

Wyoming

UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/31/2019 10.08.27 AM)

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 2020

End Year 2021

State SAPT DUNS Number

Number 809915796

Expiration Date

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 Heather

Last Name Babbitt

Agency Name Wyoming Department of Health

Mailing Address 6101 Yellowstone Rd., Ste. 220

City Cheyenne

Zip Code 82002

Telephone 307-777-3365

Fax (307) 777-5849

Email Address heather.babbitt1@wyo.gov

State CMHS DUNS Number

Number 809915796

Expiration Date 3/30/2019

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 Heather

Last Name Babbitt

Agency Name Wyoming Department of Health

Mailing Address 6101 Yellowstone Road, Suite 220

City Cheyenne

Zip Code 82002

Telephone 307-777-3365

Fax (307) 777-5849

Email Address heather.babbitt1@wyo.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ☐ Yes ☒ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Megan

Last Name Norfolk

Telephone 307-777-7903

Fax 307-777-5849

Email Address megan.norfolk1@wyo.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

*Heather Babbitt is the Interim Senior Administrator (SSA) for the Behavioral Health Division.

State Information

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

Fiscal Year 2020

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

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 Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

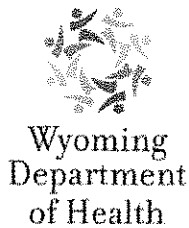
Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



401 Hathaway Building • Cheyenne, WY 82002
Phone (307) 777-7656 • 1-866-571-0944
Fax (307) 777-7439 • www.health.wyo.gov



Michael A. Ceballos
Director

Mark Gordon
Governor

MEMORANDUM

Date: July 2, 2019

To: Governor Mark Gordon

From: Michael A. Ceballos, Director
Wyoming Department of Health

Subject: Delegation of Authority - Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant

Ref.: C-2019-348

The Wyoming Department of Health, Behavioral Health Division administers the combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse Mental Health Services Administration (SAMHSA). The Community Mental Health Services Block Grant (MHBG) is authorized by section 1911 of Title XIX, Part B, Subpart I and III of the Public Health Service Act. The MHBG Program's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services. The Substance Abuse Prevention and Treatment Block Grant (SABG) was authorized by section 1921 of Title XIX, Part B, Subpart II and III of the Public Health and Human Service Act. The SABG program's objective is to help plan, implement, and evaluate activities preventing and treating substance abuse.

Pursuant to Section 529 of the Public Health Services Act requires each funding agreement and the applicable assurances is certified by the Chief Executive Officer of the state. I am requesting you delegate this authority to myself as the Director of the Wyoming Department of Health. By delegating this authority to the Department, it allows for the Department to administer the grant more efficiently.

MAC/MN/jg

c: Heather Babbitt, M.P.A., Operations Administrator, Behavioral Health Division
Chris Newman, M.H.A., Senior Administrator, Behavioral Health Division
Megan Norfolk, State Planner, Mental Health and Substance Abuse Services



July 3, 2019

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary from Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. McCance-Katz:

Mental Health and Substance Abuse Prevention and Treatment Block Grant

This delegation of authority has been requested by the Wyoming Department of Health, Behavioral Health Division, Mental Health and Substance Abuse Services Section. The purpose of this delegation is for the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application, which pursuant to Section 529 of the Public Health Services Act, requiring each funding agreement is made through certification from the Chief Executive Officer of a state.

I hereby delegate authority to Michael A. Ceballos, Director of the Wyoming Department of Health, to execute funding agreements and certification, provide assurances of compliance to the Assistant Secretary of the Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant. This delegation of authority shall remain in place until such time it is rescinded in writing.

Sincerely,

Mark Gordon
Governor

c: Michael A. Ceballos, Director, Wyoming Department of Health

State Information

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
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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
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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

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

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: _____

Signature of CEO or Designee¹: _____

Title: _____

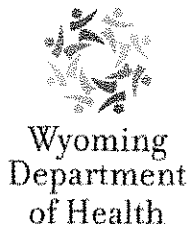
Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



401 Hathaway Building • Cheyenne, WY 82002
Phone (307) 777-7656 • 1-866-571-0944
Fax (307) 777-7439 • www.health.wyo.gov



Michael A. Ceballos
Director

Mark Gordon
Governor

MEMORANDUM

Date: July 2, 2019

To: Governor Mark Gordon

From: Michael A. Ceballos, Director
Wyoming Department of Health

Subject: Delegation of Authority - Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant

Ref.: C-2019-348

The Wyoming Department of Health, Behavioral Health Division administers the combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse Mental Health Services Administration (SAMHSA). The Community Mental Health Services Block Grant (MHBG) is authorized by section 1911 of Title XIX, Part B, Subpart I and III of the Public Health Service Act. The MHBG Program's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services. The Substance Abuse Prevention and Treatment Block Grant (SABG) was authorized by section 1921 of Title XIX, Part B, Subpart II and III of the Public Health and Human Service Act. The SABG program's objective is to help plan, implement, and evaluate activities preventing and treating substance abuse.

Pursuant to Section 529 of the Public Health Services Act requires each funding agreement and the applicable assurances is certified by the Chief Executive Officer of the state. I am requesting you delegate this authority to myself as the Director of the Wyoming Department of Health. By delegating this authority to the Department, it allows for the Department to administer the grant more efficiently.

MAC/MN/jg

c: Heather Babbitt, M.P.A., Operations Administrator, Behavioral Health Division
Chris Newman, M.H.A., Senior Administrator, Behavioral Health Division
Megan Norfolk, State Planner, Mental Health and Substance Abuse Services



July 3, 2019

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary from Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. McCance-Katz:

Mental Health and Substance Abuse Prevention and Treatment Block Grant

This delegation of authority has been requested by the Wyoming Department of Health, Behavioral Health Division, Mental Health and Substance Abuse Services Section. The purpose of this delegation is for the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application, which pursuant to Section 529 of the Public Health Services Act, requiring each funding agreement is made through certification from the Chief Executive Officer of a state.

I hereby delegate authority to Michael A. Ceballos, Director of the Wyoming Department of Health, to execute funding agreements and certification, provide assurances of compliance to the Assistant Secretary of the Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant. This delegation of authority shall remain in place until such time it is rescinded in writing.

Sincerely,

Mark Gordon
Governor

c: Michael A. Ceballos, Director, Wyoming Department of Health

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

Title

Organization

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. 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 M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Attachment: Planning Step 1

NOT FINAL



Section B Planning Step 1

Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application

Behavioral Health Division
Mental Health and Substance Abuse Section
Phone: (307) 777-5817
Fax: (307) 777-5849

Wyoming is a rural and frontier state, where approximately 577,737 people reside in the 97,093 square miles, and continues to be the least populated state in the nation (US Census Bureau, 2018). The state experienced an approximate one percent decline in residents from 2017 US Census of 578,934, and a 1.45 percent decrease since the last submitted application. The population race and origin remains the same at approximately 49 percent female and 51 percent male. The ethnicity is predominately non-hispanic white, which accounts for 84 percent of the total population. Latino or Hispanic are next with 10 percent, followed by American Indian at 2.7 percent, Black or African American at 1.3 percent, and Asian at one percent.

The two most populous towns are Cheyenne, with approximately 97,031 residents and Casper, with 81,023 residents (US Census Bureau 2018), which collectively account for about 30.8 percent of the state's population. Remaining residents live in small towns, rural communities, and frontier settings throughout the state. Wyoming has 5.8 persons per square mile, compared to the national average of 87.4 persons per square mile (U.S. Census Bureau, 2018).

The Behavioral Health Division (Division), one of four divisions within the Wyoming Department of Health (WDH), is the Single State Authority (SSA) for the delivery of mental health and substance use services. The Division is comprised of the Mental Health and Substance Abuse Services (MHSAS) section, Developmental Disabilities (DD) section, and the Early Intervention and Education Program (EIEP). The Wyoming Life Resource Center (WLRC) and the Wyoming State Hospital (WSH) are overseen by the Division.

The units within the MHSAS section include Community Systems (CS), Clinical Services (CU), and Court Supervised Treatment (CST). The CU and CS units develop contracts with Community Mental Health Centers (CMHC) and Substance Abuse Centers (SAC), which outline the specific services to be provided to individuals with mental health and substance use disorders. These centers provide evidence based mental health and substance use services within outpatient and residential settings and are funded by the Division. The CST program includes adult, juvenile, tribal and DUI categories within fourteen 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 DD section oversees home and community based waiver services for people with developmental disabilities and acquired brain injuries. EIEP administers the Part C and Part B/619 programs, as part of the Programs of the Individuals with Disabilities Education Act (IDEA); Part C consists of early intervention services for infants and toddlers with disabilities, age's birth through age two years, and their families, while Part B/619 is intended to help states ensure that all preschool- aged children (three-five years



Section B Planning Step 1

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of age) with disabilities receive special education and related services. 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 with intellectual disabilities who require intermediate care.

The Division's mission is to support the Behavioral Health Community by providing an outcomes-driven continuum of care, which promotes individualized services, wellness, and accessibility through collaboration, advocacy, and stewardship. The MHSAS section mission is to further promote a healthier Wyoming by working with partners to provide access to affordable, high quality mental health and substance use treatment services, promote evidence based treatment, quality improvement, and person centered services and supports through state contracts, grants, and collaboration with community providers.

As the SSA, the Division contracts with eighteen providers for the delivery of outpatient and residential services for mental health and substance use disorders. Of those providers, twelve provide both mental health and substance use services, four provide substance use services only, and two provide mental health services only. Through set contracts CMHC and SAC are obligated to provide services and supports as indicated by individual treatment plans, to all population groups, even after state funding has been exhausted. The Division's priority populations received a spotlight in the State Fiscal Year (SFY) 2019, two-year contracts. Providers will receive higher reimbursement rates for the services provided to priority populations. Priority populations for mental health services include persons with Serious Mental Illness (SMI) and children with Serious Emotional Disturbances (SED). Prioritized substance use service populations include pregnant intravenous drug users, pregnant women, intravenous drug users (IVDU), parenting women, women, and veterans.

The WDH has five divisions which include Administration and Support, Health Care Financing, Aging, Behavioral Health, and Public Health. The Public Health Division includes units 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, ensures safety, and promotes independent choices for *Wyoming's* older adults.

In the previous application it was stated, the Department of Family Services was administered by the WDH, and under new leadership, has transitioned back out of WDH. 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



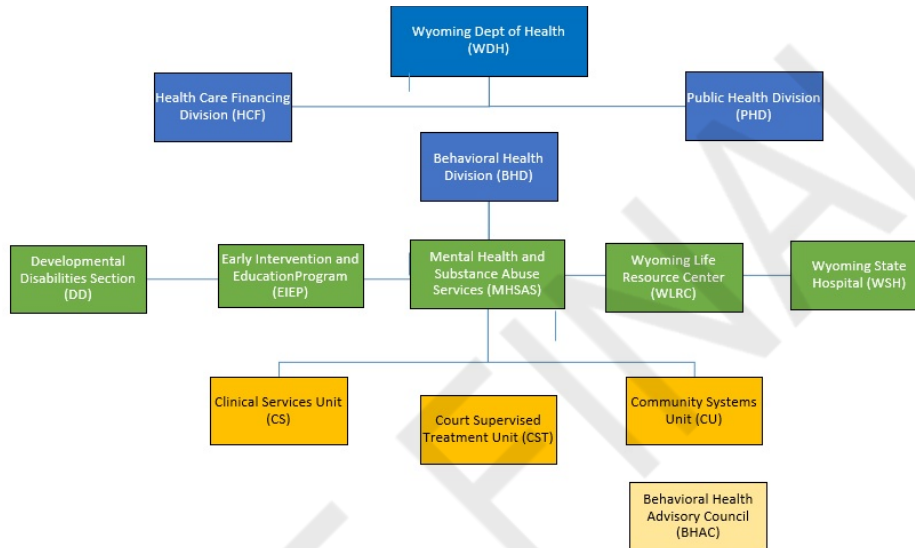
Section B Planning Step 1

Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application

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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

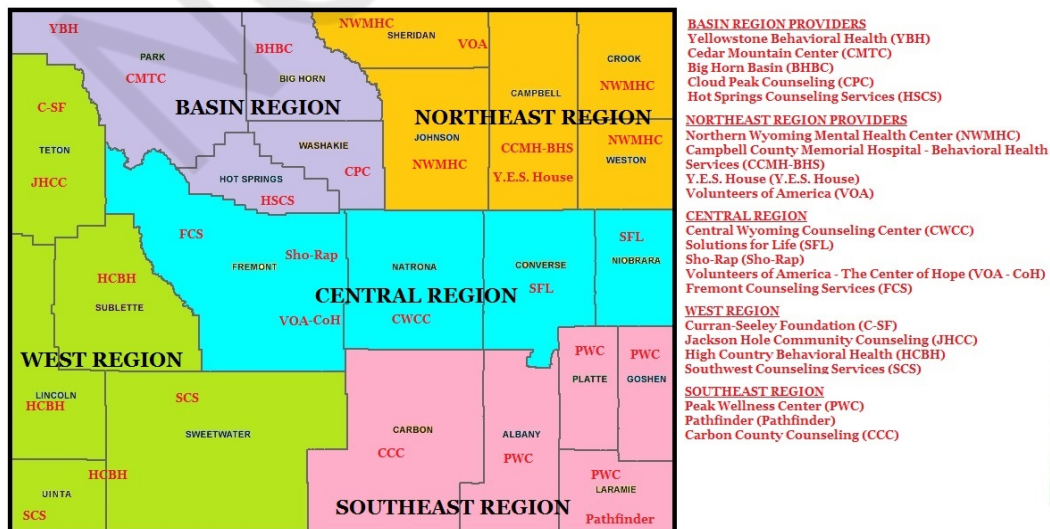


Mental Health Description of Service System

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

Comprehensive Care Regions

Wyoming Treatment Providers





Section B Planning Step 1

Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application

Behavioral Health Division
Mental Health and Substance Abuse Section
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Wyoming is a rural and frontier state with limited access to specialized services for priority populations. The population density in Wyoming has approximately 5.8 persons per square mile. Travel in winter months is often restricted due to weather related conditions. These unique limitations make service provision to individuals in need challenging and requires state staff, providers, and communities to close gaps, create bridges, and to increase services and care.

CMHC and SAC 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 and SAC, at a local level, to be accountable, responsive to needs, and provide advocacy. 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 WSH works to coordinate continuity of care for individuals with SMI and provides inpatient care for the state's most severe mentally ill clients. WSH is located in the southwest corner of the state on 160 acres, encompassing over 25 buildings and 475,000 square feet. Currently, WSH is under construction but remains open to serve the high demand. Though not initially meant to house the state's overflow of individuals in mental health crisis, this acceptance generally pushes WSH at the maximum capacity and generates a waitlist.

Historical funding has targeted adults with SMI and children with SED. Wyoming maintains the original focus of community mental health and substance abuse treatment by providing a range of services to broad populations throughout the state, with access priority given to persons with SMI, SED, and specified substance abuse populations.

The MHSAS has targeted several initiatives for individuals at the status of involuntary hospitalization or at risk of hospitalization, to increase access to the least restrictive environment. Wyoming's involuntary hospitalization statute (Wyo. Stat. Ann. 25-10-101 - 129) (Title 25) allows individuals to be detained against their will, if they are deemed to be a danger to themselves 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 closely together to implement initiatives and projects.

Adults with SMI are primary clients served in the Title 25 system. MHSAS section 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



Section B Planning Step 1

Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application

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assist in providing an increased number of available beds for individuals discharged from Title 25.

With limited diversion options from involuntary hospitalizations in rural areas of the state, most CMHC have limited or no involvement in the Title 25 processes. To increase CMHC involvement in the Title 25 process, the Division implemented gatekeeper programs and processes with contracted providers. 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 (MOU) was created with CMHC for purposes 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 CMHC 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 Mental Health Block Grant (MHBG) will be utilized to directly fund mental health providers for outpatient treatment services. MHBG funds will continue to be utilized in contract with the mental health Ombudsman program through Wyoming Guardianship Corporation, an 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.

Substance Use Description of Service System

The MHSAS section has recognized an increase in demand for opioid and methamphetamine treatment services. The Division was awarded the State Opioid Response (SOR) grant and it is being utilized throughout the state. Wyoming aims to prevent the opioid epidemic experienced in other states, focusing on providing access to Medication Assisted Treatment (MAT), expanding the opportunities to reach more people through integrated behavioral health and partnerships with criminal justice, and reducing opioid overdose related deaths through provisions of treatment and recovery activities for Opioid Use Disorder (OUD). As a priority population, substance abuse providers are required by contract to provide treatment according to the priority population hierarchy outlined in the provider contracts, i.e., Prioritized substance use service populations



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include pregnant intravenous drug users, pregnant women, intravenous drug users (IVDU), parenting women, women, and veterans.

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

According to State contract requirements, substance abuse services are to be prioritized to those persons who meet the special populations identified by Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) grant requirements for admission preference. The SAPT block grant (SABG) 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 Division continues to ensure compliance with the Wyoming State Treatment Standards and Federal Block Grant Requirements for women's treatment and parenting women, such as primary medical care for women and dependent children, prenatal care, therapeutic child care, drug-free housing, and education and employment training programs. Wyoming currently has several specific programs meeting federal requirements for priority populations. Not only are all funded providers required to meet the priority population guidelines, several programs 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 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. The Division collaborates with the Mountain Plains Addiction Technology Transfer Center (MPATTC) for all statewide provider trainings related to substance use.

The Public Health Division (PHD) utilizes a portion of the grant for community level prevention efforts. Although low incidence of tuberculosis (TB) cases are found in Wyoming, the PHD funds treatment services for TB. Mental health and substance use providers are able to refer clients to the county TB program, when necessary.



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Independent Peer Reviews

Independent Peer Reviews occur annually with both mental health and substance use providers. The Division selects providers to participate in the peer review. Selections are based on provider performance, data, and relevant initiatives within the state. Providers visit other agencies and review program areas such as clinical documentation, client satisfaction, and treatment. Providers are required to submit a report with their discoveries to the Division before the 1st of September of each year.

Recovery Support

Wyoming has one Recovery Community Organization (RCO), Recover Wyoming, located in Cheyenne. Recover Wyoming provides services only in the southeast region. RCOs are independent, non-profit entities governed and run by people in recovery, working 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 advocacy advancement and involvement for individuals 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. Heavily volunteer based, only two full-time positions exist with several part-time opportunities. The 12-24 Club is a safe haven for individuals in early recovery stages to go when in-between meetings; the club also reaches out to young individuals at risk or experiencing substance abuse. Staying open throughout the year, the 12-24 Club provides activities such as holiday dinners, a celebration rally for those involved in recovery, and provide day-to-day services. Special services include lunch and dinner meetings with reasonably-priced, home-cooked meals.

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

- Peer Specialist Certification, for individuals 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 taught by experienced Wyoming peer specialists and recovery coaches.



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- 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 in mental health and substance use recovery may qualify as a peer specialist. Wyoming Medicaid includes peer support as a billable service.

Peer specialists are 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	2018	2019
18	23	20	26	54	67	97

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.

Individuals with Co-occurring Disorders

A majority of Wyoming providers 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.

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



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location, Central Wyoming Counseling Center in Casper. 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 are contracted. 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 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, 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 expanded of individuals with disabilities. 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 SED 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, and custody relinquishment prevention. The program works to strengthen families’ skills to support the physical, emotional, social, and educational needs of the child. 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 SED, 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); must 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



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community-based services; 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 Care Management Entity (CME) pilot in Wyoming. The CME for the CMHW is Magellan.

In the past, the Division has invested extensive resources to train public and private community providers across the state in the implementation of the high fidelity wraparound model (HFWA). Through contract agreements, the Division, has fostered use of wraparound with children, youth, and their families, in addition to those families served through the CMHW 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.

Prevention

Since 2012, the Substance Abuse Prevention Program and the Tobacco Prevention and Control Program have fallen under 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 on the next page, depicts the current organization of primary prevention services in Wyoming.

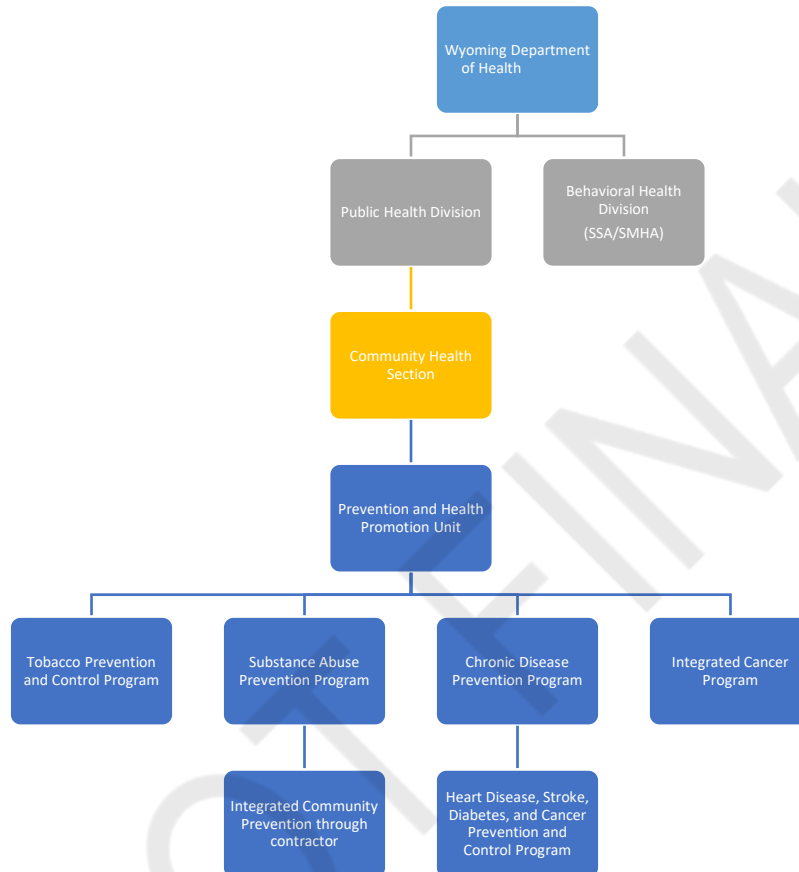


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Wyoming Substance Abuse Prevention Program Organization



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



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community coalitions to engage in data-driven strategic planning. In State FY 2016, communities updated their needs assessments, and the associated strategic plans, identifying 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, a strategy management system based on best practices 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 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.



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Behavioral Health Workforce

The Division has partnered with the University of Wyoming ECHO program, a learning community consisting of experts and various technologies. ECHO hosts live webinars to assist in obtaining resources for the behavioral health field. This partnership is utilized and has reduced the gap of behavioral health workforce.

Diverse Racial, Ethnic and Sexual Gender Minorities

Wyoming's demographic and cultural characteristics are not highly diverse and there are very few specialty programs addressing 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 cultural competency plans for relevancy on an annual basis and provide diversity training to staff, as required in CARF standards.

Fremont County Counseling is a contracted outpatient mental health and substance abuse treatment provider serving 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 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.

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 M/SUD 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 M/SUD 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.

A data-driven process must support the state's priorities and goals. 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](#), 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.

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](#)¹⁶ 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.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

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Footnotes:



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Description of Behavioral Health Needs in Wyoming

The Division has taken several progressive steps to begin analyzing the behavioral health needs of Wyoming citizens 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

Developed in 2011, the WDH performance management system involves the process of identifying challenges in program areas, by program managers of specific units, 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. In 2013, previous Governor, Matt Mead, adopted a similar system tilted WyoStat, 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, identifying several areas for improvement. It was determined 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 happened under “HealthStat 2.0” 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 stakeholders have come to expect.

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

Statewide Data as of July 22, 2019

FY 19 reporting to date (WCIS) indicates 6,184 persons were served in substance abuse outpatient treatment. The average number of substance use service hours provided per client was 18.04. There were a total of 8,981 clients with SMI who received an average of 26.32 hours of mental health services. Many of these high need individuals benefit from additional services to help achieve treatment and recovery goals. The mandate of Wyoming’s publicly funded mental health and substance abuse system is to provide



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services to those requesting assistance. 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 must be spread among those with 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.

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 Wyoming State Hospital is located in Evanston, and often is 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 CMHC 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.

Wyoming Needs Assessment – WICHE Mental Health Program

Western Interstate Commission for Higher Education (WICHE) Mental Health Program, is currently conducting a needs assessment of the statewide treatment system. Consumers, advocates, providers, medical professionals, and the Behavioral Health Advisory Council are being asked to contribute feedback to what the state lacks, the gaps, what works, and what needs improvement in regards to services. The survey results are not complete at this time, but will be available in mid to late Fall of 2019.



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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. The evidence from the various sources enables the state and behavioral health stakeholders to create positive change within the statewide system of care, 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 from the needs assessment will provide an excellent foundation for fulfilling the response to behavioral health needs of Wyoming residents. Currently, the top four identified gaps from the preliminary data is as follows:

1. Need for increased funding to the system.
2. Need for more inpatient placements for both mental health and SUD clients, including crisis stabilization.
3. Need for behavioral health professionals including prescribers.
4. Need for more services, including those for individuals with mental illness and intellectual disabilities or who require geropsychiatric services.

In addition to the gaps indicated in the survey data, the Division would like to improve service systems in regards to emergency preparedness/management. Please see number five below, as the Division addresses the gap.

Wyoming is confident the state can address the above mentioned gaps. The Behavioral Health Advisory Council will play a role in the assistance of how to best dedicate the block grant funds to prevention, treatment, early intervention, and recovery efforts.

1. Review results from year one of change to funding model. Determine what is working well and what needs to be changed for future treatment contracts.
2. Using existing provider data, review current capacity for underutilization. Develop plans for addressing underutilization and other obstacles which may hinder a client from transitioning from inpatient treatment to the next appropriate level of service.
3. The State of Wyoming is experiencing a provider shortage in many of the healthcare fields. While the Behavioral Health Division does not actively recruit professionals to work within the community mental health and substance abuse centers, we can identify resources, like grants from HRSA, to assist the CMHC/SACs with recruiting professionals.
4. The Wyoming Life Resource Center is the Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID). It is currently undergoing a change of mission transitioning to the Green House model of care. Additionally, it is under construction



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for new client cottages, day programming buildings, and recreation center. Some of the newly constructed cottages will serve as a licensed Skilled Nursing Facility for those with organic brain syndrome with difficult behaviors, persons with high medical needs, and persons that are difficult to place.

5. The Division requests emergency plans from providers. In using these plans, the Division hopes to create a safety net of communication if/when an emergency arises. For example, if there is a need for mental health services in an event (e.g. tornado) and one provider was impacted, the communication exists for a close-by provider to assist where needed. Emergency preparedness training could be offered, as most Federal Emergency Management Agency (FEMA) through the United States Department of Homeland Security training and classes are free and online.

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.



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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.

NOT FINAL

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.

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Footnotes:

NOT FINAL

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: 17.7% (BRFSS 2017)

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: 9.4%; High School: 33.7% (PNA 2018)

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, 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 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 participates in the YRBSS, so we are expecting this will help increase the number of communities participating in the PNA.

Indicator #: 2

Indicator: Alcohol Compliance Rate - Statewide

Baseline Measurement: 85.4% (2017)

First-year target/outcome measurement: 87%

Second-year target/outcome measurement: 89%

Data Source:

Alcohol and Tobacco Sales Compliance Checks Report

Description of Data:

The Wyoming Department of Health contracts with the Wyoming Association of Sheriffs and Chiefs of Police (WASCOP) to conduct alcohol retailer education and compliance checks statewide. Data from the inspections is gathered and reported to the Wyoming Liquor Division and developed into an annual report published by WASCOP and the University of Wyoming Statistical Analysis Center.

Data issues/caveats that affect outcome measures::

Priority #: 3

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 baseline data in FY16 was 525 days, goals in FY18 was 485, FY19's goals are 465 days, and the projected goals for FY20 is 456 days.

Strategies to attain the objective:

Develop inventory of mental health housing beds for each facility and center to identify how each type is utilized, and determine consistency with state definitions. 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.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Decrease average length of stay in Mental Health Housing
Baseline Measurement: 525
First-year target/outcome measurement: 465
Second-year target/outcome measurement: 456 days

Data Source:

Providers input length of stays in Wyoming Client Information System (WCIS)

Description of Data:

Providers report numbers of days individual occupies a bed in their facility to WCIS. Currently FY19's target was 465 days, we have surpassed our target and the data shows 421.02 days of individuals occupying a bed in the mental health housing facility.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 4

Priority Area: Work closely with providers 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 outpatient clients with a primary, secondary, or tertiary methamphetamine drug problem.

Objective:

Increase treatment completion rate for outpatient clients with a primary, secondary, or tertiary methamphetamine drug problem from baseline FY16 of 58% to FY18 63% to FY19's 68% and projected FY20's 73%. Currently, the total FY19 completion rate is at 63.81%, underlining we have not quite met our goal for this year.

