the IDEA and Wyoming state laws.

Section C-22: State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

The Wyoming Behavioral Health Advisory Council (BHAC) is a majority Consumer and Family member advisory body to state and local government, the Legislature, and residents of Wyoming on mental health and substance abuse services in Wyoming. The [vision and mission](#) of the BHAC guides its ability to review, and recommend evidence based approaches to be supported with the federal SAMHSA Mental Health and Substance Abuse Block Grant. The Council wants to assure that our state's system of care for behavioral health addresses necessary modifications for health care reform, and that our strategic plan allows us the flexibility to not only provide input into these changes, but also to modify the Council's processes as necessary to accommodate and support the behavioral health system.

The BHAC informs the Administration and the Legislature on priority issues and provides feedback on behavioral health policy and regulations. In addition the council monitors and evaluates the allocation and adequacy of behavioral health services in the state.

Further, the BHAC participates in the development of the block grant plan through a review and comment process. The Block Grant State Planner presents a draft copy of the Plan to the Council and invites comments and feedback from the Council. A new process was created in 2017 in which the State Planner drafted an outline of the block grant application presented it in a two part series Webinar to the council. The council Chair co-facilitated the presentation and addressed any questions on the review of the draft outline of the state plan. The council plays an integral role in the pre-submission activities relating to the Block Grant Plan. Comments are recorded and addressed within the plan whenever possible prior to submission. The council meets on a quarterly basis to monitor, review, and evaluate the allocation and adequacy of behavioral health services within the State and to provide direction to the BHD in its functioning and allocation of resources.

What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

A robust planning process is utilized each year which includes alignment with the Division's strategic plan and funding decisions. This process involves Division staff, provider staff, and other key stakeholders. Once group decisions are made regarding the specific service needs and funds available, the Division contracts with provider agencies to carry out the services. The state provides data to the Council to help prioritize the delivery of

substance abuse services. The WAMSAC representatives on the Council provide input based upon the experiences/services of their member organizations for substance abuse and mental health. Many of those agencies provide services to both populations with an emphasis on co-occurring disorders.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Yes ☒

No ☐

2. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes ☒

No ☐

Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council is responsible for the following three areas:

- To review the block grant and make recommendations;
- To monitor, review, and evaluate the allocation and adequacy of behavioral health services; and
- To advocate for people with behavioral health needs

The Council currently meets four (4) times a year. These meetings focus on addressing concerns identified by the membership. For the past two years the Council has received targeted technical assistance from SAMHSA to develop mission and vision statements and to develop a 3 year strategic plan. The strategic plan is now in a draft form and is to be finalized at the August 2015 meeting. Our membership reflects the populations identified as critical for our work: LGBTQ, persons recovering from substance abuse, persons experiencing mental health issues, and family members affected by behavioral health concerns. Members and others are encouraged to share “what is happening in their community or with the group they represent” at the beginning of each meeting. These discussions then drive the agenda for future meetings. Other agencies are also asked to provide information on data that they collect to help the Council understand behavioral health issues in a broader perspective.

There are no areas of technical assistance requested in these areas.

Section C-23: Public Comment on the State Plan

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings?

Yes ☒

No ☐

b) Posting of the plan on the web for public comment?

Yes ☒

No ☐

Other?

if yes, provide URL

c) Other (e.g. public service announcements, print media)

Yes ☐

No ☒