Strategies to attain the objective:

Develop distinct provider contract targets focusing on the individuals with methamphetamine use disorder.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase treatment completion rate for individuals with a primary, secondary, or tertiary methamphetamine drug problem.
Baseline Measurement: FY16: 58%

First-year target/outcome measurement: FY19: 68%

Second-year target/outcome measurement: FY20: 73%

Data Source:

Treatment completion rate data is collected from all Division funded MH and SA providers and reported in the WCIS. 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 WCIS. Currently, the Division has not reached the goal of FY19's 68%, but is short at 63.81%.

Data issues/caveats that affect outcome measures::

Currently reviewing semi-annual review of treatment contracts, noting shortfalls of each provider. Upon a call to the provider, the Division, will review other types of discharge statuses to determine if clients are dropping out of treatment or transferring to other programs.

Priority #: 5

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 outpatient clients with an opioid drug problem.

Objective:

Increase treatment completion rate for clients with a primary, secondary, or tertiary opioid drug problem from FY16's goal of 55%, FY18's goal of 58%, to FY19's goal of 62% (currently at 59.29%), and the Division's target for FY20 at 73%.

Strategies to attain the objective:

Expand MAT services by implementing programs throughout the state, utilizing a combination of SOR grant funds or state funds. Develop distinct provider contract targets focusing on individuals with OUD. Provide technical assistance and training on evidence-based practices for opioids. Facilitate provider discussions to highlight shared success stories and lessons learned from providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: FY16: 55%

First-year target/outcome measurement: FY19: 62%

Second-year target/outcome measurement: FY20: 67%

Data Source:

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

Description of Data:

Individuals treatment completion status is noted in their discharge information through WCIS. Target for FY19 is currently short at 59.29%.

Data issues/caveats that affect outcome measures::

Currently reviewing semi-annual review of treatment contracts, noting shortfalls of each provider. Upon a call to the provider, the Division, will review other types of discharge statuses to determine if clients are dropping out of treatment or transferring to other

programs.

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Footnotes:

For Priority Areas 3 - 5, the data is an estimate, as data will not be finalized until mid to late November 2019

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

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	\$6,229,581		\$0	\$9,548,214	\$0	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$1,120,330		\$0	\$0	\$0	\$0	\$0
b. All Other	\$5,109,251		\$0	\$9,548,214	\$0	\$0	\$0
2. Primary Prevention	\$1,678,822		\$0	\$3,648,188	\$7,988,210	\$0	\$0
a. Substance Abuse Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$66,000		\$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)	\$419,705		\$0	\$0	\$0	\$0	\$0
10. Total	\$8,394,108	\$0	\$0	\$13,196,402	\$7,988,210	\$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:

10. Total is based off the FY2020 President's Budget and multiplied by two (because it is over a two year period). $\$4,197,054(2\text{yr})=\$8,394,108$

1.a. Based off of FY19-20 Contracts

1b. All other funds = total remaining after 1-9.

Column D: State Opioid Response (SOR) Grant included. ($\$9,548,214.23$ rounded down to $\$9,548,214$)

2. $20\% = \$8,394,108(0.2)=\$1,678,922.00$

Columns D and E are from Prevention - Prevention input this information.

4. TB = $\$33,000/\text{yr} = \$66,000$; determination for next application will be based off of actual expenditures.

5. HIV- We're not a designated state, these dollars are $\$0.00$

9. $5\% = \$8,394,108(0.05)=\$419,705.00$

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

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							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$162,447	\$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	\$0	\$0	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$1,380,801	\$0	\$600,000	\$200,000	\$0	\$0
9. Administration (Excluding Program and Provider Level)***		\$81,224	\$0	\$0	\$502,240	\$0	\$0
10. Total	\$0	\$1,624,472	\$0	\$600,000	\$702,240	\$0	\$0

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

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Total based off of FY2020 President's Budget (FY2020 Mental Health Block Grant Estimated Allotments; based off of two years) = \$812,236 (2yrs) = \$1,624,472

3. 10% = \$1,624,472(0.10)=\$162,447.20 (round down \$162,447)

7. PATH Grant money (Funds \$300,000 & Match is \$100,000 multiply each by 2yrs) =\$600,000 & \$200,000.

8. Remaining amount (1624472-162447-81224=\$1,380,801

9. 5% = \$1,624,472(0.05)=81,223.6 (round up \$81224)

Column E - Admin MOE funds, based off of FY19 single BG amount budgeted is \$231,120.15(2yrs)=\$462,240.30+(200series MH Admin MOE @ \$20,000.00(2yr))=\$502,240.3

NOT FINAL

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	246	78
2. Women with Dependent Children	1479	1462
3. Individuals with a co-occurring M/SUD	155000	1736
4. Persons who inject drugs	1451	1043
5. Persons experiencing homelessness	64	253

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

Treatment data is not final data. Not all FY19 is in the system as of date run (7/22/2019). 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.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	\$3,114,790
2 . Primary Substance Abuse Prevention	\$839,411
3 . Early Intervention Services for HIV**	\$0
4 . Tuberculosis Services	\$33,000
5 . Administration (SSA Level Only)	\$209,853
6. Total	\$4,197,054

* Prevention other than Primary Prevention

** 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 a 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 will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Notes: \$4,197,054; 20%=\$839,410.80; 10%= \$419,705.40; 5%=209853;

1. Remaining amount from \$4,197,054-(2+3+4+5)=\$3,114,790
2. 20% = \$839,410.80 (rounded up to \$839,411)
3. Not a designated state = \$0.00
4. TB Services @ \$33,000/yr
5. 5% Admin cost = \$209,852.70 (round up \$209,853)

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
	Universal	

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	\$0
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
7. Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	\$0
	Total	\$0
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$0
Total SABG Award*		\$839,411
Planned Primary Prevention Percentage		0.00 %

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

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Footnotes:

Synar is funded through TSF in Wyoming

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	\$125,911
Universal Indirect	\$628,558
Selective	\$83,941
Indicated	\$1,001
Column Total	\$839,411
Total SABG Award*	\$839,411
Planned Primary Prevention Percentage	100.00 %

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

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

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

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems			
2. Infrastructure Support			
3. Partnerships, community outreach, and needs assessment			
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement	\$5,000		
6. Research and Evaluation		\$80,000	
7. Training and Education			
8. Total	\$5,000	\$80,000	\$0

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

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date:

MHBG Planning Period End Date:

Activity	FFY 2020 Block Grant
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	
6. Research and Evaluation	
7. Training and Education	
8. Total	\$15,000

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²² 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.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

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.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ 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.²⁷ Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ 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 M/SUD include: developing models for inclusion of M/SUD 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.³⁰ 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 M/SUD 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 homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD 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.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ 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.³⁶ 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.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.³⁹ 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 M/SUD 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.⁴⁰

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.⁴¹ 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.

²² 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

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ 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/>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchhstp/socialdeterminants/index.html>

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.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>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://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/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ 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>

³⁴ 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); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ 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>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ 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

³⁸ 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

³⁹ 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>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ 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>

⁴¹ 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:

1. 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.

The Division contracts with community mental health and substance use centers, who are working towards becoming Federally Qualified Health Centers. Several community mental health and substance use centers have nursing and primary care services available on site. Each agency arranges for primary care and specialty services based on individual client need. Wyoming is working on integrating Telehealth into the systems, providing M/SUD prevention, treatment, and recovery to rural areas. While also providing University of Wyoming ECHO webinars on multiple ways to promote health, good outcomes, and patient engagement.
2. 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.

Wyoming does not provide services and supports towards integrated systems of care at this time.
3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☐ Yes ☒ No

b) and Medicaid? ☐ Yes ☒ No
4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Behavioral Health Program Manager and the Program Integrity Unit of the Healthcare Financing Division are responsible for monitoring access to M/SUD services for client receiving Wyoming Medicaid.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☐ Yes ☒ No
6. Do the M/SUD providers screen and refer for:
 - a)** Prevention and wellness education ☒ Yes ☐ No
 - b)** Health risks such as
 - ii)** heart disease ☒ Yes ☐ No
 - iii)** hypertension ☒ Yes ☐ No
 - iv)** high cholesterol ☒ Yes ☐ No

v) diabetes

☒ Yes ☐ No

c) Recovery supports

☒ Yes ☐ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ☐ Yes ☒ No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ☐ Yes ☒ No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
No issues or problems related to the implementation and enforcement of parity provisions reported.
10. Does the state have any activities related to this section that you would like to highlight?
None at this time.
Please indicate areas of technical assistance needed related to this section
None at this time.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)⁴⁵.

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."⁴⁶

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 status⁴⁷. 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 populations⁴⁸. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

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, sexual orientation, gender identity, 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 M/SUD 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 M/SUD care? ☐ Yes ☒ No
7. Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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, ($V = Q \div C$)

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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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 General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² 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."⁵³ 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 M/SUD 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](#))⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA 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](#))⁵⁵ was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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.

⁴⁹ 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

⁵⁰ 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.

⁵¹ 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.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <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? ☒ Yes ☐ 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.
3. Does the state have any activities related to this section that you would like to highlight?

None at this time.

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

None at this time.

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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.

The State has two providers implementing First Episode Psychosis (FEP) treatment programs. The challenges of being a rural and frontier state complicate set models, and facilities are exploring how to best implement EBPs. Due to the geographical challenges and limited community resources, FEP models are difficult to implement. Families involvement and education are critical in the clients' treatment process, as to develop a resilience to psychotic triggers and symptoms. When families cannot participate, the alternative is natural supports. Though limited communities and social resources can cause a hindrance to the adequate treatment.

Southwest Counseling Service (SCS) utilizes many EBP's for the treatment of individuals with ESMI/FEP. These include:

- Cognitive Behavioral Therapy
- Motivational Interviewing
- Dialectical Behavioral Therapy
- Eye Movement Desensitization and Reprocessing (EDMR)

- Complementary and alternative medicine (CAMs)

In addition, SCS utilizes Peer Specialist Supports, employment supports, integrated primary health care, medication management services and family education support.

Yellowstone Behavioral Health (YBHC) provides a coordinated specialty care program to address the needs of those individuals experiencing early symptoms of a serious mental illness. Borrowing from Navigate, an FEP treatment model, YBHC's ESMI program emphasizes Individual Resiliency Training and helps clients to identify their strengths and resiliency factors and then utilize these to manage their illness and to facilitate and maintain recovery. Within this framework of individual resiliency training, a variety of evidenced based practices are incorporated as needed, to include CBT, targeted case management, family systems treatment, supported employment and education, housing supports, and illness management and recovery.

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?

Through a service contract for funded FEP providers, the State requires providers to utilize EBPs but does not specify which EBPs should be used. The state encourages providers to engage with other state's FEP programs to explore different EBP's and learn successes. For example, SCS utilizes the EBPs as a part of the individualized treatment for individuals experiencing the first onset of psychosis. Additionally, SCS employs an APRN, in which, clients have direct access to primary health care.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with 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.

Through a service contract for funded FEP providers, the State requires providers to utilize EBPs but does not specify which EBPs should be used. The State encourages providers to engage with other State's FEP programs to explore different EBPs and learn successes. For example, SCS utilizes the EBPs as a part of the individualized treatment for individuals experiencing the first onset of psychosis. Additionally, SCS employs an APRN, in which, clients have direct access to primary health care.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

The state will continue to work with the providers upon technical assistance requests.

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 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:

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

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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Southwest Counseling Service: Early Serious Mental Illness (ESMI) Bi-Annual Progress Report

FY 19 January 1, 2019 – June 30, 2019.

Progress of Program Implementation: Southwest Counseling Service started the implementation of this program on July 1, 2018. SCS ESMI Admission Criteria continues to be distributed at SCS and in the community. Community contacts continue to be made and information given.

ESMI clients have been identified and they continue to receive services. Services include Care coordination - Agency based individual treatment, Psychiatric Services including assessment and medication management, Case Management services, Individual Rehabilitation Services, Peer Specialist Services, Group therapy services, Family Nurse Practitioner medical services, Crisis services and Residential services.

A success story: A 40 year old female was identified as ESMI. She presented after making her first suicidal gesture and being hospitalized in a psychiatric hospital for a short time about 4 months ago. After being discharged from the hospital she began receiving individual therapy weekly along with psychiatric medication services and case management services as needed. She has recently been tapering down how often she is receiving services and is now provided individual treatment about every two or three weeks. She has not made any more suicidal gestures since beginning treatment and continues to work on her issues. She has not been hospitalized again since beginning treatment. She continues to see our psychiatric provider about every three months for her medications. She has received some case management services as needed. She is diagnosed with Major depression, single episode severe, and generalized anxiety disorder. She continues to make progress. We will continue to taper down how often she is seen. Client reports that “I don’t want to go back to the person I was” before she started therapy and that “I’m much happier now and don’t blame myself for everything as much, I just need to keep working on doing my coping skills and working through my issues.” Client reports that therapy and medications have helped her a great deal. “I am glad I am coming to counseling, it really has helped me.”

Quality Improvement and Monitoring of Treatment and EBP Fidelity: Client charts continue to be reviewed by the Quality Assurance team to ensure evidence based/best practices are being used. The targeted population is basically people with a condition that affects the individual regardless of their age and that is a diagnosable mental, behavioral, or

Page 1 of 3

emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-5. For a significant portion of the time since the onset of the disturbance the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance, substance use disorder, are attributable to an intellectual developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset.

Outcomes

A: Change in Functionality: 40 individuals have received and continue to receive Care coordinated ESMI services. The change in functionality using the GAF and DLA-20 are provided to the state in interim records in WCIS.

B: Screening and assessment tools used: We use the DLA-20, Clinical Assessment, Basis 32, and we just added the Columbia Suicide Screening tool. The LOCUS is also used if the client is placed in a mental health residential bed.

C: Outreach: Contact education continues with Southwest Counseling (SCS) staff, clinicians, case managers, residential coordinators, and psychiatric staff. In addition, outreach contacts/education that was made in the community are as follows:

10- 08-18	Dr. Shelley - <u>Sweetwater Foot Care</u>
10-24-18	Dr. Anderson- <u>Red Desert InstaCare</u>
11-1-18	Dr. Crane - <u>Premier Bone and Joint</u>
1-16-19	Dr. Christensen – Sweetwater Urology
2-12-19	Dr. Harmon – Harmon Family Dental
3-6-19	Dr. Bob Ramsey – Ramsey Eye Care Center
3-11-19	Dr. Kamran Khan – Memorial Hospital of Sweetwater County
3-13-19	Dr. Melynda Poyer – Family Medicine – Rock Spring Family Practice
3-21-19	Dr. Jed Shay – Pain Clinic
3-26-19	Tyler B. Carlson DMD – White Mountain Dental
10-17-18	Hazel Koenig, Social Worker- <u>Sage View Care Center</u>

11-21-18 Marilynn Dockter – Mission at Castle Rock Rehabilitation

12-17-18 Cami Treckel – Parents as Teachers Group

12-17-18 Kellie Merritt – Department of family services

1-17-19 Linda Cornell – Community Nursing

1-17-19 Amber Taylor – EOC/TRIO Grants

1-18-19 Cindi Cain – WIC

1-21-19 Kayla Maestas – Wyoming Family to Family

2-5-19 Kristy Behnke – Department of Vocational Rehabilitation

4-15-19 Joanne Reints – Rock Springs Junior High

4-15-19 A group of officers at the Rock Springs Police Department

D: Total Number of Clients Served this Period: 40 individuals have received/are currently receiving Care coordinated ESMI services.

E: Hospitalization/Emergency Detention Events: One client was held in emergency detention and then was hospitalized for about two weeks then returned to treatment. Four others were held in emergency detention briefly and then returned to treatment.

F: Additional Measured Outcomes: None at this time.

Technical Assistance Needed: None at this time.

Challenges: It has been and continues to be a challenge to be adequately staffed. SCS continues to be short staffed in most areas. We are currently as always recruiting staff. We hope to have more staff hired during this next year.

Capacity and efforts to expand ESMI services: SCS continues to and will continue to offer Care coordinated services to all individuals that come in and are identified as having an ESMI.

EARLY SERIOUS MENTAL ILLNESS

FY2019 Bi-Annual Report for Yellowstone Behavioral Health

This is the bi-annual report for the Early Serious Mental Illness program at Yellowstone Behavioral Health, funded by the Behavioral Health Division, Wyoming Department of Health. This report was focused on continued training for ESMI utilizing Individual Resiliency Training, facilitating IRT tools via an electronic shared drive, and visiting the medical community.

Prepared by Dr. Alice Russler, Behavioral Health Consultant,
ESMI Outreach Coordinator

6.30.19

Early Serious Mental illness

FY2019 Bi-Annual Report for Yellowstone Behavioral Health

For the purpose of this report, activities for the second 6 months in FY2019 are noted utilizing Attachment H of the State Contract.

1. The progress of the program implementation and service provided in the last six months. Include a success story, client feedback, or how progress has been made with a particular client.

An ESMI client assessed in October with a GAF score of 41/70, showed significant and continued improvement in the following: developing meaningful relationships, establishing career goals, increased self-esteem, developing hobbies, and increased involvement in high school activities. The family was very involved in treatment. A 6 month GAF in February was 63, a significant improvement in functioning. Having met the goals of treatment the client was discharged in February. Client graduated from high school in May and has applied to college for the fall.

With the expansion of the ESMI program to eliminate the age requirement, an older individual in their 60s with no prior history of mental illness was admitted into the program with debilitating depression. Utilizing the individual resiliency training, this individual embraced the strength based approach and two months later has already made significant improvements in functioning. Recently this individual told the clinician, "I even walk different!"

Another ESMI client, a young adult, recently admitted to the program, has also embraced the strength based approach. The client found the Brief Strengths test to be very helpful, has developed goals around the identified strengths, and continues to improve.

An ESMI client in their 30s has shown improved functionality in just two months since admission to the program. Admitted with severe and debilitating mental health symptoms, this individual has set and maintained boundaries with an addicted family member and has been promoted at work. Prior to admission, this individual had three friends who had committed suicide. With the help of the clinician, the client has educated themselves on suicidality and then educated fellow coworkers on the job.

The quality improvement and monitoring of treatment and evidence based practices fidelity, including the target population and service setting.

In the third quarter the full clinical staff received training on the expansion of the program from FEP to ESMI and the use of individual resiliency training (IRT) as the primary clinical modality. Upon request by the clinicians a shared electronic folder was created that includes multiple worksheets for IRT including a brief

strengths inventory. This allows easier access for clinicians and facilitates the completion of some worksheets electronically if so desired by the client.

To assure that new clients are being assessed appropriately for the program, during the fourth quarter, the TAC (timely access to care) clinician reviewed all new intakes to date for program eligibility. If a client was identified as eligible but not coded as ESMI, the clinical director worked directly with the assigned clinician to incorporate the client into the program if client agreed. In several cases the clinician had simply failed to code the client correctly as ESMI.

2. Outcomes:

a. Change in functionality and GAF score upon admission and every six months following utilizing the DLA-20.

Client #1 – GAF at admit	33
GAF at 6 months	54
GAF at 14 months	46
<u>GAF at 18 months</u>	<u>50</u>
Difference	17 point improvement in functioning
Client #2 - GAF at admit	43
<u>GAF at 4 months</u>	<u>44</u>
Difference	1 point improvement in functioning
Client #3 - GAF at admit	41
<u>GAF at 4 months</u>	<u>50</u>
Difference	9 point improvement in functioning
Client #4 – GAF at admit	40
<u>GAF at 5 months</u>	<u>49</u>
Difference	9 point improvement in functioning
Client #5 – GAF at admit	41
<u>GAF at 5 months</u>	<u>63</u>
Difference	22 point improvement in functioning
Client #6 - GAF at admit	45 (six month GAF not due)
Client #7 - GAF at admit	47 (six month GAF not due)
Client #8 - GAF at admit	46 (six month GAF not due)
Client #9 – GAF at admit	43 (six month GAF not due)
Client #10- GAF at admit	47
<u>GAF at 6 months</u>	<u>55</u>
Difference	8 point improvement in functioning
Client #11 – GAF at admit	49 (six month GAF not due)

Client #12 – GAF at admit 40 (six month GAF not due)

Client #13 – GAF at admit 46 (six month GAF not due)

Client #14 – GAF at admit 46 (six month GAF not due)

Client #15 – GAF at admit 39 (six month GAF not due)

- b. Provide the name of all screening and assessment tools used in the treatment.

Individual Resiliency Training is not predicated on any specific screening and assessment tools, but rather is a modality focused on utilizing a client's strengths in building resiliency to address and remediate symptoms and develop clear education, career, and interpersonal goals. Client strengths and weaknesses are assessed utilizing YBHC's standard intake and assessment tools to include a comprehensive Clinical Assessment (CARF approved), risk assessment, DLA 20, WRAP, and a basic health screening.

Should the standard assessment tools not result in clearly defined strengths, the clinicians and clients have the option to utilize other strength tools, such as the Brief Strengths test recommended by Navigate for their FEP program. Some clinicians have utilized this strengths test and they and their clients have found it very helpful for setting goals for individual resiliency training.

- c. Number of outreach efforts and details.

Five outreach efforts were provided during the second 6 months of FY2019:

1. Big Horn Basin Pediatric – an overview of the ESMI program by outreach coordinator.
2. Beck Lake Challenge Run/Walk to increase Mental Health awareness – an overview of the ESMI program by the agency's CEO.
3. Powell Valley Healthcare Walk In Clinic – an overview of the ESMI program by outreach coordinator.
4. Powell Valley Healthcare Women's Health – an overview of the program by outreach coordinator.
5. 307 Health – an overview of the program by outreach coordinator.

- d. Number of clients served by the Contractor.

FY2019

First Quarter – 0 new, 1 served (carryover from FY2018)

Second Quarter – 4 new, 5 served.

Third Quarter – 1 new, 6 served.

Fourth Quarter – 9 new, 15 served.

TOTAL ESMI clients served in FY2019 – 15.

- e. Hospitalization/emergency detention events.

None to date involving ESMI eligible individuals.

- f. Any additional outcomes measured by the Contractor.

None

- 3. Any technical assistance needed.

None requested at this time.

- 4. Any unforeseen or foreseen challenges.

None at this time.

- 5. Capacity and efforts to expand the ESMI services.

The primary goal of developing an FEP, now ESMI, rural program was to include all of the coordinated specialty care components into a process that could be seamlessly incorporated into the day to day clinical operations within a frontier environment. ESMI is not a stand alone program with dedicated staff. Instead, all clinical staff are able to provide the individual resiliency training, and coordinate the other necessary CSC components (with the agency's nurse, psychiatric provider, recovery coach, and case managers), as part of their day to day clinical responsibilities. After training on the individual resiliency training component during this reporting period, there was a significant increase in the number of clients served in the program for the 4th quarter. It is anticipated that as clinicians become more comfortable with the use of IRT and share their success stories with each other, the number of clients served by this program will continue to rise.

NOT FINAL

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 team 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, education, 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? ☒ Yes ☐ No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
N/A
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
The Division contracts with providers responsible for engaging consumers through consumer satisfactory surveys, driven boards, along with care coordination including primary care. The State provides ongoing technical assistance as requested. One provider, Recover Wyoming, provides free Shared Decision-Making (SDM) training throughout the State for both participants and providers. SDM is an emerging best practice in behavioral and physical health ensuring all clients are well-informed and involved in decisions about their health. The training provides an overview of the various ways counselors, treatment centers, and providers can apply SDM, while participants increase understanding of the process through interactive exercises, and by developing an Action Plan for future use.
4. Describe the person-centered planning process in your state.
The Division contracts with nationally accredited providers with the ability to involve clients in the planning of care and services. By national accreditation, providers are required to provide person centered services. Wyoming Rules and Regulations require clients to have an individualized treatment plan (or action plan) based on initial and on-going assessment information in which identify the client's needs, strategies to provide services meeting those needs, measurable treatment goals and objectives, and criteria for discharge. Initial treatment plans are developed with the client, which can involve other entities working with the client. Commonly, the provider's clinical team assists in integration between assessment and treatment plan, involving family and any necessary medical liaisons.
Please indicate areas of technical assistance needed related to this section.
None at this time.

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Footnotes:

Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 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?
Division staff have been able to attend Grant Management U.S.A. and SAMHSA Grant Management webinars or in-person training, which have influenced increased development of bridges between units, fiscal, and providers to ensure federal regulations. Those individuals who attend are able to provide additional information on how the Division can improve. The Division is in the process of creating grant management guidelines instructing the roles and responsibilities of Grant Managers, Fiscal Manager(s), and Department Grant Team.
Please indicate areas of technical assistance needed related to this section
None at this time.

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Footnotes:

Environmental Factors and Plan

7. 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](https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf)⁵⁶ 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.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

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) and various inner Divisions, including WDH Behavioral Health Division (BHD), WDH Public Health Division, WDH Healthcare Financing, WDH Aging Division, and Vital Statistics continue to meet quarterly with the Tribal Leadership Advisory Council. The purpose is to discuss updates in regards to health care. BHD has a contract with Sho-Rap Lodge in regards to recovery housing and maintaining communication with their representatives. Behavioral Health Advisory Council members, including representation from tribal members, are given the opportunity to join in the quarterly meetings through a conference line, if unable to attend in person.

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

No major concerns were brought forth in the meeting. The most recent minutes of the Tribal Leadership Advisory Council meeting covered information about revisions to Medicaid and care giving plans, while also providing information on data collection, changes, and how to be involved in data. The State Health Assessment will report data to inform and mobilize communities, develop priorities, gather resources, and plan actions to improve the public health. At the end of the meeting, goals were set to address "what the Advisory Council could undertake this year that affect the delivery of health care in Native Americans in Wyoming". No major concerns brought forth in regards with Sho-Rap Lodge. No major concerns brought forth from the Behavioral Health Advisory Council.

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

The Behavioral Health Division (Division) has a contract with Germaine Solutions to conduct the needs assessment for the Wind River Reservation as part of the grant activities for the State Opioid Response (SOR) Grant. The needs assessment was completed in June 2019, the report is included. The Division has Year Two (2) SOR Grant funds available for the tribes support recommendations, from the needs assessment study.

Governor Gordon has taken action to make relationships with the Northern Arapaho and Eastern Shoshone tribes a high priority. The Governor has appointed his Chief of Staff and Policy Director to be integrally involved with both tribes. Additionally, he worked with the legislature to make the two liaison positions full time rather than part time. Hiring and interacting are just now underway, and meetings and plans are getting coordinated. Relationships and program effectiveness will be of high priority.

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

None at this time.

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Footnotes:

7. State Opioid Response Grant: Wind River Indian Reservation Needs Assessment

NOT FINAL



STATE OPIOID RESPONSE GRANT: WIND RIVER INDIAN RESERVATION NEEDS ASSESSMENT

RFP #0052-D

June 30, 2019

**Wyoming Department of Health
Behavioral Health Division**

Submitted by:

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Note: This assessment includes data compiled from various data sources and literature. We attempted to present the most current available data in order to develop the most complete and accurate picture possible of Wind River's and Wyoming's opioid crisis. Our data represents a variety of time periods, depending on what was available. Please consider these variations when making comparisons. Also note that primary research through individual surveys was not an option for this project, given the confidentiality constraints from the tribes.

Executive Summary

Germane Solutions was contracted by the Wyoming Department of Health to provide a comprehensive needs assessment for the Wind River Indian Reservation for the purpose of determining the extent of the issue, the willingness of the tribes to accept state assistance and the best alternatives for additional funds coming through the State from a SAMSHA grant.

The opioid epidemic has seriously impacted the United States, and Wind River Indian Reservation is no exception. The following is a strategic and complete compilation of information of the reservation's inhabitants, the issues they are confronting for substance abuse and what they need in order to prevent, treat and provide successful recovery programs for their people. The goal of this study is to give the State of Wyoming the background needed to see how additional resources can best be utilized on the reservation.

The population of the Wind River Indian Reservation has been disproportionately affected by the opioid epidemic due to socioeconomic conditions as well as a predilection of substance abuse for Native Americans. The main factors contributing to this situation are a high rate of unemployment, the remote and rural nature of the community, low education levels, lack of access to mental health and behavioral health programs, a small police force, weak enforcement through the judicial system and the extreme element of stigma related to substance abuse in the Native American culture/family unit. This study will illustrate those points, and will make recommendations for use of funding. The tribes are completely willing to accept funding from the State; in fact, they need these funds as substance abuse has reached a critical stage on Wind River and resources are not adequate to address the problem.

Wyoming's rate of drug dispensing for opioids is above average. More than half of drug-induced deaths are opioid related. These types of deaths are significantly underreported, due to the stigma issue in the Wind River community. The Wind River Indian Reservation is primarily located in Fremont County. In order to compare Fremont County data to other counties of Wyoming, Germane also researched the number of drug poisoning deaths per 100,000 people, as well as the drug overdose mortality per 100,000 people.

Methamphetamine and alcohol have more of a presence than opioids on the Wind River reservation. However, it should be noted that most substance abusers will use whatever substance they can find and that many will ingest a cocktail of drugs as well as alcohol, so it is not appropriate to look at opioids in isolation. There is also a severe shortage of substance abuse providers, mental health providers and clinics that specialize in substance abuse treatment and recovery. We learned that successful treatment is usually done in a culturally relevant manner that incorporates elements of tribal health along with standard treatment measures, and that such treatment is ideally done close enough to home to allow family support.

Key informant interviews and focus group respondents unanimously stated that the drug abuse situation has grown much worse in the past three years. There is a significantly

lower life expectancy on the reservation -- 49 years of age -- compared to the national average of 78.6 years for the U.S. The reservation also has a high percentage of youth who never finish high school, serious family issues throughout the community and a very high unemployment rate. These social determinants all play a significant role in the drug addiction problem.

Currently, there are two outpatient clinics with limited resources on the reservation for Native Americans to seek treatment and one 24 bed inpatient clinic that is managed by the Arapahos, although Shoshone clients are welcome there. The next closest inpatient facility is located in Montana, which is over four hours travel by car. Most clients do not have the ability to travel that far, and it represents a true hardship on their families.

Based on our findings, Germane recommends focusing on several areas.

a. Prevention

Schools could do more to educate students as young as 12 years of age about substance abuse issues and their aftermath. At a minimum, Wyoming could provide appropriate literature to help with this effort. If possible, provision of the funds could allow a tribal member to offer culturally appropriate education on an ongoing basis.

This teacher could also have a presence at health fairs on the Reservation and in the surrounding towns, where they could share the prevention message with the greater population.

Provide funding for the Girls and Boys Club to offer programs and sports that will encourage greater self-esteem and a healthier approach to life.

b. Education for Prescribers

Provide instruction for all doctors and pharmacists on the use of the Wyoming Prescription Drug Monitoring Program (PDMP). Make it a mandatory annual class.

c. Education for the Public

Fund a public awareness program on the dangers of opioid use for the Wind River Indian Reservation and surrounding areas.

Encourage adoption of media campaigns to dispose of unused/expired medications and the need to safeguard pain medications.

d. Treatment Alternatives

There are no substance abuse treatment facilities reasonably located on Wind River Indian Reservation, other than the general one operated by the Arapahoe Health Director (White Buffalo Recovery Center). Provide funding for an inpatient center that could be used by both tribes to address this need from a culturally appropriate foundation. This method will have a greater chance of success than referring those with addiction issues out of state.

Provide funds for the cultural programs such as sweat lodges, drumming, chanting and tribal therapy. Provide funds for transportation, which is a significant issue on this large reservation where many members do not own cars and there is no public transportation available.

Consider funding basic mental health services to assist with treatment and act as a prevention tool. The need is great, and providers are stretched thin. Research the use of teletherapy.

Wind River Indian Reservation has implemented a Naloxone program, and all first responders, policemen and school nurse staff have been trained on its use. Additional funds could expand availability to family members or friends of those who misuse opioids.

Expand use of Medically Assisted Treatment (MAT).

e. Policy and Legislation

Tribal Nations do not need to be structured similarly to states or federal governments. Some nations have used criminal and civil jurisdiction to craft policy in response to the opioid epidemic that has been successful. The tribes will have to conquer this challenge on their own, but Wyoming may be able to assist concerned parties on the Reservation lead efforts needed to update tribal laws and enforce those already in place.

Background

The State of Wyoming secured a grant, the Statewide Opioid Response (SOR), from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). This two-year funding (9/30/2018-9/29/2020) addresses the opioid crisis by increasing access to medication assisted treatment for the treatment of opioid use disorder, reducing unmet treatment need and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities. The Wyoming Department of Health hired Germane Solutions in January 2019 to conduct a needs assessment for the Wind River Indian Reservation to determine what was needed to address this disproportionately impacted population and integrate this effort into the overall strategy for the State.

The Department of Health's approach in Wyoming includes three strategies:

- 1) Increase access to medication-assisted treatment
- 2) Increase identification and treatment of opioid use disorder in affected individuals through strategic partnerships with integrated health settings and the criminal justice system; and
- 3) Reduce opioid overdose related deaths through the provision of treatment and recovery activities.

Germane was asked to work closely with the Northern Arapaho and Eastern Shoshone tribes on the Wind River Indian Reservation (WRIR) as a linkage to disproportionately impacted communities. We conducted targeted interviews and focus groups with community stakeholders and leaders. Individual surveys were not feasible given the need for confidentiality. The information gathered from these interviews and focus groups has been combined with demographic studies and secondary research to develop a comprehensive assessment for the Wind River Indian Reservation. Lastly, Germane was asked to propose strategies for addressing the needs that were identified.

It is important to note that Germane was informed that past efforts to work with the Wind River Indian Reservation on statewide or federally funded programs have met with resistance, and that there is not a bond of trust between the Reservation and the State. Germane was asked to ascertain if SAMSHA funds were needed, how they might best be used, and whether Wind River Indian Reservation would accept the funding.

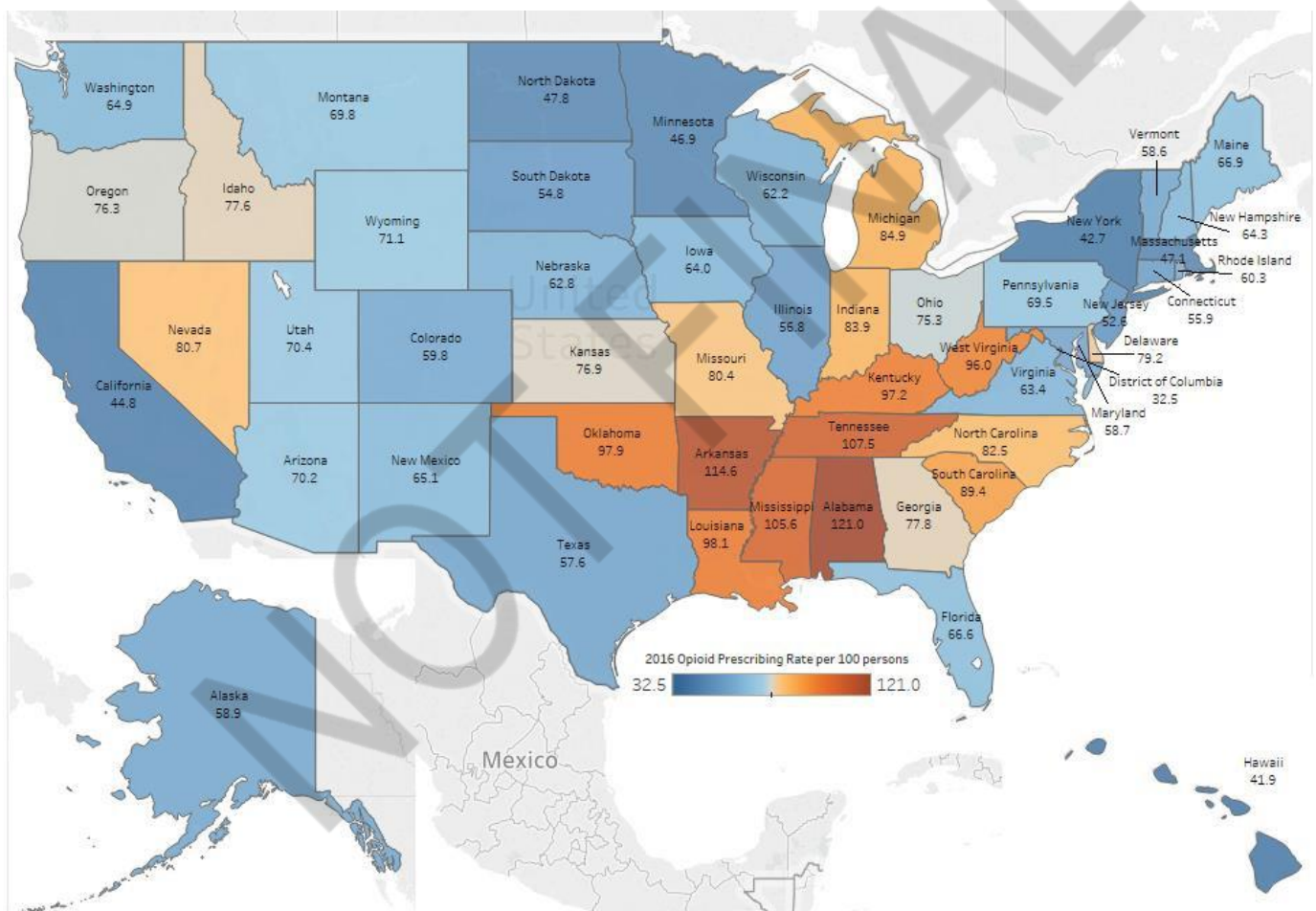
The first step to working on WRIR was to obtain a resolution from the Wind River Inter-Tribal Council to allow us to contact the Tribal Health Directors of each Tribe as our entrée into the community. That resolution was acquired on February 8, 2019 (Appendix A).

Current Situation in Wyoming

1. Indicators of Heroin and Non-Heroin Opiate/Synthetic Use, Misuse, and Dependence

- In 2016, Wyoming was above the national average for the rate of opioids dispensed per 100,000 population and several indicators suggest that Wyoming has experienced a significant increase in heroin use over the past decade. (Figure 1)

Figure 1: Opioid Prescriptions Dispensed per 100 persons by State; Centers for Disease Control and Prevention (2016)



Centers for Disease Control, U.S. Prescribing Rate Maps, July 2016

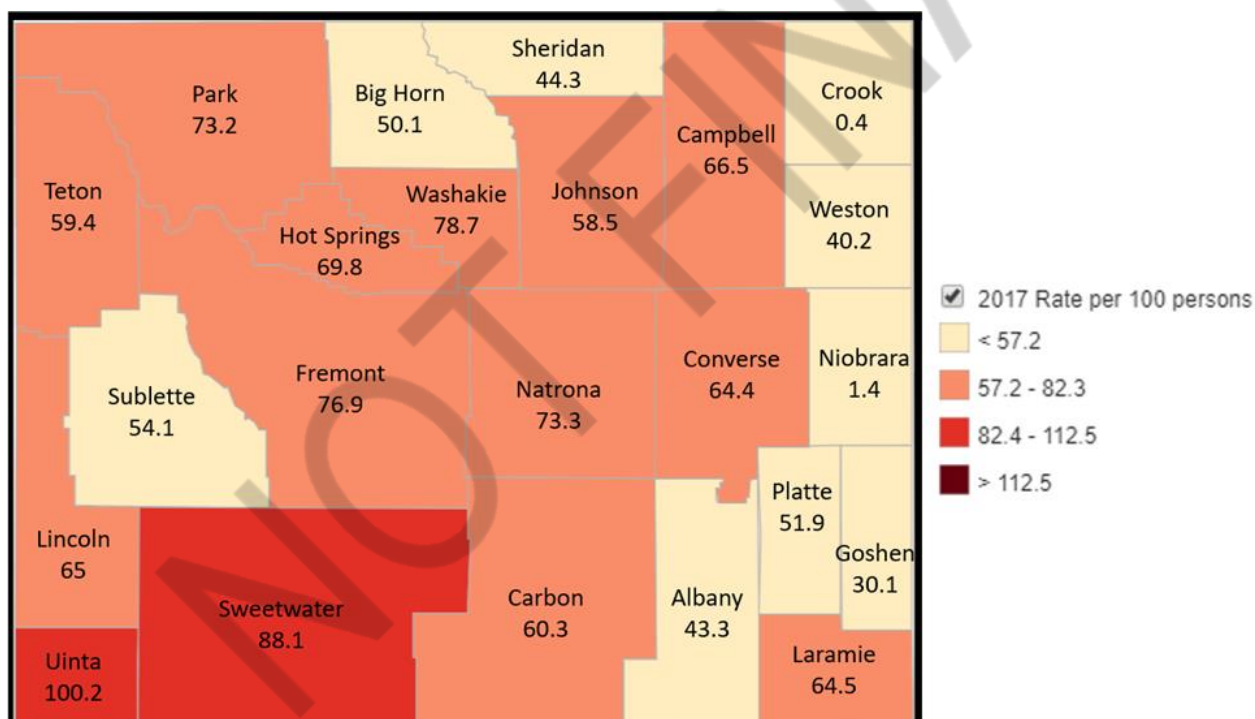
The CDC classified Wyoming as above the national average rate of opioid prescriptions dispensed in 2016.

- Wyoming: 71.1 prescriptions per 100 persons
- United States.: 66.5 prescriptions per 100 persons

Drug-Induced Deaths and Opioid-Related Mortality

- The most recent data available regarding drug-induced deaths appears to show that while rates have increased in Wyoming since 2010 and the State remains higher than the national average. In 2016, Wyoming ranked 16th in the age-adjusted rate of drug-induced deaths by state.
- It is estimated that more than half of all drug-induced deaths were associated with an opioid (62.0%).
- However, statewide the types of drugs involved with drug-induced deaths are underreported on death certificates and thus the true number of opioid-involved drug-induced deaths is likely higher than what is observed through analysis of vital records. On WRIR, this is definitely the case. Drug related deaths and deaths by suicide are underreported on the reservation given the stigma associated with it.

Figure 2: Wyoming Drug Overdose by County, 2017



Source: www.cdc.gov/drugoverdose/maps/rxcounty2017.html

Wind River Indian Reservation is primarily located in Fremont County. County health rankings do not include data for all counties; see more on page 10 regarding this data. Also, note that many drug related deaths and suicides are underreported in areas where stigma is high.

Figure 3: Wyoming Drug Poisoning Death Numbers and Rates, by County

County	Number of drug poisoning deaths per 100,000 population	Drug Overdose Mortality Rate per 100,000 population
Albany	14	12
Big Horn		
Campbell	19	13
Carbon	18	39
Converse		
Crook		
Fremont	23	19
Goshen		
Hot Springs		
Johnson		
Laramie	41	14
Lincoln	11	19
Natrona	42	17
Niobrara		
Park	12	14
Platte		
Sheridan	10	11
Sublette		
Sweetwater	25	19
Teton		
Uinta	15	24
Washakie		
Weston		
Total	230	18.27

Source: www.cdc.gov/drugoverdose/maps/rxcounty2017.html

According to the County Health Rankings website:

Some Data are Suppressed

A missing value is reported for counties with fewer than 10 drug poisoning deaths in the time frame. Pertinent information about the rate calculation:

Numerator

The numerator includes deaths from accidental, intentional, and undetermined drug poisoning by and exposure to:

- 1) nonopioid analgesics, antipyretics and antirheumatics
- 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
- 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified
- 4) other drugs acting on the autonomic nervous system, and
- 5) other and unspecified drugs, medicaments and biological substances, over a 3-year period. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14.

Denominator

The denominator is the aggregate annual population over the 3-year period.

2. Gaps in Treatment and Services

- The current substance abuse prevention system in Wyoming to address the opioid crisis attempts to use a multi-disciplinary effort employing evidence-based prevention strategies and public policy initiatives. It has many strengths including the use of a variety of evidence-based practices in prevention education. This approach has its merits, but it is not highly collaborative in its present form, and Wyoming has yet to declare the opioid situation to be at a crisis level in the state.
- There is still room to improve prescribing practices. Prescriber education regarding opioids is not currently mandated in the state. We found evidence on Wind River Indian Reservation that shows a lack of understanding of the state's guidelines, how prescribers should check current use from the statewide database, and an inconsistent adherence to doing so. This is compounded on WRIR by the Indian Health System (IHS) having its own procedures. IHS operates one of the health clinics on the Reservation.
- Adolescents and young adults in Wyoming are an important high-risk population for heroin and non-heroin opiate/synthetic use, misuse, and dependence. Attention should be directed towards improving prevention strategies aimed at Wyoming youth aged 18-25, a group historically shown to be difficult to reach, especially those who do not choose to attend a university. This is especially true on Wind River Indian Reservation.
- Many of Wyoming's substance abuse prevention workforce are over the age of 45, which emphasizes a great need for recruitment of younger peers.
- Accessing Medication Assisted Therapy (MAT) using public funding is difficult in Wyoming.

Wyoming received a failing grade from the National Safety Council in their 2018 Report of Dealing with the Opioid Crisis (Appendix B). The report recommends that each state should take these six key actions in order to save lives:

- (1) Mandate prescriber education
- (2) Implement opioid prescribing guidelines
- (3) Integrate prescription drug monitoring programs into clinical settings
- (4) Improve data collection and sharing
- (5) Treat opioid overdose
- (6) Increase availability of opioid use disorder treatment

Wyoming has recently implemented opioid prescribing guidelines and has integrated prescription drug monitoring programs into clinical settings.

Current Situation on Wind River Indian Reservation

Overview of Wind River Indian Reservation

Wind River Indian Reservation is an area about 3,500 square miles east of the Continental Divide. It is bordered on the north by the Owl Creek Mountains that join the Rocky Mountains and on the east by the Wind River Canyon. The Reservation is approximately a three-hour drive from Casper and five to six hours from Cheyenne.

The Reservation serves as the current day home of the Eastern Shoshone and Northern Arapaho tribes. It is one of the largest reservations in the United States. Public schools for grades K-12 are located on the Reservation. The population of the Wind River Indian Reservation area, including the surrounding towns of Lander and Riverton, is approximately 26,400, of which roughly half (12,500) are Native Americans. The Wind River Native American population represents over 2% of the population of Wyoming, and if you include the surrounding area, it is 5% of the population.

The Reservation is jointly owned by both tribes, with each holding 50% interest in the land, water and other natural resources. Each Tribe is fully committed to the welfare of their members. Job creation and economic development are high priorities, but the challenges are high given the remote location of the land. Summits are held to manage jointly owned resources and address other common issues. The largest employers are the tribal administration and the casinos.

Figure 4: Map of Wind River Indian Reservation and Wyoming



An article published in the Journal of Law, Medicine & Ethics in 2018¹ stated that the opioid epidemic was quietly ravaging Indian Country. Tribal nations are facing a growing rate of opioid overdose deaths and increasingly burdensome social and medical costs. Non-tribal governments, as well as society at large, have yet to recognize the extent and unique characteristics of the crisis for Native Americans.

The article states that the number of opioid deaths has grown significantly since 1999 and is at least as much of a problem as in non-tribal areas, and in some locations, is much worse. The Northern Plains areas have not, in general, experienced the high numbers of overdose deaths as other parts of the U.S. The Drug Enforcement Administration reported that no seizures of more than one kilogram of fentanyl occurred in the Dakotas, Nebraska, Wyoming or Montana from January of 2016 to June of 2017 and that few law enforcement agencies in the region view heroin as the greatest drug threat in their communities.

Our discussions with key stakeholders agreed that alcohol and methamphetamine abuse presented a larger problem than opioid abuse, but it is difficult to differentiate.

¹ Source: Summer 2018 issue, pgs 422 – 434, “The Opioid Epidemic in Indian Country” by Tipps, Buzzard and McDougall

The prevalence of methamphetamine abuse in some Northern Plains reservation communities may also play a role. The easy availability of meth coupled with the lower availability of potent opioids may contribute to the lower Northern Plains overdose mortality rates.

Tribal nations have some legal and medical policy options to control the flow of opioids and to provide treatment and reintegrate affected members back into the community. Resources, however, are extremely limited, and the judicial system will take years and a concerted effort to adequately address these issues.

The reservations are ill-equipped to deal with this crisis due to limited medical facilities as well as a lack of treatment and recovery services. The good news is that innovative medical and culturally cognizant counseling services have met with success. These treatment programs integrate the use of Tribal customs, sweat lodges, drum circles and tribal music chanting along with peer support in the recovery process.

A report from the Center for Drug Evaluation and Research made an interesting observation about how the problem goes beyond those who are prescribed opiates.

Among people who abuse prescription opioids, most obtain these from:

- ✓ A friend or relative for free (55%)
- ✓ Prescribed by a physician (20%)
- ✓ Bought from a friend or relative (11%)
- ✓ Other - undisclosed (14%)

Among new heroin users, three out of four report abusing prescription opioids before using heroin.²

Key Informant Interviews

Specific findings from interviews conducted at Wind River:

- Every person that we spoke to about the situation on Wind River said that drug misuse in general and opioid abuse specifically is worse than it was three years ago. It is difficult to isolate opioid misuse from drug misuse, as most of the substance abusers will use any drug that they can obtain. Many of those we spoke to said they had long-term issues with alcohol abuse before drugs. Opioids were just part of the mix of drugs they would use, depending on cost and availability.
- Wind River Indian Reservation is an environment that facilitates substance abuse for its residents and hinders recovery. Many of the Social Determinants of Health are a factor on WRIR and contribute to the issue of substance abuse. The area is remote, has a high rate of poverty, a lack of jobs, and suffers from extremely limited access to mental health and behavioral health services.

² The Opioid Crisis in Rural and Tribal Communities: Current Status and Future Directions, by Scott Winiecki, MD, October 26, 2017. Presentation.

- The average life expectancy for someone living on the reservation is 49 years, compared with an average life expectancy of 78.6 years in the U.S. as of 2016.³
- Education is also an issue. The Wind River Reservation dropout rate is 40 percent, more than twice the state average of Wyoming. Teenagers are twice as likely to commit suicide compared to other young adults within Wyoming. Other issues that commonly occur on the reservation include child abuse, teenage pregnancy, sexual assault, domestic violence and alcoholism. In the recent past, there was a history of gang violence. The Wind River Indian Reservation struggles with unemployment rates over 60%.
- The Reservation has a small police force of only six officers who are responsible for patrolling an area about the size of Rhode Island. Wind River's crime rate is 5-7 times the national average. The enforcement situation is further hampered by being subject to Tribal Law, which has its own laws and judicial system. Arrests for issues such as public intoxication that could be made in Riverton, WY, which borders Wind River Indian Reservation, cannot be made on WRIR. Prosecution is more difficult on WRIR.
- The Chief of Police told us that they stopped facilitating the DARE Program in the public schools because the children did not identify with the authority of the nontribal police, and that they simply did not have the manpower. He supported the idea of drug education in the schools, starting as early as middle school, but he felt strongly that it needed to come from a culturally relevant tribal perspective, and to be taught by a tribal member.
- A significant issue is the culture stigma against any kind of family problem, especially dealing with substance abuse or physical threats in the home. The Native American communities are matriarchal and multiple generations of a family live in one home. Mothers have been known to ignore theft and physical abuse in the home rather than admit to the outside that they have an addicted family member. This is a huge cultural barrier to seeking treatment.
- In the early 21st century, the media reported problems of reservation poverty and unemployment, resulting in associated crime and a high rate of drug abuse. In 2012, the New York Times released an article titled, "Brutal Crimes Grip an Indian Reservation". According to this article, written by Timothy Williams, an Iraq war strategy, "the surge", was used to attempt to fight crime taking hundreds of officers from the National Park Service and other federal agencies. This had major success at other reservations, but on the Wind River Indian Reservation, violent crime actually increased by seven percent.
- Diabetes is a significant problem on Wind River Indian Reservation. A study found that approximately 71% of the population is obese and 12% have diabetes, compared to the National average of 35% and 9.4%.⁴ (See Appendix E for Tribal Comorbidity data).
- The reservation was experiencing a methamphetamine crisis in 2013 that has since been significantly reduced, even while addiction continues to be a problem. Other residents say the Wind River Indian Reservation is a more hopeful place than is often portrayed in

³ Source: [cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf)

⁴ Source: CDC

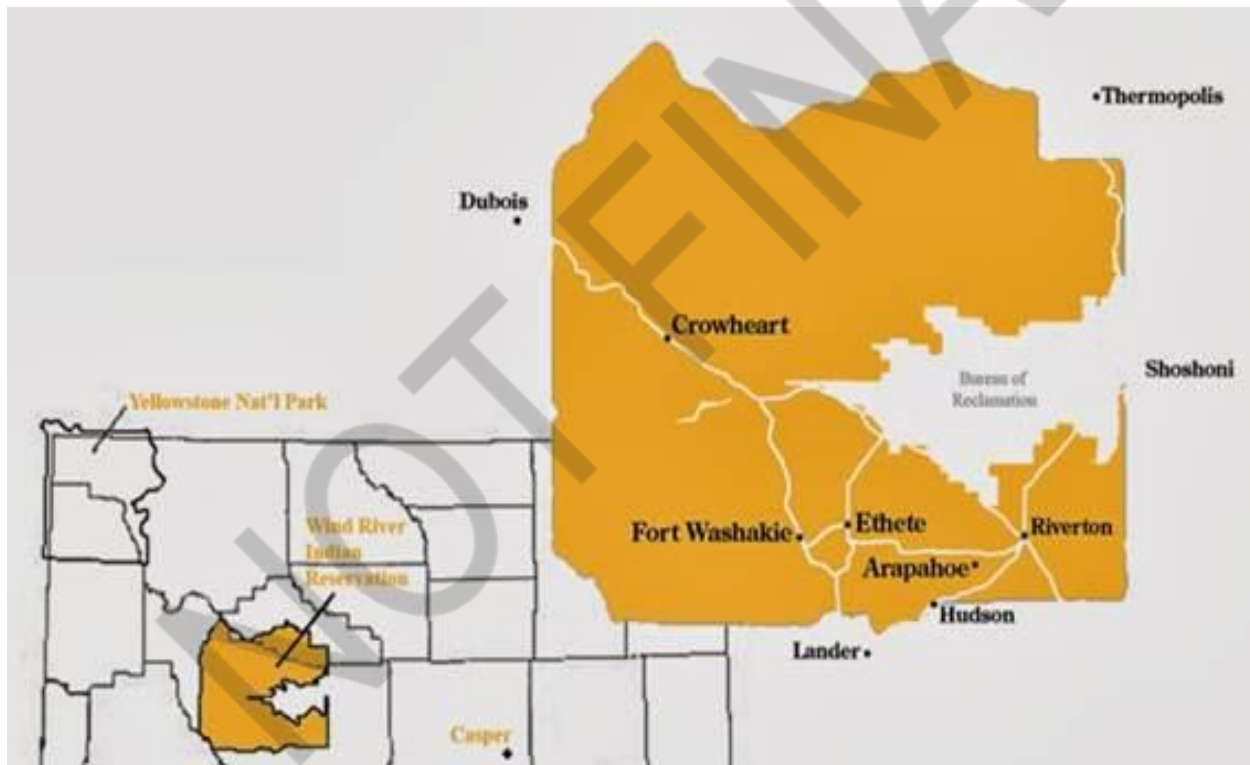
press reports. This year, the drug addiction problem has led to an increase in theft and reported attacks by vicious dogs.

Current Programs Available on Wind River Indian Reservation vs. Need

Public Health

There are two outpatient clinics on the reservation. One is located in Arapahoe and the other is in Fort Washakie. The clinics offer services such as limited Behavioral Health, Social Services, Business Office, Community Health Nursing, Purchased/Referred Care (PRC), Dental, Diabetes Program, Laboratory/Radiology, Medical Records, Medical Services, Nursing, Optometry, Office of Environmental Health, Utilization Review and Compliance.

Figure 5: Detailed Map of Wind River Indian Reservation



The Fort Washakie clinic is run by Indian Health Services (IHS), under the Billings, Montana region. Indian Health Services is run through the federal government, which funds and operates these clinics, and for many tribes these clinics are the only source of medical care on the reservation or for their tribal members. Many of these tribal members are not employed and do not have health insurance, so they can not afford to seek treatment elsewhere.

The Arapahoe Health Center, now known as Wind River Family & Community Health Care, used to be operated by IHS, but several years ago the Arapaho Tribe decided to operate the clinic

themselves (self-determined), utilizing the funds that would otherwise come from IHS as well as local funds generated by their casinos. This was done through the Tribal Self Governance Program and Public Law 638. It has enabled the Arapaho clinic to fund an onsite inpatient treatment facility for substance abuse. Currently the facility has 24 beds in a mobile home configuration, and even with a planned expansion this will only cover half of the estimated need. Those with opioid addiction feel ostracized by substance abusers who may be “simply” trying to overcome alcoholism.

The closest alternative tribal substance abuse inpatient facility is in Montana. Issues with relying on using this facility include:

- Different tribe, which means lower chance of success due to ostracism
- Transportation costs are high
- Lack of family support during recovery

Germane visited both clinics. While the clinics have adequate staff and resources to provide basic health care, they reported that they do not have the staff or facilities needed to adequately treat substance abuse, and certainly not at the level needed to meet the demand.

The Arapahoe clinic had a complete understanding of the prescription monitoring program and participated fully in Wyoming’s Prescription Data Monitoring Program (PDMP). The Fort Washakie clinic stated that they did not always have complete oversight into patient’s full prescription history, especially if patients were going to pain management clinics outside the reservation. This may be indicative of the separate nature of Indian Health Services and their database system. IHS did institute a policy in July 2016 that required utilization of the state PDMP for pain treatment longer than seven days. IHS has successfully connected with most of the 19 state PDMP databases. We believe that a training and familiarization program would address this issue.

Treatment Programs

There have been successful substance abuse programs on many reservations across the U.S. A notable feature of these tribal treatment and recovery programs is how closely the tribe integrates clinical and behavioral therapy with cultural support structures. Some tribes refer clients to work training programs and church organizations as part of the recovery plan. They organize music lessons, hold beading and canoe building classes, host the drum recitation at local dances and feasts and help clients to volunteer with tribal elders. The tribal programs operate outpatient services and sober houses.

The Shoshone and Arapaho programs use some of these elements in their treatment programs, but they lack the resources for a fully integrated approach. Additional funding could immediately be put to use to increase their ability to do so.

Focus Group Findings

- Wind River Indian Reservation residents are twice as likely as the general population to become addicted to drugs and alcohol, and three times as likely to die of a drug overdose.
- The average age of addiction is in between 18-25 years in Wind River. Many of those do not seek treatment until years later.
- Adverse childhood experiences, such as alcoholism, drug abuse and domestic violence in a family, emotional neglect, incarceration of a family member and physical or sexual abuse lead to a higher risk of addiction and other behavioral and mental health problems.
- Virtually no immediate access to inpatient services coupled with high levels of stigma make substance abuse treatment extremely challenging on Wind River.
- The matriarchal nature of both the Eastern Shoshone and Northern Arapaho tribes intensifies the 'hidden' epidemic of drug use.
- Even more than opiates, methamphetamine and alcohol use are common with poly-substance use occurring throughout the Wind River Reservation.
- Services needed include mental health treatment to resolve underlying issues, access to social determinants to remedy root causes (unemployment, career counseling, education, abject poverty) and then substance use treatment, primarily medication assisted treatment (MAT).

MAT is a proven, effective treatment for individuals with an opioid use disorder. It has been shown to increase retention and to reduce opioid use, risk behaviors that transmit HIV and hepatitis C virus, recidivism and mortality. SAMSHA has been working to expand access to MAT through increased Medicare and Medicaid ability to fund programs and increasing the number of patients a qualified physician may treat with buprenorphine.

Recommendations

The tribal health directors for both tribes clearly stated that they would welcome any resources to help them fight substance abuse in general, and opioid abuse in particular, on Wind River Indian Reservation. In accordance with the accepted solutions for the opioid crisis presented in the national literature, Germane suggests the following recommendations.

a. Prevention

Schools could do more to educate students as young as 12 years of age about substance abuse issues and their aftermath. At a minimum, Wyoming could provide appropriate literature to help with this effort. If possible, provision of the funds could allow a tribal member to offer culturally appropriate education on an ongoing basis.

This teacher could also have a presence at health fairs on the Reservation and in the surrounding towns, where they could share the prevention message with the greater population.

Provide funding for the Girls and Boys Club to offer programs and sports that will encourage greater self esteem and a healthier approach to life.

b. Education for Prescribers

Provide instruction for all doctors and pharmacists on the use of the Wyoming Prescription Drug Monitoring Program (PDMP). Make it a mandatory annual class.

c. Education for the Public

Fund a public awareness program on the dangers of opioid use for the Wind River Indian Reservation and surrounding areas.

Encourage adoption of media campaigns to dispose of unused/expired medications and the need to safeguard pain medications.

d. Treatment Alternatives

There are no substance abuse treatment facilities reasonably located on Wind River Indian Reservation, other than the general one operated by the Arapahoe Health Director (White Buffalo Recovery Center). Provide funding for an inpatient center that could be used by both tribes to address this need from a culturally appropriate foundation. This method will have a greater chance of success than referring those with addiction issues out of state.

Provide funds for the cultural programs such as sweat lodges, drumming, chanting and tribal therapy. Provide funds for transportation, which is a significant issue on this large reservation where many members do not own cars and there is no public transportation available.

Consider funding basic mental health services to assist with treatment and act as a prevention tool. The need is great, and providers are stretched thin. Research the use of teletherapy.

Wind River Indian Reservation has implemented a Naloxone program, and all first responders, policemen and school nurse staff have been trained on its use. Additional funds could expand availability to family members or friends of those who misuse opioids.

Expand use of and access to Medication-Assisted Treatment (MAT) on the reservation.

e. Policy and Legislation

Tribal Nations do not need to be structured similarly to states or federal governments. Some nations have used criminal and civil jurisdiction to successfully craft policy in response to the opioid epidemic.

- One example is the Drug “Healing to Wellness” Courts.
- Operated by 72 different tribal nations as of 2014
- Innovative responses are possible
- Drug counseling, psych, medical services provided
- Culturally specific treatment services provided

Little evaluation of effectiveness of healing to wellness courts exists in terms of preventing recidivism, but courts offer alternative to punitive criminal proceedings.

Another example is banishment of drug offenders (Saginaw Chippewa, Spirit Lake Sioux, Cheyenne River Sioux and others). This has primarily been successful as a tool to dissuade non-native drug traders.

The tribes will have to conquer this challenge on their own, but Wyoming may be able to assist concerned parties on the Reservation lead efforts needed to update tribal laws and enforce those already in place.

Appendix A

Resolution from Inter-Tribal Council

NOT FINAL



**RESOLUTION
OF THE
WIND RIVER INTER-TRIBAL COUNCIL**



**RESOLUTION NO. 2019-11229
NABC NO. NABC-2019-1082**

**A RESOLUTION IN SUPPORT OF GERMANE SOLUTIONS APPLICATION FOR
STATE OPIOID RESPONSE GRANT FOR THE WIND RIVER INDIAN
RESERVATION.**

WHEREAS, the Eastern Shoshone Tribe ("EST") and the Northern Arapaho Tribe ("NAT") as federally recognized Indian tribal governments, with inherent rights of self-governance, exercises rights of self-determination through its elected Eastern Shoshone and Northern Arapaho Business Council ("ESBC and NABC"); and

WHEREAS, the Wind River Inter-Tribal Council (WRIC) of the Eastern Shoshone and the Northern Arapaho Tribes ("Tribes") is the governing body duly authorized by the General Councils of each Tribes to conduct business on behalf of the Tribes; and

WHEREAS, the Eastern Shoshone and Northern Arapaho Tribes are concerned with the opioid use and abuse on the Wind River Indian Reservation; and

WHEREAS, Germane Solutions are to contact the Tribal Health Director(s) of each Tribe and share information with them in connection to this grant proposal.

NOW THEREFORE BE IT RESOLVED, the Wind River Inter-Tribal Council are in support of Trish Wampler, Project Manager Germane Solutions application for a federal grant to the State Opioid Response grant: Wind River Indian Reservation Needs Assessment; and

BE IT FINALLY RESOLVED, as the Chairman of the Eastern Shoshone Business Council (ESBC) and the Chairman of the Northern Arapaho Business Council (NABC) are hereby delegated the authority and responsibility to sign all documents necessary to effect this action.

CERTIFICATION

The undersigned, as the Chairman of the Eastern Shoshone Business Council hereby certifies that the Eastern Shoshone Business Council, consists of six (6) members, of whom six (6) members of the Eastern Shoshone Business Council constituting a quorum, were present at a meeting duly called, noticed, convened, and held this eighth (8th) day of February, 2019; that the foregoing resolution was adopted by an affirmative vote of five (5) members of the Eastern Shoshone Business

The undersigned, as the Chairman of the Northern Arapaho Business Council hereby certifies that the Northern Arapaho Business Council, consists of six (6) members, of whom five (5) members of the Northern Arapaho Business Council, constituting a quorum, were present at a meeting duly called, noticed, convened, and held this eighth (8th) day of February, 2019; that the foregoing resolution was adopted by an affirmative vote of five (5) members of the Northern Arapaho Business

Appendix A

Resolution – Page 2

RESOLUTION NO. 2019-11229
NABC RESOLUTION NO. NABC-2019-1082
PAGE TWO (2) OF TWO (2)

Council, and one (1) abstention vote, and that the said resolution has not been rescinded or amended in any way.

Done at Fort Washakie, Wyoming this 8th day of February, 2019.


Vernon Hill Sr., Chairman
Eastern Shoshone Business Council

Attest:


Carolyn Shoyo, WRIC Executive Secretary

Councils, and that the said resolution has not been rescinded or amended in any way.

Done at Fort Washakie, Wyoming this 8th day of February, 2019.


Lee Spoonhunter, Chairman
Northern Arapaho Business Council

Attest:


Debbie Antelope, NABC Executive Assistant

NOT FINAL

Appendix B

National Safety Council Report

NOT FINAL



PRESCRIPTION NATION 2018

Facing America's opioid epidemic

- Defining the issues
- Grading states' progress
- Recommending
life-saving actions

Eliminating Preventable Deaths™

CEO LETTER



STEMMING THE TIDE OF AN EPIDEMIC

The numbers don't lie, and they are terrifying. Over 42,000 Americans lost their lives to an overdose involving opioids in 2016 alone: 115 people a day. That means hundreds of thousands of family members, friends, neighbors and co-workers are left to pick up the pieces of these lost lives. The heartbreaking truth is that every one of these deaths was preventable.

Highly addictive opioid medications—Vicodin, Percocet, OxyContin and others—have been improperly marketed to the medical community as the most effective method for treating pain. Since the 1990s, opioids have been liberally prescribed, setting the stage for a flood of people suffering from opioid use disorder, overdose and death.

Prescription opioids are a gateway drug to heroin, which is nearly identical chemically and may be cheaper and easier to get. Increasingly, heroin and other drugs are being combined with illicitly made fentanyl, a synthetic opioid that is 50 to 100 times more potent than morphine. This trend has led to a spike in opioid overdoses in every single state in the nation. The crisis now is an epidemic that has taken a greater toll than AIDS at the height of that epidemic. Without strong action, increased funding and dedicated resources, we face a grim future.

The National Safety Council is committed to eliminating preventable deaths in our lifetime, and we go where the data tell us to go. For years, the data on opioid-related deaths predicted the reality we face today. The Council is responding by creating public education campaigns, providing resources for employers and partnering with the medical community, survivor advocates and committed corporate partners. However, legislation and policy are needed if we want to fundamentally change behaviors.

As the death toll increases, addressing the crisis becomes even more urgent. The federal government declared the opioid epidemic a public health emergency in 2017, shining a spotlight on the problem without dedicating needed funds. More federal resources are essential, but states play a significant role in implementing programs that will stem the loss of life. Decision makers must continue to challenge the status quo, to think differently moving forward, and to implement more effective solutions.

We can prevent deaths, provide adequate treatment to people suffering from opioid use disorder and help those in recovery to have productive, healthy lives. We must face this crisis head-on. We cannot afford further delay.



DEBORAH A. P. HERSMAN
President and CEO of the National Safety Council

This report provides government officials with the blueprint they need to address this emergency and save lives. On pages 4 and 5, we have graded the states on actions taken. While there has been improvement since our *Prescription Nation 2016* report, the scope of the problem has outpaced interventions. Overdose deaths are still rising. This report shows that with the right actions, reversing the opioid overdose trend is possible: it just hasn't been done yet.

EXECUTIVE SUMMARY

It's time to face the facts. Our nation is confronting the most fatal drug crisis in U.S. history.

Our friends and family members are dying in unprecedented numbers. One in 10 Americans knows someone who has died from an opioid overdose (National Safety Council, 2017).

- Eleven million Americans misused an opioid pain reliever in the past year (SAMHSA, 2017)
- More than 2.1 million people suffer from an opioid use disorder (SAMHSA, 2017)
- More than 63,600 families lost loved ones to a drug overdose in 2016 (Kochanek, Murphy, Xu, & Arias, 2017)
- Opioids such as Vicodin (hydrocodone), OxyContin (oxycodone), heroin and fentanyl accounted for 42,000 deaths in 2016 (Kochanek, Murphy, Xu, & Arias, 2017)
- U.S. lifespan estimates declined for the second year in a row, primarily due to deaths from drug overdose (Dowell, Arias, Kochanek, Anderson, & al, 2017)

The opioid epidemic is affecting our economy.

- Opioid over-prescribing is shrinking the number of eligible workers (Krueger, 2017)
- Labor force participation among prime-age workers 25–54 is more likely to be lower in areas with high opioid prescribing rates; this age group has been hardest hit by the opioid epidemic (Krueger, 2017)

- Seven in 10 companies report being directly impacted by prescription drug misuse (National Safety Council, 2017)

This report discusses the major dimensions of the opioid crisis, and identifies six key actions every state should take to save lives:

- Mandating prescriber education
- Implementing opioid prescribing guidelines
- Integrating prescription drug monitoring programs into clinical settings
- Improving data collection and sharing
- Treating opioid overdose
- Increasing availability of opioid use disorder treatment

The recommendations listed on pages 28-29 will guide states in developing and strengthening laws and regulations to achieve these key actions, improve their state grade and save lives.



HOW DOES THIS CRISIS COMPARE TO OTHERS?

- **63,632** people died from drug overdose in 2016; of those, over 42,000 deaths were from opioids (Hedegaard, Warner, & Miniño, 2017)
- **47,000** American soldiers died in battle in the Vietnam War 1964–1975 (U.S. Department of Veterans Affairs, 2017)
- **351,602** Americans have died from opioid overdose since 1999 (National Center for Health Statistics, 2016)
- **291,000** American soldiers died in battle in World War II 1941–1945 (U.S. Department of Veterans Affairs, 2017)
- **50,000** Americans died from HIV in 1995, the peak year for HIV deaths: HIV was the number one cause of death for Americans age 25 to 44 (CDC, February 28, 1997)
- **6,700** Americans died from HIV in 2014 (Kochanek K. , Murphy, Xu, & Tejada-Vera, 2016)

Public education, treatment and prevention measures do work. For example, the spread of HIV has been dramatically curtailed and deaths have decreased since its identification and public health response in the 1980s.

The National Safety Council is committed to working with federal and state leaders and other organizations to end opioid overdose.

STATE GRADES

STATE PROGRESS

Results on achieving six key actions for ending the opioid crisis.

Three states met all six key actions and no state met zero key actions. State progress based on best available data as of Dec. 31, 2017.

- ✓ 13 states and District of Columbia are IMPROVING: meeting five or six key actions
- 🔄 30 states are LAGGING: meeting three or four key actions
- ✗ 7 states are FAILING: meeting one or two key actions

STATE	PRESCRIBER ED	PRESC GUIDELINES	PDMP	DATA SHARING	TREATING OVERDOSE	OUD TREATMENT	STATE TOTAL
Alabama	✓	✓	✓		✓		4
Alaska	✓		✓		✓	✓	4
Arizona	✓	✓	✓	✓		✓	5
Arkansas			✓		✓		2
California	✓	✓			✓	✓	4
Colorado		✓	✓		✓	✓	4
Connecticut	✓	✓	✓		✓	✓	5
Delaware	✓	✓	✓		✓	✓	5
District of Columbia	✓	✓	✓		✓	✓	5
Florida	✓	✓			✓	✓	4
Georgia	✓	✓	✓		✓	✓	5
Hawaii		✓			✓	✓	3
Idaho	✓	✓	✓				3
Illinois			✓		✓	✓	3
Indiana		✓	✓		✓		3
Iowa	✓	✓					2
Kansas			✓			✓	2
Kentucky	✓	✓	✓		✓		4
Louisiana	✓	✓	✓		✓		4
Maine	✓	✓	✓			✓	4
Maryland	✓		✓		✓	✓	4
Massachusetts	✓		✓			✓	3
Michigan	✓	✓	✓		✓	✓	5

STATE	PRESCRIBER ED	PRESC GUIDELINES	PDMP	DATA SHARING	TREATING OVERDOSE	OUD TREATMENT	STATE TOTAL
Minnesota			✓		✓	✓	3
Mississippi	✓				✓	✓	3
Missouri						✓	1
Montana					✓	✓	2
Nebraska		✓	✓		✓		3
Nevada	✓	✓	✓	✓	✓	✓	6
New Hampshire	✓	✓	✓		✓	✓	5
New Jersey	✓				✓	✓	3
New Mexico	✓	✓	✓	✓	✓	✓	6
New York	✓		✓			✓	3
North Carolina	✓	✓	✓		✓	✓	5
North Dakota			✓		✓		2
Ohio	✓	✓	✓		✓	✓	5
Oklahoma	✓	✓	✓			✓	4
Oregon	✓				✓	✓	3
Pennsylvania	✓		✓		✓	✓	4
Rhode Island	✓	✓	✓	✓	✓	✓	6
South Carolina	✓	✓	✓			✓	4
South Dakota			✓		✓	✓	3
Tennessee	✓	✓	✓		✓		4
Texas	✓	✓	✓	✓			4
Utah		✓	✓		✓	✓	4
Vermont	✓	✓			✓	✓	4
Virginia	✓	✓	✓		✓	✓	5
Washington		✓			✓	✓	3
West Virginia	✓	✓	✓	✓	✓		5
Wisconsin			✓	✓	✓	✓	4
Wyoming		✓	✓				2
TOTALS	35	34	40	7	39	38	

STATE GRADES

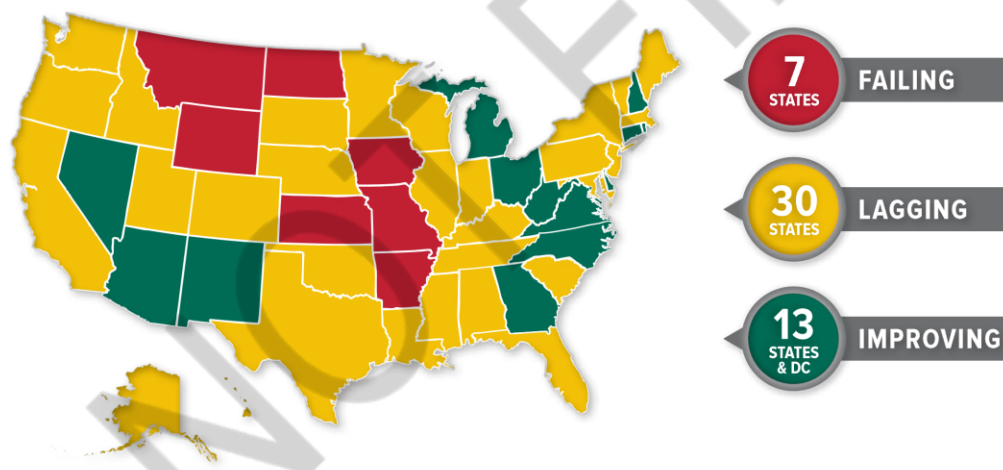
STATE-BY-STATE PROGRESS ON STRENGTHENING LAWS AND REGULATIONS

Multiple key actions will be needed to end this drug epidemic and reduce the loss of life. Concentrated state focus is needed to reduce opioid over-prescribing, and to improve the ability to identify and offer help to those at risk. By ensuring that effective and coordinated treatment for opioid use disorder is available, we can reduce the loss of life to opioid overdose.

The six key actions every state should take to save lives are:

- Mandating prescriber education
- Implementing opioid prescribing guidelines
- Integrating prescription drug monitoring programs (PDMPs) into clinical settings
- Improving data collection and sharing
- Treating opioid overdose
- Increasing availability of opioid use disorder treatment

This report provides a road map for strengthening laws and regulations. NSC provides a variety of tools and resources to assist states as they navigate this epidemic.



FAILING		LAGGING		IMPROVING	
MEETS 1 INDICATOR	MEETS 2 INDICATORS	MEETS 3 INDICATORS	MEETS 4 INDICATORS	MEETS 5 INDICATORS	MEETS 6 INDICATORS
MO	AR, IA, KS, MT, ND, WY	HI, ID, IL, IN, MA, MN, MS, NE, NJ, NY, OR, SD, WA	AL, AK, CA, CO, FL, KY, LA, ME, MD, OK, PA, SC, TN, TX, UT, VT, WI	AZ, CT, DE, DC, GA, MI, NH, NC, OH, VA, WV	NV, NM, RI

REPORT METHODOLOGY

Prescription Nation evaluates six key actions that can help states prevent and address opioid misuse, addiction and overdose. Each section is comprised of one or more indicators identified by NSC subject matter experts as policies, programs or practices that can impact the U.S. opioid epidemic.

The final selection of indicators was based on the availability of state-level data from trustworthy public entities including nonprofit organizations, associations and government agencies. See the reference section for the complete list of referenced data sources. A total of 16 indicators are included in the *Prescription Nation 2018* report. Every attempt was made to provide the most recent data available, reflecting state laws enacted as of Dec. 31, 2017.

This report is intended as a communication tool to highlight best practices and state-level actions, but it is not an exhaustive scientific study. NSC was careful to evaluate states only on indicators for which comparable data is available, on actions being taken at the state level. No single indicator should be considered a proxy for how well any given state is performing in addressing the opioid epidemic.

States continue to make progress in addressing the opioid epidemic

Prescription Nation 2018 examines the progress of states in facing the opioid epidemic. Since our 2016 report, significant progress has been made by states:

- Fifty states and District of Columbia have established prescription drug monitoring programs, with many states moving to bring their PDMP in line with model or best practice program guidance
- Fifty states and District of Columbia have implemented programs and enacted laws to expand access to naloxone, a drug to treat opioid overdose, saving tens of thousands since 1996

Key actions and indicators examined in prior reports have changed. These changes include:

- Additional indicators have been added for key actions to improve PDMPs and provide access to naloxone. It is no longer enough for each state to

have a PDMP and provide access to naloxone. States must strengthen these programs and move to best practices in order to stop the epidemic.

- A key action related to data collection and data sharing has been added to the 2018 report. With a rapidly changing epidemic and entry of newer and deadlier opioids such as fentanyl and its analogs, data are needed to understand these changes and how key populations have been most impacted by the epidemic.
- The key action regarding laws to eliminate pill mills has been removed in the 2018 report. Laws to regulate pill mills and pain clinics and bring them under the purview of state licensing officials continue to be a promising practice.
- State enhancements to PDMPs and implementation of opioid prescribing guidelines are reducing the need for separate laws to eliminate pill mills.

DEFINING MISUSE, DEPENDENCE, DISORDERS AND ADDICTION

MISUSE: Using medication saved from a previous medical condition or surgery for a non-prescribed purpose, using another person's prescription and using medication without a prescription.

DEPENDENCE: Physical need for medication or a substance, leading to tolerance—taking more to get the same response—or leading to physical withdrawal when the substance is not supplied.

SUBSTANCE USE DISORDER (SUD): A diagnosis meeting criteria for drug or alcohol dependence or misuse as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

OPIOID USE DISORDER (OUD): A substance-specific subset of substance use disorder.

ADDICTION: A chronic brain disease, characterized behaviorally by losing control of drug use and then losing control of life functions due to drug use.

The terms "substance use disorder" and "addiction" are often used interchangeably to describe the same chronic health condition.

UNDERSTANDING THE CRISIS

OPIOID USE DISORDER IS A CHRONIC BRAIN DISEASE

To mitigate the devastating effects of opioid misuse, we must acknowledge that opioid use disorder is a chronic disease, not a moral failing or lack of willpower, and ensure that treatment is available for all Americans who need it. Evidence-based treatment programs are vital for supporting people with opioid use disorder.

There is some resistance to public and private funding of opioid use disorder (OUD) treatment due to the misconception that those who misuse opioids are doing so for pleasure, as a conscious choice. Too often, OUD sufferers are treated as though they should be ashamed or have a moral failing, leading to policies that set unreasonable requirements to obtain treatment and limit duration or recurrence. In fact, OUD, like other substance use disorders, is a chronic brain disease.

“We don’t tell diabetics that we won’t give them medicine if they don’t follow their diet,” says Kelly Clark, M.D., an addiction expert. “We don’t expect a person with a chronic disease to be 100 percent adherent to their treatment. There is no cure for a chronic disease, so we need to help people with management of that disease. We need to erase the stigma of OUD through public education and by showing people that evidence-based treatment can help those with OUD.”

Successful evidence-based treatment programs address the interdependent aspects of addiction: biological, psychological and social. Understanding the effect of opioids on human biology explains why medication assisted treatment (MAT) is necessary.

“The human brain was not meant to process opioids,” Dr. Clark says. “Opioids permanently change nerve cells in the brain, sometimes within a very short period of use. So, simply taking away opioids doesn’t change the brain’s requirement for them.”

MAT is not substituting one drug for another, contrary to widely held belief. Buprenorphine and methadone, the two primary medications used in MAT, satisfy the brain’s pain receptors without the respiratory suppression or addictive euphoria of opioids. Keeping the physical craving at bay allows the patient to address psychological issues and reconnect to social support networks. Many people who use MAT simultaneously attend school, work, are productive members of society and successfully find recovery.¹

Many drug treatment programs address the psychological and social aspects of addiction but do not include medication as a necessary component. “If people leave rehab without MAT, they are more likely to die than if they hadn’t completed rehab,” Dr. Clark says. “We need to develop a structured, standard model of care and then adapt it for each person. A full assessment and individualized treatment should be a core piece of best practices.”

¹It is important to note that some workers in recovery may not be able to return to safety-sensitive jobs while using MAT. They may need training and other support to successfully re-enter the workforce.

RISK OF ADDICTION IS SERIOUS AND WIDESPREAD

The first opioid prescription may spark an addiction that was never anticipated.

After as few as five days of opioid pain reliever use, one in five opioid users runs the risk of becoming dependent and continuing to use opioids one year later. The risk increases with each additional day of use. A refill or a second opioid prescription doubles the risk of opioid dependence (Shah, Hayes, & Martin, 2017).

It is clear that most people do not understand this risk. A 2017 National Safety Council public opinion poll found nearly 84 percent of opioid users were not worried about addiction, even though 64 percent of respondents reported having a personal or family history of addiction risk factors. Additionally, 53 percent of survey respondents identified a personal (lifestyle) risk factor of addiction. Further, one-third of Americans surveyed did not even realize a medication they had taken was an opioid (National Safety Council, 2017).

THE PATH FROM OPIOID PAIN RELIEVER USE TO HEROIN ADDICTION

In the U.S. in 2016:

97 million people used opioid pain relievers (SAMHSA, 2017)

2.1 million started misusing opioid pain relievers for the first time (SAMHSA, 2017)

4.4 percent of the population over the age of 12—11.5 million people—misused opioid pain relievers, putting them at 40 times greater risk for transitioning to heroin (SAMHSA, 2017)

Of the 948,000 people who used heroin, 170,000 used it for the first time (SAMHSA, 2017)

RISK FACTORS FOR OPIOID ADDICTION

(SAMHSA Center for the Application of Prevention Technologies, 2018)

- ✓ Having depression, anxiety or other mental health illness
- ✓ A personal and/or family history of alcohol or substance misuse
- ✓ A history of physical, mental or sexual abuse
- ✓ Long-term use of opioid pain medications

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UNDERSTANDING THE CRISIS

THE OPIOID CRISIS IS ENDANGERING OUR FUTURE

Shorter lifespans and reduced workforce participation impact American employers.

Opioid overdose is reducing U.S. lifespan estimates

Life expectancy in the U.S. declined for the second year in a row in 2016. A baby born in the U.S. today can expect to live 78.6 years, down from 78.9 years in 2014 (Kochanek, Murphy, Xu, & Arias, 2017). Much of this decrease is due to deaths from opioid overdose, and U.S. lifespan is anticipated to continue to decline as the opioid crisis becomes more deadly (Dowell, Arias, Kochanek, Anderson, & al, 2017).

Unintentional injuries are now the third leading cause of death in the U.S. due to the spike in drug overdose deaths. People die of drug overdose at much younger ages than cardiovascular disease or cancer, the first and second causes of death in the U.S. (National Safety Council Injury Facts, 2017). Overdose mortality rates are highest for people who are 25 to 54 years old, adults in their prime working years (Kochanek, Murphy, Xu, & Arias, 2017).

Opioid over-prescribing is shrinking the U.S. labor force

U.S. labor force participation—people over the age of 16 who are employed or actively looking for work—peaked in 2000, and since then has declined by 4 percent (Krueger, 2017). Especially concerning is the decline in workforce participation among prime-age

workers 25 to 54. This age group has been hardest hit by the opioid epidemic (Kochanek, Murphy, Xu, & Arias, 2017). An estimated 20 percent of the decline in male labor force participation and a 25 percent decline in female participation correlate with increases in opioid prescribing (Dews, 2017). Labor force participation is more likely to be lower in counties with high opioid prescribing rates (Krueger, 2017).

Our nation's employers are paying the price

Employers in areas that are hard-hit by opioid addiction, and those in certain industries like construction and manufacturing, report increasing difficulties in filling open positions. A 2017 NSC survey found:

- Seven in 10 employers are impacted by prescription drug misuse
- Nearly half (48 percent) identified a negative business impact—lower productivity, missed work, an increase in near-miss or close-call events, and an increase in workplace injuries
- One-third reported workers had a family member affected by the crisis, with one in 10 companies reporting an employee overdose
- One in five companies reported knowledge of employees selling or borrowing prescription medications or having drug-related arrests

Opioid Prescription Rates Directly Affect Workforce Participation Rates

A comparison of 2015 county-level opioid prescription rates to individual labor force participation data found that labor force participation fell more in counties with higher opioid prescribing rates (Krueger, 2017).

Employers face mounting costs related to untreated substance use disorder (SUD) among their workforce. Opioid use disorder (OUD) is even more costly.

Workers with OUD miss more work and have higher health care usage than workers with other SUDs. These costs quickly add up. Industries with highly compensated or highly skilled workers will bear a greater burden. The annual cost per worker with an untreated SUD ranges from \$2,600 in agriculture to \$13,000 in information and communications industries (Goplerud, Hodge, & Benham, 2017).

UNDERSTANDING THE CRISIS

OPIOID EPIDEMIC ENTERS EVEN MORE DEADLY PHASE

The U.S. is facing the deadliest drug crisis on record (CDC, 2017). Drug overdoses—mostly caused by opioids—end far too many lives, too soon. More than 63,600 families lost loved ones to a drug overdose in 2016. Opioids such as Vicodin (hydrocodone), OxyContin (oxycodone), heroin and fentanyl accounted for 42,000 of these deaths in 2016 (CDC, 2017).

Rapid rise in opioid prescriptions mirrors rise in addiction and overdose deaths

The mid-1990s saw changes in prescribing practices and aggressive marketing of prescription opioids as a safe and effective treatment for chronic pain management, resulting in over-prescribing of these addictive medications. Centers for Disease Control and Prevention (CDC) data show that as sales of opioids increased, so did overdose deaths, emergency room visits and treatment admissions (Paulozzi, Jones, Mack, & Rudd, 2011). More than 11 million Americans over the age of 12 misused an opioid pain reliever in the last year (SAMHSA, 2017).

Prescription opioid misuse transitions to heroin use

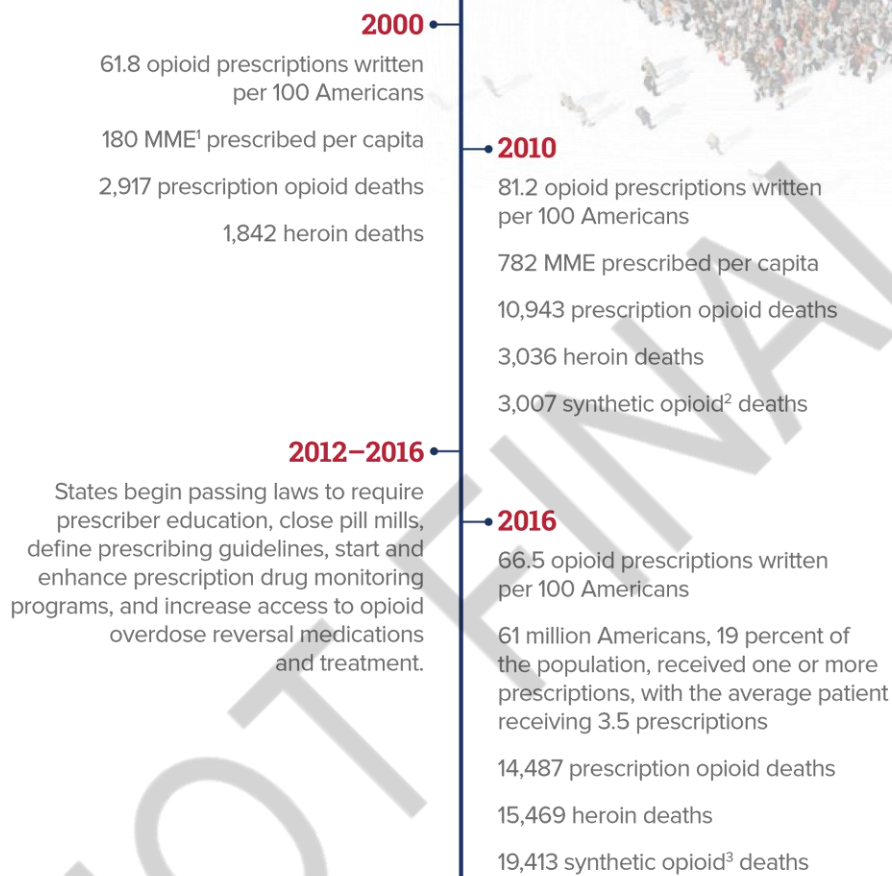
Heroin deaths more than quadrupled in the six-year period from 2010 to 2016, increasing from 3,300 to more than 15,400 deaths annually (Kochanek, Murphy, Xu, & Arias, 2017). Nearly a million people reported using heroin in 2016 (SAMHSA, 2017). Misuse of prescription opioids often drives an increase in heroin use, with four out of five heroin users reporting that their addiction began with prescription opioids (Jones, 2013). Non-medical users of opioid pain medications were 40 times more likely to use heroin than people reporting no misuse of opioids (Jones, Logan, Gladden, & Bohm, 2015).

Rise in fentanyl deaths

Fentanyl, a synthetic opioid, is 50 times more potent than heroin and 100 times more potent than morphine (CDC, 2016). Pharmaceutical fentanyl is commonly prescribed to manage pain for advanced-stage cancer patients. Illicit fentanyl is manufactured in clandestine labs and is more profitable for drug dealers than heroin (DEA, 2017). Illicit fentanyl has been seized by law enforcement agencies in all 50 states and the District of Columbia (DEA, 2017). Pressed into counterfeit prescription opioids or added to heroin and other drugs, fentanyl in all of its forms—both legitimate and illicit—was involved in more than 20,000 overdose deaths in 2016, twice as many as in 2015 (Kochanek, Murphy, Xu, & Arias, 2017).



BY THE NUMBERS



Opioid pain medications like hydrocodone and oxycodone are chemically similar to heroin, and have a similar effect on minds and bodies. More research is needed to fully understand why people misusing opioid pain medications transition to heroin. It is widely believed that dealers who supply opioids offer heroin as a cost-saving measure (Pollini, et al., 2011).

Overall, opioid exposure has been slightly reduced but still remains high. Opioids are still commonly prescribed at higher doses than needed and for more days than needed, increasing the risk of misuse (Pollini, et al., 2011). However, much more work needs to be done to continue the reduction in prescriptions for opioids.

¹Morphine milligram equivalent (MME, a way to compare potency of different types and dosages of opioid pain relievers); ²Primarily fentanyl; ³Excludes methadone

KEY ACTIONS

SIX KEY ACTIONS


Some states have made significant progress in the fight against the opioid epidemic. Others have much more to do. States were given a rating of “Improving,” “Lagging” or “Failing” based on careful evaluation of actions taken in six key areas:



MANDATING PRESCRIBER EDUCATION

Mandatory prescriber education keeps providers up to date on best practices and the latest research in pain treatment and addiction. Academic programs for medical, dental and nursing students should include instruction on effective pain management and identifying and treating addiction. **States should:**

- Require all medical providers to complete continuing education related to opioid prescribing or chronic pain management

 **34 STATES AND DISTRICT OF COLUMBIA ACHIEVED THIS INDICATOR AND MET THIS KEY ACTION**



IMPLEMENTING OPIOID PRESCRIBING GUIDELINES

Opioid prescribing guidelines are recommendations for pain treatment based on current knowledge of the risks and benefits of opioid use and alternative non-opioid treatments. The 2016 CDC Chronic Pain Guideline should be adopted by states, and states should also take action to reduce the risks for acute pain patients. **States should:**

- Adopt recommendation that practitioners have a written treatment plan for the treatment of chronic pain
- Adopt recommendation that practitioners perform a physical examination and substance use disorder assessment prior to prescribing controlled substances


 **33 STATES AND DISTRICT OF COLUMBIA ACHIEVED THESE TWO INDICATORS AND MET THIS KEY ACTION**



INTEGRATING PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) INTO CLINICAL SETTINGS

PDMPs curtail doctor shopping and identify providers who prescribe outside of accepted medical practice. **States should:**

- Have an operational PDMP
- Require prescriber use of the state PDMP for initial prescriptions
- Permit delegate access
- Require collection of prescription information within 24 hours or less
- Permit interstate sharing of state PDMP data

 **39 STATES AND DISTRICT OF COLUMBIA ACHIEVED AT LEAST FOUR OF THE FIVE INDICATORS AND MET THIS KEY ACTION**



IMPROVING DATA COLLECTION AND SHARING

Improved data collection is vital to fully understand and address the scope of the epidemic. Critical actions include screening for—and identifying—all drugs present in overdose fatalities and the prompt reporting of drug overdoses by hospitals, EMTs, law enforcement, coroners and medical examiners.

States should:

- Require the reporting of drug overdose cases

 **7 STATES ACHIEVED THIS INDICATOR AND MET THIS KEY ACTION**



TREATING OPIOID OVERDOSE

Naloxone, a lifesaving opioid overdose reversal medication, should be widely available and covered by all insurance plans. Good Samaritan laws should ensure that people can administer naloxone and call emergency services without fear of criminal penalty. **States should:**

- Provide immunity to prescribers, dispensers and community members to possess, prescribe, distribute and administer naloxone by a third party with or without a standing order
- Pass Good Samaritan laws
- Require insurers and third-party payers to include coverage of naloxone

 **38 STATES AND DISTRICT OF COLUMBIA ACHIEVED AT LEAST TWO OF THE THREE INDICATORS AND MET THIS KEY ACTION**




INCREASING AVAILABILITY OF OPIOID USE DISORDER TREATMENT

States must expand capacity for treatment, requiring both public and private health insurers to cover medication-assisted treatment (MAT) and remove caps on duration of treatment. As the number of treatment centers grows, oversight is needed to address minimum treatment standards and predatory practices.

States should:

- Require Medicaid formulary to reimburse for all three forms of MAT—methadone, naltrexone and buprenorphine—in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders

 **37 STATES AND DISTRICT OF COLUMBIA ACHIEVED THIS INDICATOR AND MET THIS KEY ACTION**

KEY ACTIONS

MANDATING PRESCRIBER EDUCATION

The medical community is a vital partner in addressing the opioid epidemic. An Institute of Medicine report recommends that all health care providers keep their knowledge of pain management current through continuing medical education (CME) (National Research Council, 2011). Licensure, certification and recertification examinations should include assessments of providers' pain management knowledge. Unfortunately, research has shown that practicing physicians received fewer than 12 hours of pain management education in medical school (Mezei & Murinson, 2011).

Addressing this knowledge gap is necessary to reduce dangerous prescribing practices and improve pain treatment. Twenty-five states, an increase of eight since 2016, require education for physicians and other

professionals who prescribe controlled substances to treat pain (Federation of State Medical Boards, 2017). For example, Kentucky doctors are required to take 4.5 hours of training related to KASPER (Kentucky All Schedule Prescription Electronic Reporting), pain management and addiction disorders. In New Mexico, prescribers who are registered with DEA must complete a five-hour CME class on pain and addiction.

Not all prescribers are required to register with DEA—only those who prescribe controlled substances such as opioid pain medications. Therefore, DEA controlled-substance registration and renewal provide a targeted opportunity to address this knowledge gap. In 2015, the National Safety Council called on DEA to require education for opioid prescribers.



34 STATES AND DISTRICT OF COLUMBIA ACHIEVED THIS INDICATOR AND MET THIS KEY ACTION

- Require all medical providers to complete continuing education related to addiction, opioid prescribing or chronic pain management

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID
IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA
RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	

New Mexico Implements Effective Continuing Education Program

Development and implementation of a mandatory continuing medical education program in New Mexico helped reverse the high overdose death rate and save lives.

In 2011, the New Mexico Medical Board assembled a coalition to develop CME content. The coalition consisted of members from the New Mexico Department of Health; medical, nursing and pharmacy boards; a community health care outcomes group; and a veterans' health care group. Because primary care physicians treat the majority of patients with non-cancer chronic pain, the Board focused on targeting them with education efforts. Guidelines for the CME programs were implemented in August 2012:

- Five hours of CME on chronic pain management, prescribing best practices, non-opioid pain alternatives, addiction education and use of state prescription monitoring program (PMP)
- All prescribers were required to complete the CME between Nov. 1, 2012 and June 30, 2014
- All DEA-registered practitioners were required to take the CME when renewing their licenses—no specialty was exempt

In addition, the rule mandated that all prescribers sign up for the state PMP, query it before writing new opioid prescriptions and query it every six months after a prescription was written

(New Mexico Board of Medicine, 2017).

Measurable Success

Clinicians were surveyed before and after taking the new CME course. They averaged a 17 percent increase in knowledge scores on opioid and addiction topics. In addition, from 2011 to 2012, these improvements were achieved:

- Reduction in total morphine milligram equivalents (MME) prescribed
- Reduction in opioid MME per prescription
- Reduction of 7 percent in total drug overdose death rate (from 25.9 to 24 per 100,000)
- 6.9 percent fewer deaths (521 to 485)

By prioritizing creation and rapid implementation of a CME for all prescribers, New Mexico reduced the amount of opioids prescribed and saved lives (Katzman, et al., 2014).

KEY ACTIONS

IMPLEMENTING OPIOID PRESCRIBING GUIDELINES

Opioid prescribing guidelines help medical providers make informed decisions about pain treatment based on risks and benefits of opioid use compared to non-opioid treatments. Medical professional organizations, state licensing agencies, state medical boards and the CDC have published opioid prescribing guidelines.

Forty-one states have adopted their own opioid prescribing guidelines, using regulatory and/or voluntary approaches for development and implementation. Guidelines may cover a variety of clinical settings including chronic pain, emergency medicine and workers' compensation. These prescribing guidelines are crucial to ensure that physicians follow best practices to help legitimate patients receive the pain relief they need and minimize risk of addiction.

CDC 2016 Opioid Prescribing Guideline for Chronic Pain

The guideline includes recommendations on the use of opioids in treating pain that lasts longer than three months, or past the time of normal tissue healing. This guideline informs primary care providers on treatment of chronic, non-cancer pain, including:

- Dosage recommendations—even relatively low doses (20–50 morphine milligram equivalents (MME) per day) increase risk
- Risk assessment criteria for all patients, not just those at high risk
- Specific recommendations on monitoring and discontinuing opioids when risks and harms outweigh benefits

Iowa, Kentucky, North Carolina, Oregon, West Virginia and Wisconsin have adopted the CDC opioid prescribing guideline for chronic pain.



33 STATES AND DISTRICT OF COLUMBIA ACHIEVED TWO INDICATORS AND MET THIS KEY ACTION

- Adopt recommendation that practitioners have a written treatment plan for the treatment of chronic pain
- Adopt recommendation that practitioners perform a physical examination and substance use disorder assessment prior to prescribing controlled substances

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID
IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA
RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	

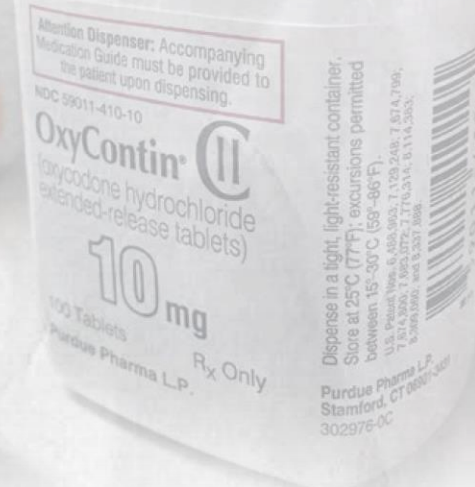
West Virginia Adopts CDC Prescribing Guideline

A panel of West Virginia medical and public health experts determined how the CDC guideline would be implemented across the state.

West Virginia had the highest opioid overdose death rate in the nation in 2015 (CDC National Vital Statistics Report, 2017). It needed a solution that would reduce opioid misuse and overdose without restricting legitimate use by acute and chronic pain patients.

In 2017, West Virginia implemented the Safe & Effective Management of Pain (SEMP) guidelines to give both prescribers and patients clear direction on safe practices for the use of prescription opioids in the management of pain. These guidelines are based on the CDC 2016 Opioid Prescribing Guideline for Chronic Pain, with special emphasis on making them easy to incorporate into pain management practice.

The SEMP guidelines offer objective methods to determine whether chronic pain patients can benefit from non-opioid treatments, reducing patient risk of dependence and misuse. Clinical treatment algorithms offer the clinician and patient alike a clear plan for pain treatment. A robust toolkit, available at www.semp.org/handouts, clearly shows how clinicians can incorporate all facets of the CDC guideline into everyday practice.



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KEY ACTIONS

INTEGRATING PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) CLINICAL SETTINGS

PDMPs are state-run electronic databases designed to monitor the prescribing of controlled substances and to identify individuals who are at high risk of using opioids for non-medical purposes. In some states, these are mandatory and require physicians to participate; other states have voluntary programs. At the time of publication, Missouri was the only state that did not have a statewide PDMP.

In states where physicians were required to check an electronic database before writing an opioid prescription, the odds that two or more doctors would be giving pain relievers for non-medical purposes to a single patient were reduced by 80 percent. States that implemented voluntary monitoring programs showed a 56 percent reduction in doctor-shopping

(Ali, Dowd, Classen, Mutter, & Novak, 2017).

Mandatory PDMP use is a critical component in the fight against opioid misuse and overdose. A 2015 study found that requiring a PDMP helped reduce numbers of prescriptions and pills per prescription, while moderately increasing prescriptions for non-opioid pain relievers such as ibuprofen and acetaminophen (Rasubala, Pernapati, Velasquez, Burk, & Ren, 2015). A 2016 study found that a mandatory PDMP policy helped significantly reduce overall opioid prescriptions and opioid overdose death rates (Dowell, Zhang, Noonan, & Hockenberry, 2016). States requiring both the use of a PDMP and regulating pain clinics saw opioid prescription rates fall by 10.6 percent and reduced opioid overdose death rates

(American Medical Association, 2018).



39 STATES AND DISTRICT OF COLUMBIA ACHIEVED AT LEAST FOUR OF THESE FIVE INDICATORS AND MET THIS KEY ACTION

- Have an operational PDMP
- Require prescriber use of the state PDMP for initial prescriptions
- Permit delegate access
- Require collection of prescription information within 24 hours or less
- Permit interstate sharing of state PDMP data

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID
IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA
RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	

CDC Opioid Guideline Can Be Integrated at the Point of Care

Ezekiel Fink, M.D., Medical Director of Pain Management at Houston Methodist Hospital, was a member of the advisory panel on developing the CDC 2016 Opioid Prescribing Guideline for Chronic Pain. This standard redefined best practices, including the recommendation that prescribing guidelines be used with all patients instead of only high-risk patients, and recommending lower dosages for fewer days.

Dr. Fink and his colleagues at Houston Methodist, including nursing and pharmacy staff, helped develop opioid guideline technology that advises clinicians on opioid prescribing best practices. The software integrates with patients' electronic health records (EHR) for use at the point of care. When a clinician prescribes opioids outside the CDC guideline, the messaging pops up over the patient's EHR, prompting a conversation between the patient and clinician about options for pain management. The clinician can override the guideline based on the patient's needs.

"Our goal is to transition away from the opioid-centered pain management model and ensure doctors have exhausted all non-opioid options before writing the prescription," Dr. Fink says. "Primary care physicians are the first line in managing patients. They are treating people for chronic pain every day. And they are writing the lion's share of opioid prescriptions."

Future goals include integration with state PDMPs to provide a seamless experience for prescribers.

KEY ACTIONS

IMPROVING DATA COLLECTION AND SHARING

Tracking opioid use by making overdose a reportable condition helps medical providers, law enforcement and public health officials understand the scope of the problem.

Months-long lags in the reporting of overdose fatalities delay public health and law enforcement response. Often, critical data is not collected or shared between state and community stakeholders in a timely manner. A better understanding of the circumstances associated with an overdose can improve state response and coordination. States currently require the reporting of a number of infectious diseases and other health conditions within specific time frames in order to mount an appropriate health response. Therefore, states should make overdose and overdose fatalities a reportable health condition, so that stakeholders have accurate, timely and actionable information.

In 21 states, more than 25 percent of overdose death certificates did not specify the drugs involved in the death (Ruhm, 2017). Better mortality data is needed to accurately track the involvement of fentanyl and other drugs in opioid-related deaths. A 2013 study documented variation in how states certify manner of death, including toxicology, and found that death certificates often do not specify the drugs involved in overdose deaths (Warner, Paulozzi, Nolte, Davis, & Nelson, 2013).

A CDC Health Advisory Network (HAN) alert recommends that medical examiners and coroners screen for fentanyl in suspected opioid overdose cases, especially in areas reporting increases in fentanyl seizures or unusually high spikes in heroin or unspecified drug overdose fatalities (CDC HAN Alert, 2016). The HAN alert further recommends that coroners and medical examiners use Substance Abuse and Mental Health Services Administration (SAMHSA) consensus recommendations to report opioid-related deaths (Goldberger, Maxwell, Campbell, & Wildford, 2013). The National Safety Council urges states to adopt these recommendations. Improved data collection is vital to fully understand the scope of the epidemic and react quickly when deadly new drugs are entering the community.



7 STATES ACHIEVED THIS INDICATOR AND MET THIS KEY ACTION:

- Require the reporting of drug overdose cases

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID
IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA
RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	

Arizona Compels Data Collection and Sharing

Arizona opioid overdose deaths increased 74 percent from 2012 to 2016 (2016 Arizona Opioid Report, 2017). **In 2017, the governor declared a state of emergency and issued an executive order mandating real-time reporting of opioid overdoses.**

The emergency declaration allowed immediate dedication of public funds toward fighting the opioid epidemic. In addition to the declaration, the governor also issued an executive order mandating real-time reporting of opioid overdoses. This order allows the Arizona Department of Health Services (ADHS) to put more life-saving resources into the hands of law enforcement, first responders and community partners.

Since the emergency declaration, hospitals and medical providers have been sending data to the state health department. State health officials and other crucial parties can better understand the circumstances surrounding overdoses and deaths, and more effectively respond and allocate state resources. As part of the data reporting requirements, the ADHS created a real-time dashboard listing opioid overdoses and deaths.

ADHS also worked with the Arizona Attorney General's Office to develop emergency rules for continued reporting. The emergency rules went into effect Oct. 9, 2017, ensuring continued reporting of suspected opioid overdoses, suspected opioid deaths, suspected cases of infants experiencing neonatal abstinence syndrome, naloxone dispensed by pharmacists and naloxone administered by first responders.

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KEY ACTIONS

TREATING OPIOID OVERDOSE

Opioid overdoses are reversible with the timely administration of naloxone, an opioid antagonist that binds to receptors in the brain and blocks the effects of opioids. Administered as a nasal spray or injection, naloxone is not a controlled substance and has no misuse potential. Making naloxone widely available will save lives.

All 50 states and the District of Columbia have passed laws that improve access to naloxone. Some of these laws grant immunity from prosecution to prescribers and dispensers. Others allow licensed health care professionals to prescribe naloxone for use by a third party such as a family member. A naloxone standing order lets pharmacies and community programs dispense naloxone without a prescription. Because of naloxone laws, more than 150,000 people have been trained and more than 26,000 overdoses reversed (Wheeler, Jones, Gilbert, & Davidson, 2015).

The removal of legal barriers, however, may not be enough to increase naloxone access among uninsured and underserved populations. Strong state efforts are needed to improve the affordability of naloxone (Gupta, Shah, & Ross, 2016). The price of naloxone has increased significantly, part of a larger trend of

increasing prices for generic medications, placing a greater burden on organizations that put this lifesaving drug in the hands of first responders and distribute the medication at no cost to opioid users and their families. (Davis & Carr, 2017).

Individuals with insurance may have fewer problems accessing naloxone. Federal regulations require many private insurers and all Medicaid expansion plans to cover the opioid overdose reversal medication. At the state level, Illinois, New York and Rhode Island require private insurers to cover naloxone, and remove prior approvals and cost sharing requirements (Davis & Carr, 2017).

Friends or family members may be in the best position to save a life by calling emergency services and administering naloxone. However, some overdose bystanders sometimes fail to summon medical assistance for fear of police involvement (Tobin, Davey, & Latkin, 2005). Forty states have passed Good Samaritan laws that protect bystanders from any legal actions. These laws protect individuals from criminal prosecution or parole violations if they contact emergency responders in response to a drug overdose.



38 STATES AND DISTRICT OF COLUMBIA ACHIEVED AT LEAST TWO OF THE THREE INDICATORS AND MET THIS KEY ACTION

- Provide immunity to prescribers, dispensers and community members to possess, prescribe, distribute and administer naloxone by a third party with or without a standing order
- Have a Good Samaritan law*
- Require insurers and third-party payers to include coverage of naloxone

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID
IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
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* State achieved this indicator if it has a Good Samaritan law that addresses drug overdoses, though the law might not be comprehensive. For example, the law could apply only to controlled substance possession, paraphernalia or other violations, but not necessarily all three. And it may not apply to arrests or charges, but does apply for prosecution.

Naloxone Is Only the First Step in Saving Lives

Emergency departments can take additional measures with opioid overdose survivors, ensuring access to naloxone and introducing survivors to medication assisted treatment program options before they are released.

"Naloxone is usually administered before an overdose victim even reaches the emergency department—by a family member or emergency medical technician," says Natalie Kirilichin, M.D., attending emergency medicine physician and assistant professor with the George Washington University Department of Emergency Medicine.

"While these patients are still in the emergency department, we must also capitalize on the opportunity to initiate treatment for opioid use disorder," Dr. Kirilichin says. "People whose overdose has been reversed are at their most vulnerable. They have been given a second chance at life, and may be more open to hearing about treatment options. ED clinicians need to change their perspective to treating OUD rather than treating an overdose."

A 2015 clinical trial reported excellent results for patients receiving ED-initiated buprenorphine, with increased engagement in addiction treatment, reduced illicit opioid use and decreased use of inpatient substance use treatment programs (D'Onofrio, et al., 2015). Dr. Kirilichin notes that a comprehensive program should include care coordination, counseling and community support. "It's our responsibility to stay a step ahead and keep people from overdosing again," she says.



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KEY ACTIONS

INCREASING AVAILABILITY OF OPIOID USE DISORDER TREATMENT

Opioid use disorder (OUD) occurs when the recurrent use of opioids causes health issues, disability, and the failure to meet major responsibilities at work, school or home. OUD is a brain disease, and a serious chronic health condition like heart disease or diabetes. As with other chronic conditions, medication and support to make lifestyle changes are necessary to treat and manage OUD. If left untreated, OUD will worsen, often resulting in death. In 2016, more than 2.1 million people had an OUD related to use of opioid pain relievers or heroin (SAMHSA, 2017).

Only one in 10 people with a substance use disorder (SUD) receives any specialized treatment. Medication assisted treatment (MAT)—the combination of psychological and behavioral therapy with FDA-approved medications such as methadone, buprenorphine and naltrexone—is the most effective way to treat OUDs (Volkow, Frieden, Hyde, & Cha, 2014). However, availability of treatment using these medications lags behind the need for OUD treatment in nearly every state (Jones, Campopiano, Baldwin, & McCance-Katz, 2015). Many treatment facilities either do not offer MAT or fail to offer patients all three FDA-approved medications to treat opioid use disorder.

Analysis of more than 12,000 U.S. treatment facilities found that about 40 percent offer at least one form of MAT, with 23 percent offering two forms of MAT (Jones, Honermann, Sharp, & Millet, 2017). Only 319 facilities report offering all three forms of MAT and even fewer, 234 facilities, also accept Medicaid patients. Eight states do not have any treatment facilities that report offering all three forms of MAT (Jones, Honermann, Sharp, & Millet, 2017). Fourteen states do not have facilities offering all three MAT options that also accept Medicaid patients (Jones, Honermann, Sharp, & Millet, 2017).

The American Society of Addiction Medicine (ASAM) developed evidence-based clinical guidance and criteria to ensure that patients suffering from OUD are offered proven treatment options and appropriate levels of care. These guidelines incorporate various forms of MAT, which are needed to address patients in various stages of dependence, withdrawal or relapse. States can require that insurers and managed care organizations (MCOs) use ASAM or other evidence-based guidelines when determining what level of care is needed or covered (ASAM, 2015).



37 STATES AND DISTRICT OF COLUMBIA ACHIEVED THIS INDICATOR AND MET THIS KEY ACTION

- Require Medicaid formulary to reimburse for all three forms of MAT, methadone, naltrexone and buprenorphine, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID
IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA
RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	

Rhode Island Requires Levels of Care for Opioid Overdose Patients in Emergency Departments

These levels of care were implemented in 2017 to improve emergency department (ED) response to drug overdoses. The act mandates that Rhode Island EDs and hospitals must provide appropriate care and recovery support, and insurers must cover expanded medication assisted treatment (MAT).

Each Rhode Island ED or hospital determines the level of care to be provided by its facility and completes requirements for state certification.

Level Three standards of care are the minimum acceptable:

- Provide comprehensive discharge planning
- Screen all patients for substance use disorder
- Provide safe storage and disposal education to all patients who are prescribed opioids
- Dispense or prescribe naloxone to all patients at risk
- Offer patients peer recovery support services in the ED
- Report all overdoses within 48 hours to state Department of Health
- Perform lab screening on overdose patients, including screening for fentanyl

Level Two takes the requirements a step further by requiring facilities to have addiction specialists on staff, actively integrating subject matter expertise and implementing infrastructure to provide a more complex level of care.

Level One represents organizations that have become accredited Centers of Excellence, with the capacity to meet the health care needs of the most complex patients with OUD and overdose.

PUBLIC HEALTH APPROACH

SOLVING THE CRISIS WITH A PUBLIC HEALTH APPROACH

According to the Association of State and Territorial Health Officials (ASTHO), a public health approach is vital to addressing the societal consequences of opioid misuse and addiction. The public health community is positioned to educate Americans that substance use disorders are chronic brain diseases that require prevention, treatment and intervention to save lives.

The six key actions in this report can be viewed through the ASTHO public health prevention framework: primary prevention actions, secondary treatment-oriented actions and tertiary rescue actions.

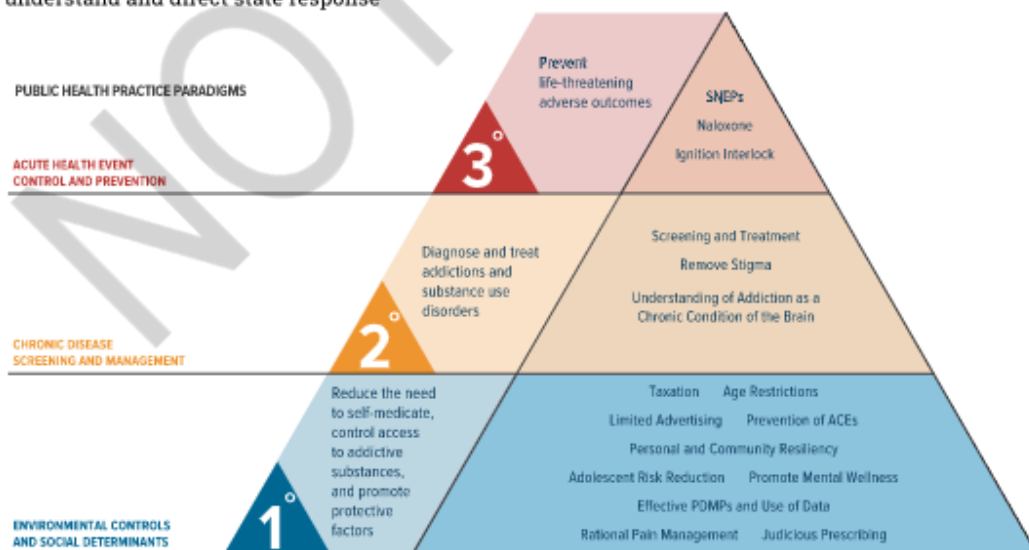
Primary actions (pyramid bottom) focus on personal, community and other risk factors that may lead to opioid misuse and addiction. These preventive actions include:

- Implementing clinical guidelines to optimize opioid prescribing and pain treatment
- Encouraging regular and widespread use of PDMPs to reduce doctor shopping and eliminate pill mills
- Expanding of data collection and data sharing to better understand and direct state response

- Addressing individual risk factors for addiction through programs to promote mental wellness and prevent adverse childhood events (ACEs)

Secondary actions (pyramid center) identify, diagnose and treat addiction and substance use disorders. This report identifies a number of actions that states can implement to remove barriers to effective substance use treatment and expand access to medications to treat opioid use disorders. Equally important is erasing the stigma of substance use disorder, which makes it difficult for people suffering from addiction to seek and receive the treatment and services they need.

Tertiary actions (pyramid top) prevent death and lessen adverse outcomes. This report recommends naloxone best practices that states can implement to widen naloxone access and reverse more opioid overdoses. Other actions include expanding availability of syringe and needle exchange programs (SNEPs) to prevent HIV and hepatitis infections, which are deadly and costly health conditions that result from intravenous drug use.



RECOMMENDATIONS

The following recommendations should be implemented by state leaders to reverse this epidemic and save lives.



KEY ACTION: Mandating prescriber education

Require prescribers to have ongoing medical education on effective pain management and identifying substance use disorders.

Require continuing medical education (CME) for prescribers of controlled substances. The proposed CME should include the following topics:

- Relative efficacy and risks of medications used to treat acute and chronic pain
- Responsible prescribing, including the use of tools such as state Prescription Drug Monitoring Programs (PDMPs)
- Overview of substance use disorders and effective treatments
- Linkage to treatment for those with substance use disorder



KEY ACTION: Implementing opioid prescribing guidelines

State opioid prescribing guidelines should address:

- When opioid treatment is appropriate, the appropriate maximum dose and duration of opioid treatment
- Monitoring treatment to ensure patient safety
- Ownership requirements to ensure that pain and treatment clinic owners can be held accountable by state licensing authorities for prescribing outside the standard of care



KEY ACTION: Integrating Prescription Drug Monitoring Programs (PDMPs) Into Clinical Settings

Make PDMPs easy to use by:

- Requiring prescribers to access PDMP prior to prescribing a controlled substance
- Requiring collection of prescription data within 24 hours
- Allowing physicians and dispensers to appoint delegates or staff to access PDMP data
- Allowing insurer and delegate access
- Upgrading PDMP technology to deliver real-time data into clinical settings
- Integrating PDMP data into physician and hospital electronic health record systems

- Simplifying the PDMP registration process and integrating with other licensing processes
- Allowing interstate sharing of PDMP data



KEY ACTION: Improving Data Collection and Sharing

Improve reporting of drugs involved in drug overdose fatalities:

- Require reporting on overdose, deaths from overdose and neonatal abstinence syndrome within five days
- Encourage medical examiners and coroners to screen for fentanyl for suspected opioid overdose cases
- Require coroners and medical examiners to use SAMHSA consensus recommendations to report opioid-related deaths



KEY ACTION: Treating Opioid Overdose

- Expand access to naloxone and remove barriers to its purchase and use
- Enact laws allowing standing orders and third party prescriptions for naloxone
- Require insurers and other relevant payers to ensure that naloxone is covered by insurance plans, including public plans
- Enact Good Samaritan laws to remove barriers to seeking help for a drug overdose



KEY ACTION: Increasing availability of opioid use disorder (OUD) treatment

Expand use of medication assisted treatment (MAT); ensure it is offered and available at state-funded treatment providers

- Require that level of care determinations be made using ASAM criteria or other evidence-based guidelines
- Assess the adequacy of insurer treatment-provided networks
- Require public and private health insurers to cover all FDA approved medications to treat addiction
- Remove any caps on MAT duration

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The National Safety Council grades the
50 states and District of Columbia on
their efforts to combat the opioid crisis.

7 states earned a failing grade

30 states are lagging

**13 states and District of Columbia
are improving**



How does **your state** measure up?



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The National Safety Council is a nonprofit organization whose mission is to eliminate preventable deaths at work, in homes and communities, and on the road through leadership, research, education and advocacy. Founded in 1913 and chartered by Congress, NSC advances this mission by partnering with businesses, government agencies, elected officials and the public in areas where we can make the most impact.

Visit our prescription drug initiative timeline to learn how the Council has addressed the opioid epidemic at:

nsc.org/OpioidTimeline

Explore drug overdose trends in more detail at:

injuryfacts.nsc.org/DrugOverdoses

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Appendix C

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Kathryn LaCroix	Director of Behavioral Health, Wind River Family & Community Clinic
Kathleen Brannan	SOAR Representative (SSI/SSDI Outreach Access and Recovery)
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Kelly Webb	Director of Eastern Shoshone Recovery Center
Andrea & Mary	Assistants and Counselors at Eastern Shoshone Recovery Center
Recovery Group	Eastern Shoshone Recovery Center

Appendix D

Articles from The New England Journal of Medicine



Perspective
JANUARY 3, 2019

Facing Opioids in the Shadow of the HIV Epidemic

Caroline M. Parker, M.A., Jennifer S. Hirsch, Ph.D., Helena B. Hansen, M.D., Ph.D., Charles Branas, Ph.D., and Silvia S. Martins, M.D., Ph.D.

The United States is in the midst of an opioid crisis. An estimated 2.1 million Americans had an opioid use disorder in 2016. The rate of opioid overdose deaths has increased by 500%

since 1999, and each day an estimated 115 Americans die from opioid overdose.¹ Despite the proven effectiveness of medication-assisted treatment (MAT) for opioid use disorders, the opioid mortality rate has now surpassed that of the AIDS epidemic during its peak in the early 1990s — a time when there was no effective treatment for HIV/AIDS.²

Given that U.S. HIV incidence and AIDS mortality declined dramatically after the advent of antiretroviral therapy in the mid-1990s, it is not surprising that the AIDS response is often celebrated not just as an unqualified success, but also as a blueprint for the response to other emerging threats to population health.³

However, there are vital lessons to be learned from failures in the response to HIV as well as from the successes. Learning these lessons will require a less celebratory accounting of where we stand with the current HIV epidemic than we have seen so far.

Effective treatment for HIV has been available in the United States for more than two decades, and the majority of people living with HIV in this country (86%) have now received that diagnosis. Still, less than two thirds of people living with HIV remain in care (62%), and viral suppression has been achieved in less than half the cases (49%).² The benefits of scientific progress have been unequally distributed, with growing

ethnic and sexuality-related disparities in new infections, dual diagnoses, and overall mortality. If current HIV diagnosis rates persist, one in two black men who have sex with men in the United States will contract HIV during their lifetime.²

This failure of equity should draw our attention to the importance of social factors in shaping who benefits from effective biomedical therapies. Each of the following lessons has the potential to improve the population health impact of MAT for opioid use disorder in the United States.

First, the existence of effective medical treatment does not mean that people who need treatment can and will obtain it. Even as efforts are under way to scale up access to MAT, it is vital not to assume a position of “if we build it, they will come.” Though MAT scale-up is a necessary step for increasing access, engaging the

80% of people with opioid use disorders who currently receive no treatment also requires identifying cultural, social, economic, and structural barriers to access to care.⁴ In areas where MAT is available, studies already reveal age-based, racial, and ethnic disparities in treatment engagement and completion.⁵ If we fail to address the contextual barriers that shape engagement with MAT, biomedical advances may actually exacerbate health disparities by benefiting people who are more socially advantaged rather than the population as a whole.

Second, we need to stop considering only one person at a time and address the structural drivers of the crisis. Since the 1990s, HIV researchers have recognized that the virus's spread is driven by structural factors such as economic inequality, sexual oppression, gender inequality, and racism. A key lesson for the opioid epidemic is that without achieving long-term changes in the structural inequalities that render some populations vulnerable to opioid addiction, we will not be able to slow the epidemic. Structural drivers of the opioid epidemic include eroding economic opportunity, market-driven health care, insufficient regulation of pharmaceutical markets, evolving approaches to pain treatment, and limited access to effective drug treatment. Combating the epidemic will require addressing these drivers.

Third, reducing stigma could improve access and adherence to treatment. Decades of HIV research demonstrate that stigma is an important structural barrier that undermines people's ability to access and engage with treatment, yet the vast majority of anti-

stigma interventions for HIV/AIDS have focused on changing individual attitudes, rather than on community or societal norms. If responses to the opioid crisis took a comprehensive approach to stigma, they could address family, community, and societal norms, extending far beyond targeting individual attitudes. Interventions that could combat drug-related stigma include legislative change to stop the criminalization of substance use disorders; antistigma training workshops for key community actors such as churches, police, and health care providers; and social marketing campaigns that promote tolerance and combat widespread discriminatory attitudes toward people with opioid use disorder. Development of these strategies could be greatly assisted by engaging directly affected communities in policymaking, service provision, and social marketing campaigns.

Fourth, mobilized family and community support networks can help improve health care engagement. Although HIV research shows that social support from family, community, and other social networks can facilitate HIV treatment and adherence, U.S. policymakers and public health practitioners have done little to leverage such resources for improving access. Similarly, there are unrealized opportunities to mobilize family support networks to improve access to MAT. Opioid interventions could include the creation of community groups to support the families of people living with opioid use disorder; coscheduling of health care appointments for patients and family members, including both biologic and de facto (chosen) families; and development of pol-

icies that recognize and compensate people for the care work that can be vital in the path to recovery.

Finally, community activism is crucial to making MAT widely available and increasing its uptake. Community activism and the engagement of civil society and stakeholders were crucial to expanding access to antiretroviral therapy. For the opioid epidemic, an analogous "opioid movement" may be required for MAT to become acceptable to — and demanded by — communities throughout the United States. This lesson is particularly pertinent given that methadone clinics have historically faced considerable community resistance in the United States. To promote civic mobilization among communities affected by opioid use, state and city governments could invest more money in existing community organizations, and universities and hospitals could implement community-based participatory interventions that engage community actors as partners in addressing the epidemic.

Taken together, these lessons add up to one powerful reminder: the response to the opioid epidemic must incorporate social as well as biomedical approaches in order to ensure effectiveness. In the United States, our failure to address the structural drivers of the HIV/AIDS epidemic led to the concentration of suffering among the most socially disadvantaged populations. As millions of dollars are appropriated at the state and federal levels for the opioid crisis, we face a choice. Committing those resources exclusively to biomedical solutions is likely to reproduce the sharp disparities that we have seen with HIV. Al-

tematively, learning from the failures of our response to HIV as well as our successes can help us leverage social and community support to ensure that the opioid response is maximally successful and benefits all sectors of society.

Disclosure forms provided by the authors are available at NEJM.org.

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The SUPPORT for Patients and Communities Act — What Will It Mean for the Opioid-Overdose Crisis?

Corey S. Davis, J.D., M.S.P.H.

Opioid-overdose deaths have increased every year for the past two decades, driving a drug-overdose epidemic that killed more than 72,000 Americans in 2017.¹ Thanks in large part to sustained efforts by health advocates, medical professionals, and affected people, Congress has acted on several occasions to address this ongoing and largely preventable crisis. In 2016, President Barack Obama signed the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, which contain numerous provisions designed to increase access to evidence-based care and treatment for people with substance use disorders (SUDs). Neither law substantially altered the federal policy landscape, however, and overdose-related deaths have continued to increase.

More than a decade into this crisis, the country still lacks an integrated federal response to reduce the rates of overdose-related death and disability. Although the office of the surgeon general has fought to address the stigma still

associated with addiction and has strongly supported proven public health interventions such as increased access to sterile syringes and the opioid-antagonist naloxone, the office of the attorney general has embraced a “war on drugs” approach focused on arrest and incarceration. Meanwhile, the Office of National Drug Control Policy has been without a director since President Donald Trump was inaugurated, and the Trump administration has threatened crippling cuts to its budget and purview. Republicans in Congress have repeatedly attempted to repeal the Affordable Care Act, a law that significantly reduced the number of people with heroin use disorders who are uninsured.²

Against this backdrop, Trump signed the SUPPORT for Patients and Communities Act in October 2018. Although the 250-page law does little to further a coordinated federal strategy for addressing the epidemic, many of its provisions will be beneficial for people with SUDs and those at risk for SUDs, including provisions

that are designed to improve pain management, support the development of the SUD-treatment workforce, and eliminate kickbacks for referring patients to so-called recovery homes. The law’s most important provisions, however, are those intended to increase access to evidence-based treatment and follow-up care, particularly for pregnant women, children, people in rural areas, and people in recovery from an SUD.

Opioid-agonist therapy with methadone or buprenorphine is the standard for treating opioid use disorder (OUD), but legal restrictions and lack of funding have made these medications inaccessible for many people: only about 20% of Americans with OUD report having received treatment in the previous year.³ The law attempts to address this lack of access to opioid-agonist therapy and other services and supports.

It focuses particular attention on pregnant women and children. Perhaps most notably, it requires that state Children’s Health Insur-

ance Program plans provide mental health and SUD benefits on par with those for physical health conditions. It also clarifies that states may use Medicaid funds to pay for services for babies with neonatal abstinence syndrome, including counseling and other services for mothers and other caretakers, and makes a technical change to permit pregnant and postpartum women in what are known as Institutions for Mental Disease (IMDs) to receive Medicaid-covered care outside those facilities. The SUPPORT law also addresses a wrinkle in existing law by permitting young adults who were formerly in foster care to receive Medicaid coverage until 26 years of age, even if they leave the state where they aged out of the foster-care system.

SUPPORT focuses on older Americans as well, in part by improving screening for SUDs among Medicare beneficiaries and mandating coverage of services provided in opioid treatment programs, including opioid-agonist therapy and related counseling. Because Medicare does not currently cover services provided in these federally certified outpatient facilities — which traditionally provided methadone but increasingly offer buprenorphine as well — this change has the potential to dramatically increase access to these proven treatments.

The law also seeks to increase access to treatment more generally. In one potentially substantial change, it partially repeals the so-called IMD exclusion through September 2023. Under existing law, Medicaid does not cover treatment in IMDs that have more than 16 beds, including inpatient treatment facilities, for people younger than 65 years of age. The

new law permits states that meet certain requirements to use Medicaid funds to cover up to 30 days per year of treatment in certain IMDs for people with an SUD who are 21 to 64 years of age. Because of extensive advocacy by the addiction medicine and health policy communities, funded IMDs must follow evidence-based practices, including offering both opioid-antagonist medications and buprenorphine. The law prohibits states that expand IMD treatment under this provision from reducing spending on outpatient and community-based SUD services and requires them to have a plan to ensure that people with SUDs are placed in an appropriate level of care and to cover the cost of that care.

SUPPORT also aims to expand both the number and reach of SUD providers. Less than 5% of practicing physicians have the necessary authorization to prescribe buprenorphine to treat OUD, and federal law caps the number of patients each provider can treat. In part because of these restrictions, nearly half the counties in the United States — and more than 60% of rural counties — don't have a single physician authorized to prescribe buprenorphine.⁴ SUPPORT makes permanent CARA's temporary authorization for some nurse practitioners and physician assistants to prescribe buprenorphine to treat OUD, temporarily permits certain other nurses to prescribe the medication, and liberalizes the patient cap. It also creates a loan-repayment program for certain SUD-treatment professionals practicing in high-need areas, although no funds are appropriated to implement the program.

The law further aims to reduce

disparities in access to treatment by requiring the Department of Health and Human Services (HHS) to issue guidance outlining opportunities for states to receive Medicaid reimbursement for assessment, medication-assisted treatment, counseling, and related SUDs services delivered using telehealth. This guidance, combined with a recently issued memo that clarifies that buprenorphine may be prescribed using telemedicine and a separate provision in the law that expands Medicare payment for some SUD services provided using telehealth, may help alleviate barriers to opioid-agonist therapy for people in rural areas and others without easy access to providers who offer SUD treatment.

Finally, the law takes several steps to improve transitions for people leaving institutional settings and those in recovery from an SUD. Medicaid does not cover services provided in jails and prisons, and many states terminate enrollees' coverage if they become incarcerated. Under the SUPPORT law, coverage for juvenile Medicaid enrollees must be suspended rather than terminated if they are incarcerated and must be reinstated on their release. The law also authorizes (but does not fund) a pilot program that would direct funding to states to provide people in recovery with stable housing for up to 2 years and requires HHS to convene a stakeholder group to develop best practices for care coordination for people leaving incarceration and to publish minimum standards for recovery housing. HHS is also required to issue a letter to state Medicaid directors outlining opportunities for improving care transitions for people leaving institutions, including the possibili-

ity of allowing such people to receive Medicaid coverage up to 30 days before their release date — although it is not clear that this policy is permissible under current Medicaid law.⁵

Although SUPPORT is a step in the right direction, substantially altering the trajectory of the opioid epidemic requires a comprehensive, integrated, and public health-oriented response coordinated throughout all branches and levels of government. Every dollar spent on incarcerating a person who uses drugs is a dollar that is not spent on prevention or treatment, and every person removed from the Medicaid rolls is a person who is unable to receive evidence-based care. We

have the tools and knowledge to reverse the unprecedented, and largely preventable, avalanche of overdose-related morbidity and mortality. The question is not how to end the crisis of opioid-related harm but whether we will choose to mount an effective, evidence-based, and equity-focused response. The lives of thousands of people depend on the answer.

Disclosure forms provided by the author are available at NEJM.org.

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Reducing Protections for Noncitizen Children — Exacerbating Harm and Trauma

Ryan Matlow, Ph.D., and Daryn Reicherter, M.D.

On June 26, 2018, a federal judge ordered the Trump administration to reunite families that it had separated at the U.S.–Mexico border. As of mid-October, however, an analysis by the American Civil Liberties Union showed that 245 children were still in government custody. About half those children remained in the United States when their parents were deported and were not seeking reunification; the other half were still waiting to be reunited with their parents.¹ Meanwhile, the total number of undocumented immigrant children in U.S. government custody has reached unprecedented levels (more than 14,000 as of mid-November), and President Donald Trump con-

tinues to crack down on immigrant families seeking asylum.

As part of the ongoing effort to deter immigrants from attempting to enter the United States, the Departments of Homeland Security (DHS) and Health and Human Services (HHS) have released a proposal (DHS Docket No. ICEE-2018-0002) to establish new regulations to replace the existing standards of care for noncitizen children. The current standards were established by the 1997 Flores Settlement Agreement, which resulted from a class action lawsuit filed against the government in response to the mistreatment of immigrant children in U.S. custody. Although the proposed regulations mirror much of the lan-

guage in the Flores Settlement Agreement, the new proposal includes provisions that would permit the detention of noncitizen children and their families for indefinite periods in facilities without appropriate and independent monitoring. According to the proposal, the goal of the regulations is to reduce operational difficulties stemming from state licensing requirements for housing children and families who are undergoing immigration proceedings.

We believe that this proposal presents a grave and urgent risk to the health and well-being of noncitizen children and their families and would have important negative consequences for the United States. Children and fam-

REVIEW ARTICLE

Julie R. Ingelfinger, M.D., Editor

Understanding Links among Opioid Use, Overdose, and Suicide

Amy S.B. Bohnert, Ph.D., and Mark A. Ilgen, Ph.D.

IN THE UNITED STATES, DEATHS DUE TO SUICIDE AND UNINTENTIONAL overdose pose a major, and growing, public health concern. The combined number of deaths among Americans from suicide and unintentional overdose increased from 41,364 in 2000 to 110,749 in 2017 and has exceeded the number of deaths from diabetes since 2010.¹ The increase represents more than a doubling in the age-adjusted rate of deaths from suicide and unintentional overdose (Table 1), according to data from national surveillance systems.² Accordingly, both suicide and unintentional overdose have been the focus of large-scale prevention efforts, such as the National Strategy for Suicide Prevention³ and the State Targeted Response to the Opioid Crisis grant program of the Substance Abuse and Mental Health Services Administration.

Both problems have connections with pain and opioid use.⁴⁻⁶ The use of potentially lethal drugs such as opioids has a clear, direct relationship to the risk of unintentional overdose. Perhaps less well known, opioids also are linked to suicide risk.⁹ Furthermore, opioid use disorders have a distinctly strong relationship with suicide as compared with other substance use disorders.¹⁰ In all, more than 40% of suicide and overdose deaths in 2017 were known to involve opioids (Table 1), with many more likely to have had unrecorded opioid involvement.

The common theme of opioid use underlying suicide and overdose poses questions of how these problems may be related to one another.⁶ This review describes what is known about the links between suicide and overdoses, with a focus on pathways through opioid use, issues of intent, risk factors, prevention strategies, and unresolved issues.

BIOLOGIC, MEDICAL, AND SOCIAL FACTORS AS LINKS

Many factors promote the initiation and persistence of opioid use, but several specific pathways toward vulnerability to overdose and suicide are worth highlighting.

PAIN AND RISK OF SUICIDE AND OVERDOSE

Pain causes alterations in the neurocircuitry related to reward, which result in vulnerability to suicide¹¹ and potentially to riskier use of opioids. This biologic mechanism is supported by epidemiologic data that have shown that chronic-pain diagnoses are linked to suicide,¹² and these associations are only partially explained by co-occurring mental health conditions.⁵ Pain is also associated with opioid overdose, but in contrast to suicide, the limited analyses available suggest that this association is mediated by the quantity of opioids prescribed.⁷

MEDICAL-SYSTEM DRIVERS OF OPIOID PRESCRIBING

Beginning in the early 2000s, opioids were increasingly used to treat chronic pain in the United States. This change came in response to concerns about the under-

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Table 1. Rates of Death from Suicide and Overdose in the United States, According to Year.^a

Cause of Death	Age-Adjusted Rate per 100,000 Americans																	
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Suicide	10.4	10.7	10.9	10.8	11.0	10.9	11.0	11.3	11.6	11.8	12.1	12.3	12.6	12.6	13.0	13.3	13.5	14.0
Intentional overdose	1.2	1.3	1.4	1.3	1.4	1.4	1.5	1.6	1.6	1.6	1.7	1.7	1.7	1.6	1.6	1.6	1.5	1.5
Intentional overdose involving opioids	0.3	0.3	0.4	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Unintentional overdose	4.3	4.7	5.8	6.5	6.9	7.7	9.0	9.6	9.9	10.0	10.4	11.3	11.2	11.9	12.8	14.5	17.8	19.7
Involving opioids	2.2	2.4	3.1	3.4	3.6	4.0	4.8	5.0	5.3	5.5	5.7	6.3	6.4	6.9	7.9	9.3	11.9	13.5
Suicide and unintentional overdose combined	14.7	15.4	16.8	17.2	17.9	18.6	19.9	20.9	21.5	21.7	22.5	23.6	23.8	24.6	25.8	27.8	31.3	33.7
Involving opioids	2.5	2.7	3.5	3.7	4.0	4.5	5.2	5.5	5.9	6.0	6.3	6.8	6.9	7.4	8.5	9.8	12.5	14.1

^aCategories were determined on the basis of the codes of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, that were obtained from death records. Suicide deaths were those with an underlying cause of death coded as X60 through X84, Y87.0, or Y87.1. Unintentional overdose deaths were those with an underlying cause of death coded as X40 through X45. Deaths involving opioids were those with multiple cause of death codes recorded as T40.0 through T40.4 or T40.6. Data were obtained from the Centers for Disease Control and Prevention.²

treatment of pain, new clinical guidelines, and the declaration by the Joint Commission on the Accreditation of Healthcare Organizations of pain as the "fifth vital sign."¹³ Consequently, the average dose of prescribed opioids in the United States increased from approximately 100 to approximately 700 morphine milligram equivalents per person per year between 1997 and 2007.¹⁴ The connections between the increased use of opioids medically and increases in overdoses was recognized toward the end of the first decade of the 2000s,^{8,15} but only more recently has a connection to death by suicide been recognized.⁶ In addition, given that opioid use disorders are linked to suicide and unintentional overdose,^{16,17} iatrogenic increases in opioid use disorders may also be contributing to the increasing rates of suicide and overdose. These population-level associations are consistent with patient-level analyses showing that higher dosages of prescribed opioids are associated with higher rates of fatal and nonfatal overdose and suicide events.^{4,7,18,19}

LARGE-SCALE SUPPLY AND DEMAND

There are two primary theories as to how opioid use functions as a common thread in the influence of large-scale factors on increasing rates of suicide and overdose deaths in the United States. One theory traces the causes to increased demand for opioids, and the other emphasizes the role of the supply of opioids.

First is the theory that both types of death represent "Deaths of Despair."^{20,21} This conceptualization posits that the rising rates of suicide and overdose among non-Hispanic, middle-aged white men are caused by the declining fortunes of the working class. In that framework, opioid use both within and outside of pain treatment is a way of coping with lack of opportunity. This theory is consistent with the declining opportunity for some as economic inequality rises²² and posits that these large-scale (macro-level) social factors cause some persons to feel despair and turn to opioid use to cope. Opioid use then worsens depressive symptoms, which increase the risk of suicide, and directly causes death from intentional and unintentional overdose. However, when an opioid use disorder develops, it has a profound influence on the risk of suicide and overdose as well as an effect on factors such as increased social isolation, legal problems, and unemployment. Thus, it is challenging to study

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this hypothesis without individual-level, longitudinal data.

An alternative hypothesis is that the increased availability of opioids is the underlying cause of increased nonmedical opioid use and opioid use disorders, which result in increased rates of suicide and overdose.²³ Previous drug “epidemics” have been based on the emergence of new drug forms (e.g., “crack” cocaine) or increased availability and have resulted in increases in adverse effects (e.g., poor birth outcomes²⁴). Specific to opioids, a spike in heroin availability in the late 1990s and early 2000s in Australia dramatically increased overdose rates, and subsequent reductions in availability led to a decline in overdoses.²⁵

As opioids became more available in the United States because of prescribing¹⁴ and, more recently, because of influxes of heroin^{26,27} and illicitly manufactured synthetic opioids,²⁸ the number of persons with opioid use disorders increased, as did the frequency of opioid use.^{29,30} The timing of these increases relative to trends in overdose and suicide is consistent with a supply-focused hypothesis. Nonetheless, it is impossible to know how much of the increase in supply was a response to demand. For example, escalating problems with respect to prescription opioid use could have created demand for heroin use, given differences in price and drug effects³¹ or because prescription opioids became less available for misuse.³²

Among patients who receive treatment with opioid analgesics, the quantity prescribed is another way to conceptualize opioid availability. The association between higher dosages of prescribed opioids and higher risk of overdose has been replicated repeatedly.^{7,18,29,33} A study involving patients at Veterans Affairs facilities also showed an association between higher prescribed dosage and higher rates of suicide death.⁴

Understanding the large-scale causes of the increases in suicide and unintentional overdose is important for implementing a policy response. The demand-side hypothesis (i.e., the “Deaths of Despair”) argues for a focus on social and economic policies, whereas the availability hypothesis may argue for law enforcement and regulatory efforts to reduce access. In general, with evidence from individual-level opioid availability and supply changes in Australia, support for a supply hypothesis is stronger than that for a demand hypothesis with respect to how opioid use

relates to overdose. There is much less research with regard to suicide. Moreover, a complex, integrated theory for both outcomes is indicated. Even if one of the two pathways has a greater role, ignoring the potential influence of the other pathway may result in a policy response that causes harm. Furthermore, factors that sustain existing problems related to opioids may be different from those underlying the initial development of these problems. Observers of the Australian heroin shortage hypothesized that the reductions in overdose would have been unlikely without the comprehensive programs of addiction treatment and harm reduction in that country.²⁵

OVERDOSE INTENT

An additional conceptual link between suicide and overdose emerges when we consider intentional overdoses, one type of suicide.⁶ It is challenging to classify overdose events according to intent, and this is particularly true for those that are fatal.^{34,35} Although the presence of a suicide note can make a determination relatively straightforward, such notes are found in fewer than a third of overdose deaths.³⁵ Furthermore, there is some evidence that intentionality of overdose events is dimensional, rather than categorical, and both fatal and nonfatal events may not be fully intentional or unintentional. For example, patients sometimes report that they cannot differentiate whether an overdose was a suicide attempt or unintentional.³⁶ In other cases, when a given patient survives an overdose, his or her perceived intent may change in retrospect. Consequently, intentional and unintentional overdoses may not be fully distinct outcomes.

SHARED RISK FACTORS

Research has identified several key factors, beyond opioid use, that are related to both suicide and overdose. The demographic characteristics that are associated with each cause of death are similar. Age-adjusted mortality rates in 2017² for both suicide and unintentional overdose in the United States were approximately twice as high among men as among women. In addition, death rates for both were highest in 2017 among people who identified as white or Native American and lowest among people who identified as

black or Asian. Rates were also highest during midlife (41 to 64 years of age) and lowest among older persons (≥ 65 years of age). When we examined groups defined according to age, sex, and race (Fig. 1), there were several notable divergences between the two causes of death. Suicide rates remained high for white men 65 years of age or older, but rates of unintentional overdose declined dramatically after 64 years of age in this group. In addition, black and Native American men and women as well as white women had notably higher rates of unintentional overdose than of suicide during midlife. Some of these differences may reflect known racial biases in medical-examiner rulings.³⁷

Most mental health conditions are linked to an increased risk of suicide.^{38,39} Similarly, nearly all common mental health conditions are associated with unintentional overdose, including both overdoses of illicit drugs and medication-related overdoses.⁴⁰ In a study that compared patients who died by intentional overdose with those who died by unintentional overdose, the associations of substance use disorders were generally stronger for unintentional overdoses and the associations of other mental health conditions were generally stronger for intentional overdose.⁴¹ Among the subgroup of patients receiving opioid analgesics, the association of mental health diagnoses and risk of overdose persists.⁴²

Persons with substance use disorders should be given particular attention for prevention of both suicide and overdose,^{10,40} and co-occurring mental health conditions within this group can further contribute to risk. Depressive symptoms that are reported by patients are associated with both suicide attempts and nonfatal overdoses in survey-based studies involving persons with substance use problems.⁴³ Given that people with opioid use disorders also are more likely than those without such disorders to meet criteria for additional mental health conditions,⁴⁴ the risk of both suicide and overdose is likely to be highest among those with these co-occurring conditions.

Use of other medications and drugs in combination with opioids can further increase risk. Concurrent use of recreational drugs, such as alcohol and cocaine, increases the risk of death.⁴⁵ Within patient populations, specific prescribing

patterns are related to the risk of both suicide and unintentional overdose. Use of benzodiazepines among patients who have received prescriptions for opioids is associated with unintentional overdose,^{33,46,47} and benzodiazepines are also associated with an increased risk of suicide.⁴⁸ Other central nervous system depressants, such as medications prescribed to treat insomnia, have not been well-studied but may potentiate the effects of opioids. In contrast, concurrent use of antidepressants, a well-established treatment for suicidality,⁴⁹ has also been shown to reduce the risk of drug overdose among patients with depression who were receiving opioid analgesics.³³

SHARED PREVENTION APPROACHES

There are a number of potential prevention opportunities based on these shared conceptual links. The design and structure of the prevention strategies vary according to type of opioid exposure and whether they aid in identifying risk or preventing harm among those at risk. Table 2 positions each strategy within this framework.

To assess risk among patients who have received prescriptions for opioids, several research teams have developed risk scores, which are electronic tools that calculate a specific patient's level of risk for suicide, overdose, or both on the basis of data from electronic health records.⁵⁰⁻⁵² Such an approach is agnostic to whether the risk factors are causal and serves to identify persons who could benefit from additional services. In the Veterans Health Administration, a risk score was developed for both suicide and overdose together and has been implemented nationally.⁵⁰ For patients who are identified as being at increased risk, an in-depth assessment of behavioral risk factors, suicidal thoughts or plans, and previous suicide attempts and nonfatal overdoses is an important clinical next step.

Counseling or psychotherapy that is delivered by mental health professionals to at-risk persons is an additional shared prevention approach. Cognitive behavioral therapy is an evidence-based treatment for the prevention of suicide.^{53,54} There is emerging evidence that behaviors associated with overdose risk can be reduced among persons with medical and nonmedical use of opioids through the counseling method of motivational

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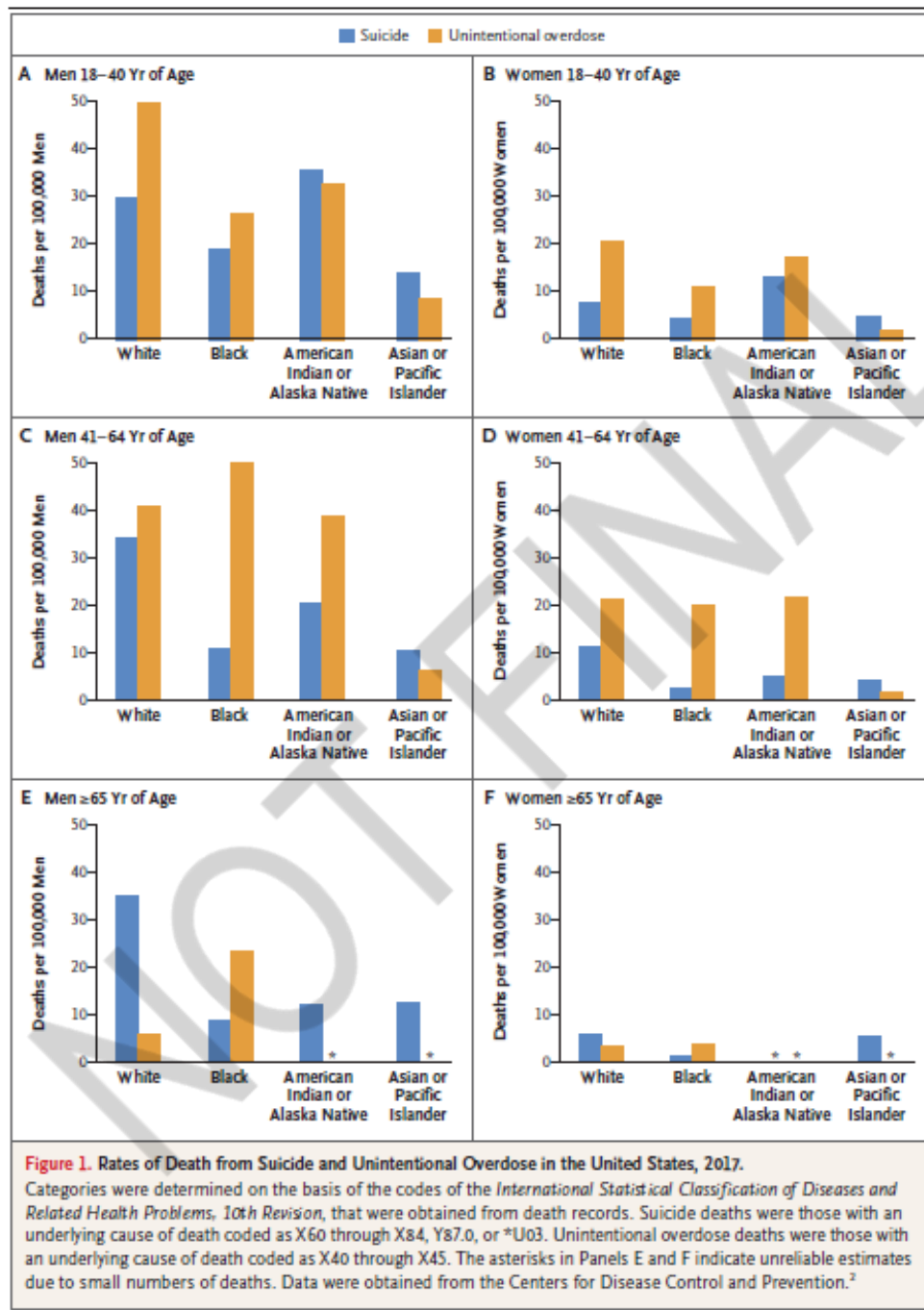


Table 2. Interventions to Address the Risk of Suicide and Overdose Related to Opioid Use.

Goal and Intervention	Population, Defined According to Level of Opioid Exposure and Misuse		
	Low-Risk Regimen of Prescription Opioids	High-Risk Regimen of Prescription Opioids or Opioid Misuse	Opioid Use Disorder or Illegal Opioid Use
Identifying who is at risk for suicide and overdose			
Determination of risk score on basis of medical record	+	+	
Assumption that high level of opioid exposure and misuse puts the patient at risk			+
Preventing suicide or overdose among those identified as being at risk			
Treatment for mental health conditions, when present	+	+	+
Cognitive behavioral therapy for suicide risk and motivational interviewing for overdose risk*		+	+
Patient-centered taper of opioid dosage†		+	
Overdose education and naloxone distribution*		+	+
Medication-assisted treatment‡			+

* Although these interventions would ideally be available to all persons identified as having any risk of suicide or unintentional overdose, resource constraints are likely to preclude this approach. Given that these approaches can address risks specifically related to opioid use, they should be prioritized for those with riskier levels of use.

† Patient-centered tapering is based on an evaluation of the risks and benefits for a specific patient, at a reasonably slow pace of dosage reduction and with the patient's engagement in the treatment decision making.

‡ Treatments include methadone, buprenorphine-naloxone, and naltrexone.

interviewing.^{55,56} Given the degree to which mental health problems are robust risk factors for both problems, it is likely that general mental health counseling and pharmacotherapy may reduce the risk of suicide as well as unintentional overdose. Addiction treatment and mental health clinics are well-positioned to provide these treatments, but providers of mental health care who are integrated into primary care practices may also provide this care.⁵⁷ Furthermore, behavioral pain-management interventions are associated with improvement in functional outcomes among those with pain.⁵⁸ It is plausible that improvements in pain-related domains through counseling could also reduce the risk of suicide and overdose.

Reduction in opioid dosage is a controversial strategy relevant for people who receive prescriptions for potentially risky medication regimens or who exhibit signs of opioid misuse. On the basis of an analysis of deaths from opioid overdose,⁵⁹ the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain⁶⁰ recommends against escalating

dosages for new patients above 90 morphine milligram equivalents, and this same threshold has been interpreted as a goal for tapering efforts. A reduction in the quantity of prescribed opioids may function as a "means restriction" by reducing patients' access to a lethal means of causing an intentional or unintentional opioid overdose. To this end, clinicians should ask about their patients' access to opioids, including past prescriptions and medications prescribed to others in the same home. Taper protocols that involve small decreases in dosage over time are successful for reducing dosages and may actually reduce pain intensity.⁶¹ However, whether tapering changes the risk of either suicide or overdose is unknown.

The distribution of naloxone, an opioid-overdose antidote, reduces opioid-related emergency department visits.⁶² Naloxone is ideally provided to someone who lives with a person at risk for overdose. Although naloxone distribution for layperson administration has been championed largely as a solution for unintentional opioid overdoses, it is also relevant to reversing suicide attempts.

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Finally, improving access to medication-assisted therapy, which is the combined approach of medication (methadone, buprenorphine-naloxone, or naltrexone) and counseling for opioid use disorders, may reduce rates of suicide and overdose.⁶³ Several decades of research show that medication-assisted therapy can reduce mortality, and this is especially true for overdose-related mortality.⁶⁴ However, both suicide and overdose still occur even when at-risk persons receive these treatments. The risks of death among those receiving medication-assisted therapy are highest when the medication is initiated and when the treatment is suddenly stopped.⁶⁴ Prevention should involve addressing these critical transition periods.

UNRESOLVED ISSUES
AND CONTROVERSIES

Several areas that need more research should be prioritized owing to their potential to influence policy and system interventions. First, there is concern that opioid tapering has resulted in patients' transitioning to heroin use⁶¹ or resulted in uncontrolled pain, which increases suicidality.⁶⁵ However, evidence for these relationships, beyond case reports, is lacking. As noted above, a study involving patients at Veterans Affairs facilities showed that higher prescribed dosages are associated with greater suicide risk than lower dosages.⁴ This same study also showed that rates of suicide among patients who were prescribed opioids for any length of time and stopped were similar to those among patients in ongoing treatment at low dosages (1 to 20 morphine milligram equivalents) and lower than rates among patients receiving higher dosages (≥ 21 morphine milligram equivalents). The findings of this study are not suggestive of suicide-related harm from discontinuation.

It is premature to conclude that discontinuation of prescription opioids leads to suicide or heroin use independent of risk factors that predated (or directly caused) the decision to discontinue. Nonetheless, abrupt discontinuation is physically unpleasant and potentially distressing. Protocols to reduce opioid withdrawal and provide alternative pain management are critical. In addition, only a small number of patients are

transitioned to medication-assisted treatment at the point of opioid discontinuation,^{66,67} but this should be a common care transition for patients with opioid use disorders.

Second, most research that identifies a risk of overdose and suicide is based on data from medical claims or records. Even well-designed risk scores have only moderate predictive value.^{50,51,68} One possible measure that could improve risk detection is the level of opioid misuse. Several measures have been validated (e.g., the Current Opioid Misuse Measure⁶⁹) to assess misuse, but none are used commonly enough to permit study in connection to suicide and overdose. Cohort studies that involve high-risk patients might help to fill this knowledge gap.

Third and finally, both suicide and overdose continue to result in a substantial burden of deaths in the United States, despite many clinical initiatives and numerous changes in state and federal policy. Prevention efforts may not have addressed important causes of suicide and overdose. Alternatively, efforts may have been effective for addressing harms related to prescription opioids, because deaths due to commonly prescribed medications have stabilized, but the "wave" of heroin use and use of illegal synthetic opioids masked the effects.⁷⁰ Regardless, it is clear that prevention efforts have been insufficient.

SUMMARY

Rates of suicide and unintentional overdose in the United States have climbed during the past two decades. Opioid use plays a critical role in fueling both of these public health problems. Consequently, interventions that address the shared causes and risk factors, such as programs to improve the quality of pain care, expand access to psychotherapy, and increase access to medication-assisted treatment for opioid use disorders, have the potential to be high-value investments by addressing both problems simultaneously.

Dr. Ilgen reports serving as cofounder of and owning shares in Arborsense. No other potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Appendix E

Health Disparities



Indian Health Service

Indian Health Disparities

Members of 573 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency within the Department of Health and Human Services that provides a comprehensive health service delivery system for approximately 2.2 million of the nation's estimated 3.7 million American Indians and Alaska Natives. The IHS strives for maximum tribal involvement in meeting the health needs of its service population, who live mainly on or near reservations and in rural communities, mostly in the western United States and Alaska.

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2009-2011).

American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively).

American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.

Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. In trying to account for the disparities, health care experts, policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system.

*Additional information on the IHS is available at
<https://www.ihs.gov> and <https://www.ihs.gov/aboutihs>*

MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area

2009-2011 and U.S. All Races 2010

(Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 2009-2011	U.S. All Races Rate – 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES*	999.1	747.0	1.3
Diseases of the heart (heart disease)	194.1	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.5	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular disease (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	12.9	1.8
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1
<p>* Unintentional injuries include motor vehicle crashes.</p> <p>NOTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. U.S. All Races columns present data for a one-year period. Rates are based on American Indian and Alaska Native alone; 2010 census with bridged-race categories.</p>			

April 2018

Appendix F

Health and Human Services April 2019 Update on Opioid Initiative

NOT FINAL

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



HHS BY THE NUMBERS

Combating the Opioids Crisis

484%

Increase in naloxone prescriptions per month from January 2017 to February 2019¹



\$2 BILLION+

in grants from HHS to states, tribes, and local communities to fight the opioids crisis in FY 2018

162



defendants charged for prescribing or distributing opioids and other dangerous drugs as part of the largest Healthcare Fraud Takedown Day in history

Approved



18 state waivers since Jan. 2017 in Medicaid to expand access to inpatient options for substance-use disorder

From Jan. 2017 to Feb. 2019

23%

Increase in number of patients receiving buprenorphine monthly²

34%

decrease in total opioids dispensed monthly by pharmacies³



64%

increase in medication-assisted treatment patients at HRSA-funded community health centers from 2016 to 2017

1.14M+

Americans now receiving medication assisted treatment

\$350M+

awarded as part of Healing Communities initiative to reduce opioid overdose deaths by 40% in communities in four states

In 2018

provisional drug overdose deaths began to **flatten and decline** for the first time

¹ IQVIA National Prescription Audit.

² IQVIA Total Patient Tracker.

³ This figure is based on the reduction in total morphine-milligram equivalents (a measure of opioid activity) dispensed.

UPDATED APRIL 2019

Environmental Factors and Plan

8. 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:

1. **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;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **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;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **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
 - a) ☒ Data on consequences of substance-using behaviors
 - b) ☒ Substance-using behaviors
 - c) ☒ Intervening variables (including risk and protective factors)
 - d) ☐ Other (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)

<input type="checkbox"/>	Children (under age 12)
<input checked="" type="checkbox"/>	Youth (ages 12-17)
<input checked="" type="checkbox"/>	Young adults/college age (ages 18-26)
<input checked="" type="checkbox"/>	Adults (ages 27-54)
<input checked="" type="checkbox"/>	Older adults (age 55 and above)
<input checked="" type="checkbox"/>	Cultural/ethnic minorities
<input type="checkbox"/>	Sexual/gender minorities
<input checked="" type="checkbox"/>	Rural communities
<input type="checkbox"/>	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 assessment 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:

NOT FINAL

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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 highly 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.

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 conducted 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.

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:

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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

1. 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 by going to the [Attachments Page](#) and upload the plan
Wyoming has a current alcohol strategic plan and is in the process of creating a prescription drug and related illicit drug strategic plan this year.
2. 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) ☒ Yes ☐ No ☐ N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) ☒ Timelines
 - c) ☐ Roles and responsibilities
 - d) ☒ Process indicators
 - e) ☒ Outcome indicators
 - f) ☐ Cultural competence component
 - g) ☐ Sustainability component
 - h) ☐ Other (please list):
 - i) ☐ Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ☒ Yes ☐ No
5. 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

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 and researchers from WYSAC, our current outside evaluators for prevention efforts administered by WDH. 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, Wyoming counties have Community Prevention Specialists (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.

NOT FINAL

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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:

Our 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 (WHSAA) to target youth and their guardians. WHSAA is the organization that runs and regulates all high school activities in Wyoming. They have direct access to both youth and their guardians through those activities and we are able to share information and promote prevention efforts at high school activities throughout the state in addition to having access to publishing in their newsletter.
 - b) Education:

Our 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), a program that provides officers with general knowledge related to drug impairment and by promoting the use of Drug Evaluation and Classification programs in the state
- 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:

Our 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:

Our 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 that address common risk and protective factors to provide substance abuse prevention framework in the workplace
- Driving while under the influence/driving while intoxicated education programs

e) Community-Based Processes:

Our 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, CPSs, 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:

Our 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 to implement environmental strategies and policies

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.

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:

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5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **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):

NOT FINAL

Footnotes:

NOT FINAL

Wyoming Department of Health Alcohol Prevention Plan

2018-2020



Wyoming
Department
of Health

Commit to your health.

Prepared by

Substance Abuse Prevention Program, Public Health Division, Wyoming Department of Health



Wyoming
Department
of Health

Commit to your health.

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Wyoming Department of Health Alcohol Prevention Goals

Goal 1: Reduce alcohol misuse/abuse and associated harmful consequences

Goal 2: Strengthen capacity across the state to address the problem of alcohol misuse/abuse

Goal 3: Reduce the availability of, and access to, alcohol by persons under the age of 21

NOT FINAL

Overview of Substance Abuse Prevention in Wyoming

Preventing drug abuse and excessive alcohol use improves quality of life, academic performance, workplace productivity, and military preparedness; reduces crime and criminal justice expenses; reduces motor vehicle crashes and fatalities; and lowers health care costs for acute and chronic condition (National Prevention Council, 2014). Substance use disorder is prevalent in our nation, with approximately 21.5 million people in the United States aged 12 or older in 2014 reporting a substance use disorder in the past year, of which 17 million people had an alcohol use disorder, 7.1 million had an illicit drug use disorder, and 2.6 million had both an alcohol use and an illicit drug use disorder (Center for Behavioral Health Statistics and Quality, 2015). Proper implementation of evidence-based substance abuse prevention programs reduces the use of alcohol, tobacco, and illicit drug use and abuse.

Prevention Funding Sources

Current funding sources for alcohol use and abuse prevention initiatives include:

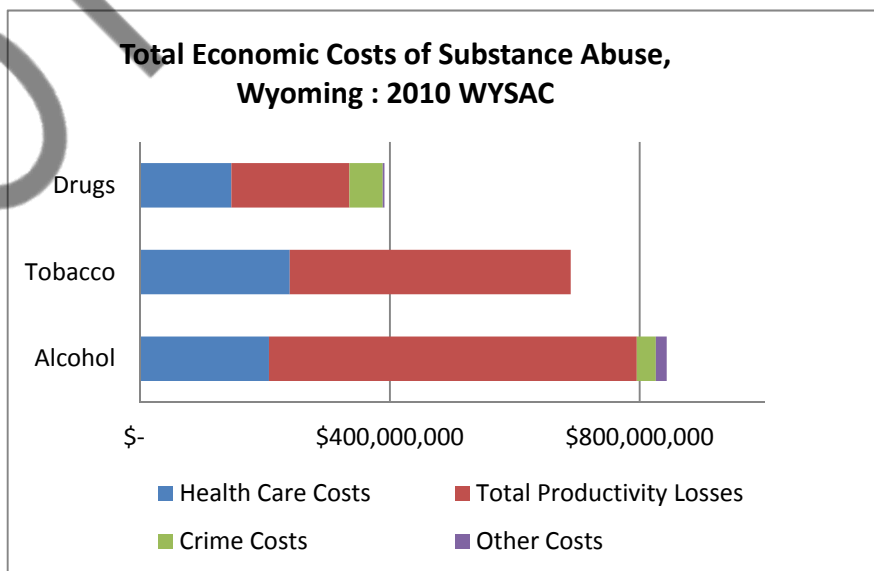
- State of Wyoming General Fund
- Wyoming Tobacco Settlement Funds
- Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPTBG)
- SAMHSA's Strategic Prevention Framework Partnerships for Success Grant

Wyoming communities conduct needs assessments that help determine the allocation of substance abuse primary prevention funds.

Focus of Prevention in Wyoming

Wyoming currently focuses on the prevention of alcohol misuse/abuse, tobacco prevention, and prevention of prescription drug misuse and abuse.

Based on the highest levels of need and associated consequences, Wyoming consistently identifies alcohol as a priority area and will continue focusing efforts on reducing alcohol misuse/abuse. In 2010, a cost of illness analysis of alcohol, tobacco, illicit drug abuse, prescription drug abuse, and mental health in Wyoming found that alcohol abuse constituted the greatest costs at \$843,220,902 in total. (WYSAC, 2012)

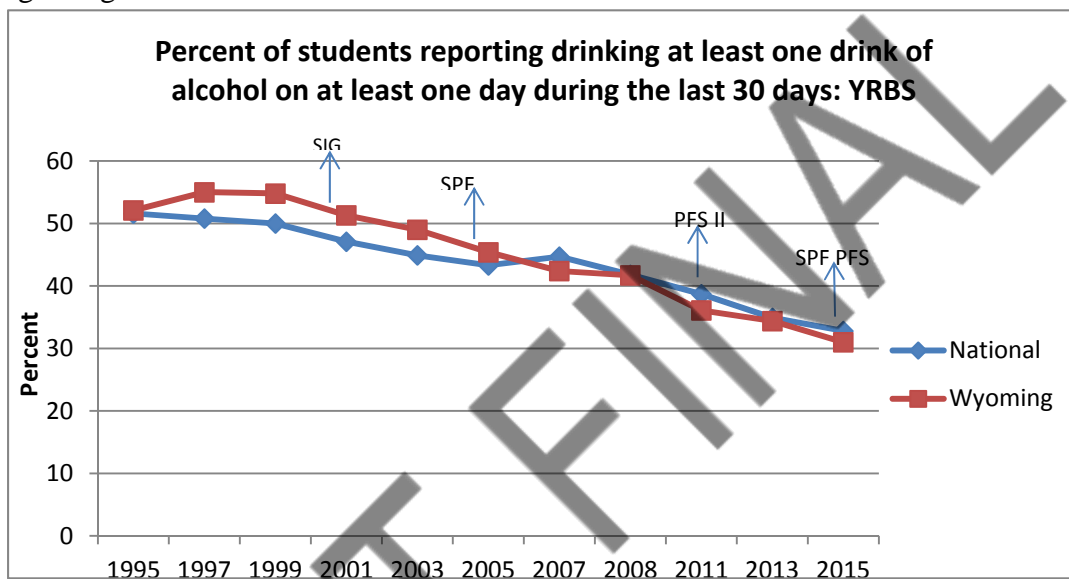


Wyoming Prevention Efforts Show Results

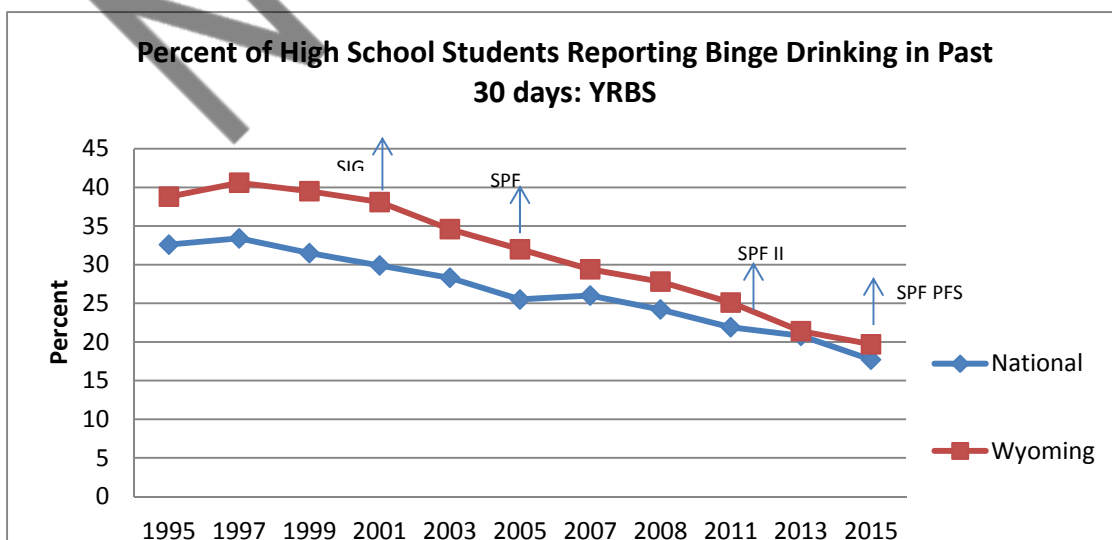
Prevention efforts in Wyoming are reducing youth alcohol use. Before Wyoming began engaging in scientific-based prevention efforts, youth past-month alcohol use hovered around 50% and binge

drinking at around 40%. In 2015, youth past-month alcohol use is down to 31% and past-month binge drinking is down to 19.7% (Youth Risk Behavior Survey Results, 2015). Wyoming received the State Incentive Grant in 2001, followed by the Strategic Prevention Framework State Incentive Grant (SPF SIG) in 2005 to prevent underage drinking and prescription drug abuse in Wyoming communities. In 2012, Wyoming received the Partnerships for Success II (PFS II) to continue efforts to prevent underage drinking and prescription drug abuse in Wyoming communities. Wyoming currently has the Strategic Prevention Framework Partnerships for Success (SPF PFS) Grant, which started in 2015.

With increased prevention efforts, Wyoming youth are reporting a statistical decrease in past 30 day use of alcohol from 2001 to 2015. Data from 1995 through 2015 shows a steady decline in underage drinking beginning in 2001.



Data from 1995 through 2015 shows similar success in the percent of high school students reporting binge drinking in the past 30 days. Binge drinking is defined as five (5) or more drinks for a male or four (4) or more drinks for a female on any occasion within the last 30 days. In Wyoming and nationally, the number of students reporting binge drinking has been decreasing over the last 20 years.



Value of Prevention

The Wyoming Survey & Analysis Center at the University of Wyoming conducted a value of prevention study on the potential cost savings from delaying youth alcohol use in Wyoming. (WYSAC, 2017) Alcohol use disorders are one of the most prevalent use disorders in the United States. In 2010, the societal cost of alcohol use disorders to Wyoming was approximately \$843 million. In 2014, it was estimated that 389 cases of future alcohol use disorders were avoided due to prevention efforts in Wyoming communities and at the national level. The potential cost savings of delaying the onset of alcohol use for the 2014 senior high school class is approximately \$122 million.

TOTAL BENEFIT OF PREVENTION IN 2014

\$122 million

potential cost savings

389 cases

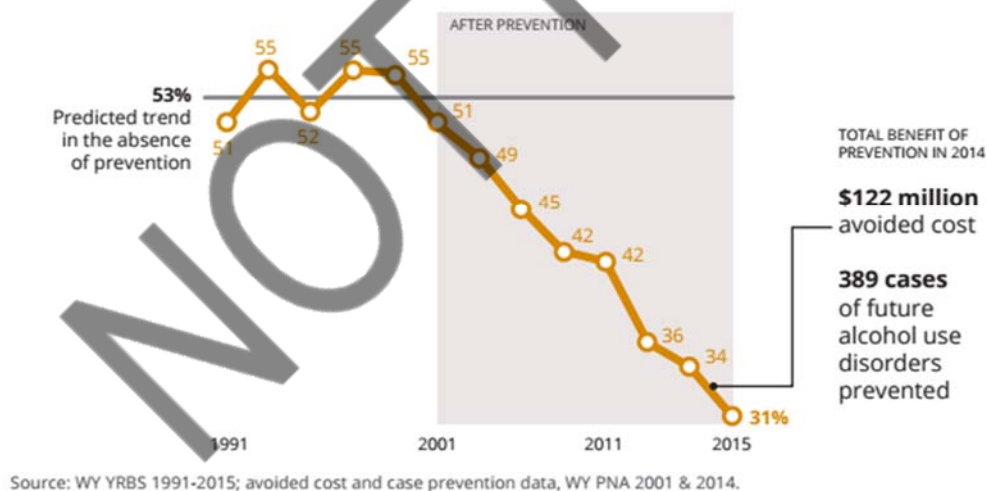
of future alcohol use disorders avoided

This study estimated the potential cost savings realized by prevention of a single alcohol use disorder to be \$313,700. The benefits from prevention accrue in the future and equal the costs that would have been incurred by an individual over the time period they engaged in disordered behavior.

Since 2001, Wyoming communities have pursued a comprehensive approach to preventing underage drinking using mostly evidence-based strategies that impact the entire population. Prevention efforts in Wyoming are proving to be effective.

Prevention Efforts Impact Usage, Cost and Future Health Problems in Youth

Percent of Wyoming youth who used alcohol in the past 30 days, 1991 - 2015



Substance Abuse Prevention Program Overview

The Substance Abuse Prevention Program, a part of the Prevention and Health Promotion Unit in the Public Health Division, works closely with the Tobacco Prevention and Control Program to provide prevention services throughout Wyoming. Alcohol, tobacco, prescription drug, and other drug prevention services are conducted at the community level with oversight and accountability provided by the Substance Abuse Prevention Program and Tobacco Prevention and Control Program. All 23 counties

in Wyoming and the Wind River Indian Reservation (WRIR) receive resources and support for prevention services.

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 requires all funded communities to implement the Strategic Prevention Framework (SPF) public health model in their prevention efforts, which assists community coalitions in engaging in data-driven strategic planning. With a consistent vision of creating community-level change across Wyoming, a requirement of the prevention services provider is that community level staff, in collaboration with their local prevention coalitions, complete a Comprehensive Needs Assessment Workbook that addresses all relevant data covering local demographics, socioeconomic conditions, community norms and other risk/protective factors. The results of this analysis are used to create and implement local strategic plans that focus on policy changes, systems transformation, and mental health information dissemination.

Funded communities participate in evaluation of prevention efforts at the community level. Evaluators work 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 Program contracts with prevention service providers to provide technical assistance and training for 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 team 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 to create 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.

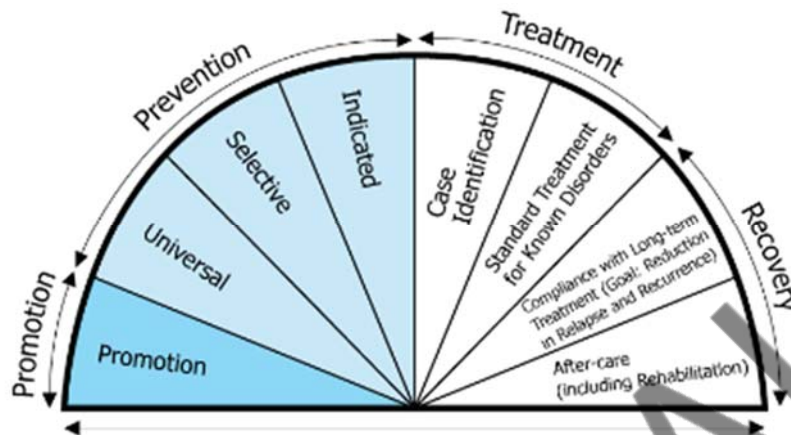
What is Prevention

Prevention is actively working prior to the onset of a disorder to prevent substance use or abuse, limit the development of problems associated with substance use or abuse, and reduce the risk of developing a behavioral health problem.

Wyoming Substance Abuse Prevention Program's approach to prevention is to gather and use data to guide prevention decisions specific to community needs. This means working with diverse community partners to choose culturally appropriate, effective, and sustainable evidence-based strategies according to the needs of the community, and to work with individuals who are passionate and knowledgeable

about both their communities and prevention to reduce the risk of alcohol and other drug-related problems throughout Wyoming.

Behavioral Health Continuum of Care Model



Prevention is an important part of the behavioral health continuum of care model, a comprehensive approach to behavioral health that recognizes multiple opportunities for addressing behavioral health problems and disorders. Each component presents opportunities for addressing behavioral health problems and for collaborating across sectors. Based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report, the model includes the following components:

- **Promotion** - Strategies designed to create environments and conditions that support behavioral health and the ability for individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention** - Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use.
- **Treatment** - These services are for people diagnosed with a substance use or other behavioral health disorder.
- **Recovery** - These services support individuals' abilities to live productive lives in the community and can often help with abstinence.

The Substance Abuse Prevention Program works in both the Promotion and Prevention realms.

Risk and Protective Factors

Research over the past two decades has tried to determine how substance use begins and how it progresses. Many factors can add to a person's risk for substance abuse. Risk factors can increase a person's chances for substance abuse, while protective factors can reduce the risk (NIDA, 2013). People have biological and psychological characteristics that can make them vulnerable or resilient to substance abuse problems. These characteristics are classified either as a protective factor or a risk factor (SAMHSA, 2015).

- **Protective Factor:** a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes. Protective

factors might include: belief in a moral order, religion, family, social skills, and community connectedness.

- **Risk Factor:** a characteristic that is biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcome. Risk factors might include: academic failure, perceived risk of substance use, rebelliousness, parents attitude favors substance use, family conflict, friends use of substances, and sensation seeking.

Prevention Categories

Prevention doesn't only happen on an individual level, it also focuses on creating environments that support healthy behavior.

- **Universal Prevention** - Strategies are designed to reach the general public, regardless of level of risk or problem behaviors in that population. Universal prevention can be direct or indirect.
 - **Universal Direct** - Interventions directly serve an identifiable group of participants who have not been identified on the basis of individual risk. For example, school curriculum, after-school program, parenting class. This could also include interventions involving interpersonal and ongoing/repeated contact, like with coalitions.
 - **Universal Indirect** - Interventions support population-based programs and environmental strategies, such as establishing alcohol, tobacco, and other drug (ATOD) policies. This could also include interventions involving programs and policies implemented by coalitions.
- **Selective Prevention** - Strategies that target individuals or subgroups of the general population that are determined to be at a higher risk. Examples of subgroups are: college-age students or adolescent parents.
- **Indicated Prevention** - Interventions target individuals at high risk who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse

Six Primary Prevention Strategies

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines six strategies used in primary prevention.

Information Dissemination

Activities that provide awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities. Examples include: social media campaigns that target underage drinking by targeting youth or parents, radio announcements, and speaking engagements.

Education

Activities aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgement abilities. Examples include: responsible beverage service training through TIPS (Training for Intervention Procedures); law enforcement training through Advanced Roadside Impaired Driving Enforcement (ARIDE); educating parents about the health and safety risks of providing alcohol to youth through programs such as Parents who Host Lose the Most; and educating youth on use of texting tip lines, such as Safe2Tell.

Alternatives

Activities that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. Examples include: alcohol-free drop-in activities.

Problem Identification and Referral

Activities that aim 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. Examples include: promotion of policies and procedures that align with best practices of employee assistance programs, and educational programs on driving while under the influence/driving while intoxicated.

Community-Based Process

Activities that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking. Examples include: community-based strategic planning through local coalitions, Community Prevention Specialists (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; and strengthening coalition capacity by increasing multi-agency coordination and collaboration ensuring that stakeholders are involved.

Environmental Strategies

Activities 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. Examples 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; and providing technical assistance to coalitions.

Evidence-Based Programs

Evidence-based programs are designed based on current scientific evidence and have shown to produce positive results. Prevention programs work to boost protective factors and eliminate or reduce risk factors. When research-based substance use prevention programs are properly implemented, a decrease in the use of alcohol, tobacco, and illicit drugs should occur.

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 WYSAC, 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.

Strategic Prevention Framework (SPF)

The Strategic Prevention Framework (SPF) is a planning process for preventing substance use and misuse developed by SAMHSA. The five steps and two guiding principles of the SPF offer a comprehensive process for addressing the substance misuse and related behavioral health problems facing communities.



Step 1: Assess Needs - Identify pressing substance use and related problems and their contributing factors and assess community resources and readiness to address these factors.

Step 2: Build Capacity - Identify resources and build readiness to address substance use and misuse.

Step 3: Plan - Form a plan for addressing priority problems and achieving prevention goals.

Step 4: Implement - Deliver evidence-based interventions.

Step 5: Evaluate - Quantify the challenges and successes of implementing a prevention program.

The framework is guided by the following principles:

Cultural Competence - The ability to interact effectively with people of different cultures to ensure the needs of all community members are addressed.

Sustainability - Sustain prevention outcomes by building stakeholder support for your program, showing and sharing results, and obtaining steady funding.

Alcohol in Wyoming

Preventing excessive alcohol use increases people's chances of living long, healthy, and productive lives. In the United States, approximately 21.5 million people aged 12 or older in 2014 had a substance

use disorder in the past year, of which 17 million people had an alcohol use disorder, 7.1 million had an illicit drug use disorder, and 2.6 million had both an alcohol use and an illicit drug use disorder. Preventing drug abuse and excessive alcohol use improves quality of life, academic performance, workplace productivity, and military preparedness; reduces crime and criminal justice expenses; reduces motor vehicle crashes and fatalities; and lowers health care costs for acute and chronic condition (National Prevention Council, 2014). Proper implementation of evidence-based substance abuse prevention programs will reduce the use of alcohol, tobacco, and illicit drug use and abuse.

Adults and Alcohol

Alcohol is one of the most commonly used substances. According to a 2016 survey, 55% Wyoming adults have had at least one drink of alcohol within the past 30 days, which is comparable to the national median of 54% (BRFSS, 2016). Alcohol is a part of our culture, but drinking too much, either on a single occasion or over time, can have serious health consequences. Research demonstrates “low-risk” drinking levels for men are no more than four (4) drinks on any single day and no more than 14 drinks per week. For women, “low-risk” drinking levels are no more than three (3) drinks on any single day and no more than seven (7) drinks per week. To stay low risk, one must keep within both the single-day and weekly limits. Even with these limits, there can be problems if a person drinks too quickly, has health conditions, or is over age 65. Older adults should have no more than three (3) drinks on any day and no more than seven (7) drinks per week

(<https://pubs.niaaa.nih.gov/publications/Hangovers/beyondHangovers.htm>).

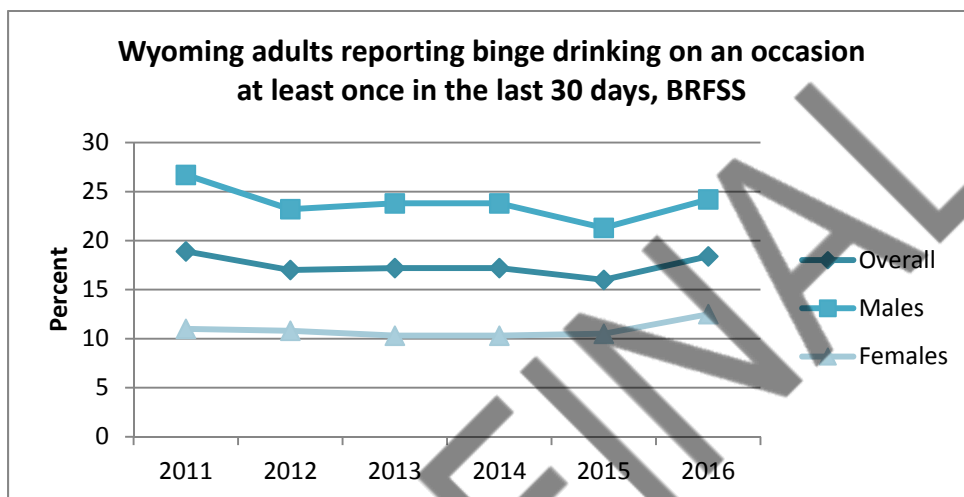
Excessive Drinking

Excessive alcohol use is associated with an array of social, economic, and health costs. Excessive alcohol use, either in the form of binge drinking (consuming 5 or more drinks on an occasion for men or 4 or more drinks on occasion for women) or heavy drinking (drinking 15 or more drinks per week for men or 8 or more drinks per week for women) is associated with an increased risk of many health problems (CDC, 2017).

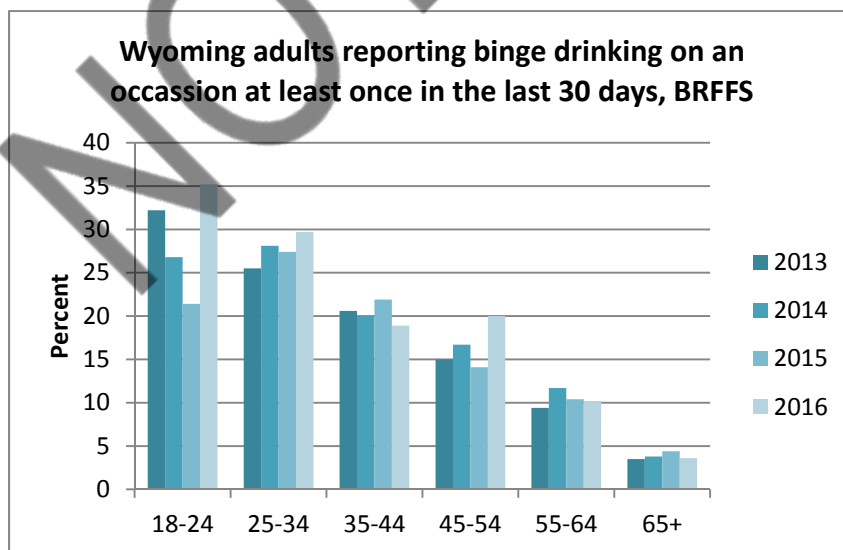
Excessive alcohol consumption cost the United States \$249 billion in 2010. Costs due to excessive drinking largely result from losses in workplace productivity, health care expenses, and other costs due to a combination of justice expenses, motor vehicle crashes, and property damage (CDC, 2017). Nationally, this cost amounts to about \$2.05 per drink, or about \$807 per person. The cost in Wyoming is slightly higher at about \$2.33 per drink (CDC, 2017). Binge drinking was responsible for about three quarters (77%) of the cost of excessive alcohol use in all states and the District of Columbia (CDC, 2017).

Binge Drinking

Wyoming saw a decrease during 2011-2015 in the percent of adults reporting binge drinking on an occasion at least once in the last 30 days. However, binge drinking rates did increase slightly in 2016. According to a 2016 survey, 18.4% of Wyoming adults reported binge drinking at least once in the last 30 days, which is comparable to the national median of 16.9% (BRFSS, 2016). The rate of males binge drinking was significantly higher, with 24.2% binge drinking at least once in the last 30 days compared to 12.5% of females.



Younger age groups have consistently reported binge drinking at higher rates than older adults. In 2016, Wyoming residents aged 18-24 had the highest percentage of binge drinking of all age groups among residents reporting binge drinking on an occasion at least once in the last 30 days. There was a significant increase in this age group reporting binge drinking compared to previous years.

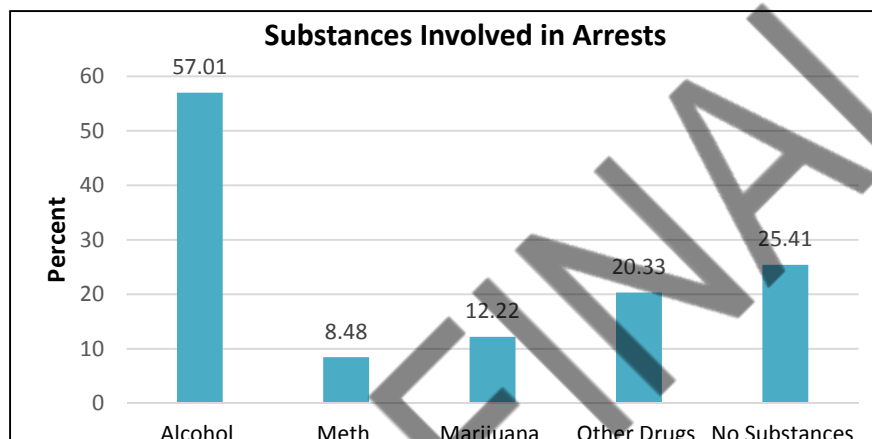


Heavy Drinking

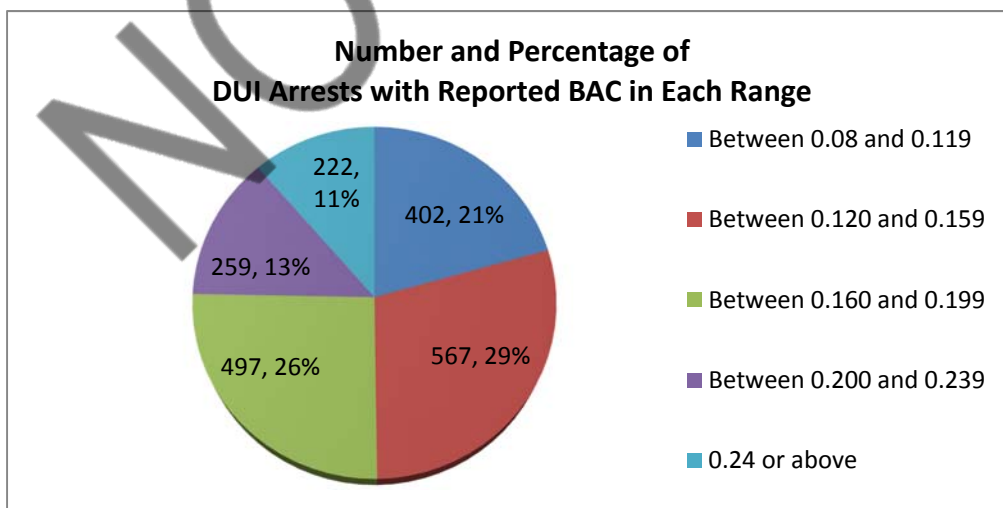
Wyoming adults reporting heavy drinking is similar to national rates at 6.2% compared to the national median of 5.9%. The percent of heavy drinkers has stayed fairly consistent over the past five years, both in Wyoming and nationally.

Alcohol and Crime

The high percentage of alcohol-involved arrests, the inordinate number of arrests for public intoxication and driving under the influence, and the high levels of blood alcohol content for drivers arrested for being impaired represent a real and significant threat to public safety in Wyoming (WASCOP, 2017). Alcohol was involved in 57% of all custodial arrests. Driving under the influence arrests accounted for 26.7% of all arrests. Some arrests involve more than one substance.



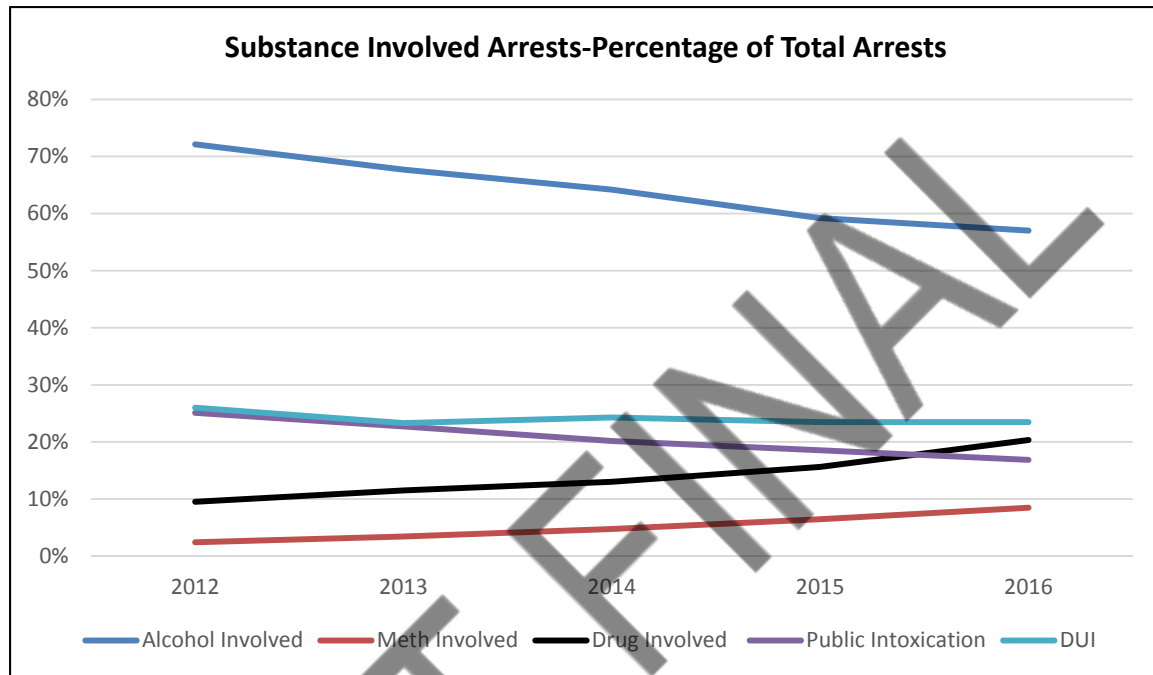
The average reported blood alcohol content for driving under the influence (DUI) arrests statewide was .1591. The average reported blood alcohol content (BAC) for 562 persons who were arrested for DUI after being involved in traffic crash was .1975. The age group with the highest percentage of DUI arrests was age 21-25, followed by age 26-30 and 31-35.



Arrests for public intoxication accounted for 12.86% of all arrests of all arrests statewide. Per BAC statistics, it should be noted that a physically fit male who weighs 180 pounds would have to consume at

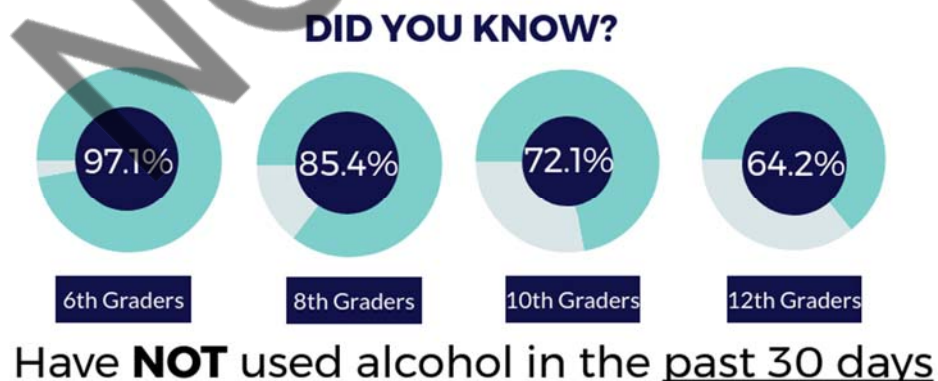
least seven drinks in one hour to achieve a BAC of .15 and a female weighing 120 pounds would have to consume five drinks in one hour (WASCOP, 2017).

Despite alcohol being the drug most often present in arrests from 2010-2016, the number and percentage of alcohol-involved arrests have decreased.. Alcohol arrests in 2016 were 4,545 fewer in number (33% decrease) than in 2010. Unfortunately, the number and percentage of other drug-involved arrests have increased. Drug-involved arrests in 2016 were 1,437 more in number (80% increase) than in 2010 (WASCOP, 2017).

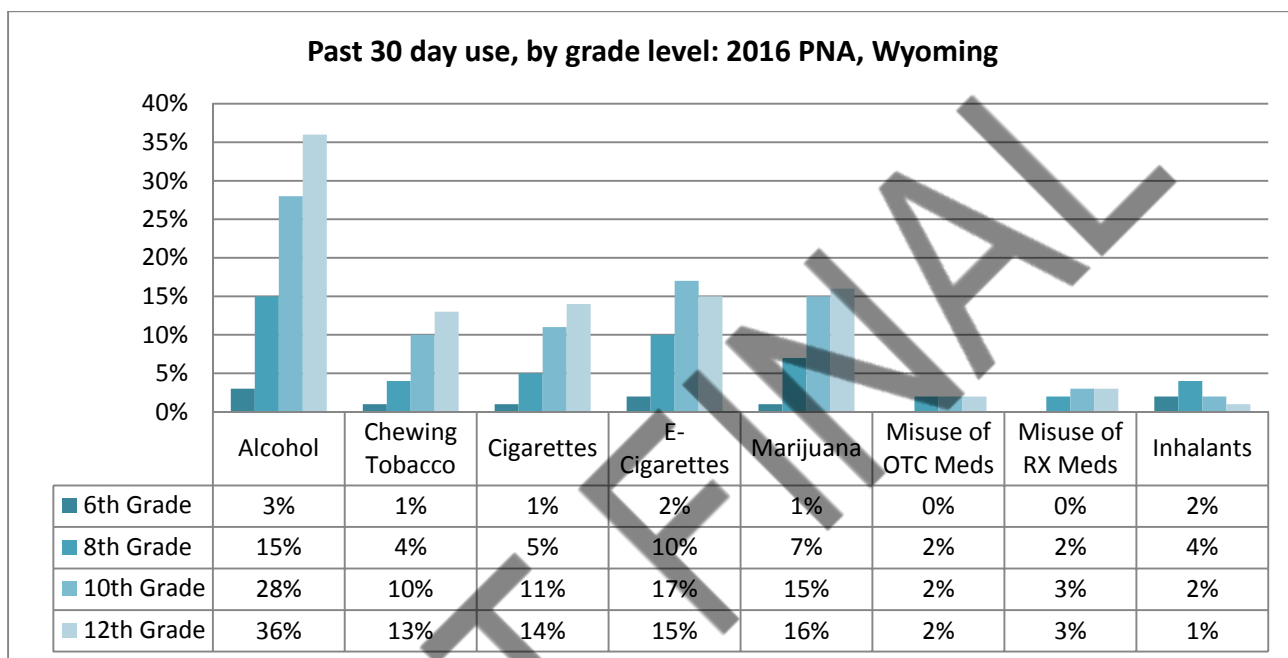


Youth and Alcohol

A majority of Wyoming youth reported that they have not used alcohol in the past 30 days. (PNA, 2016)
In fact, drinking among Wyoming youth continues to decline.



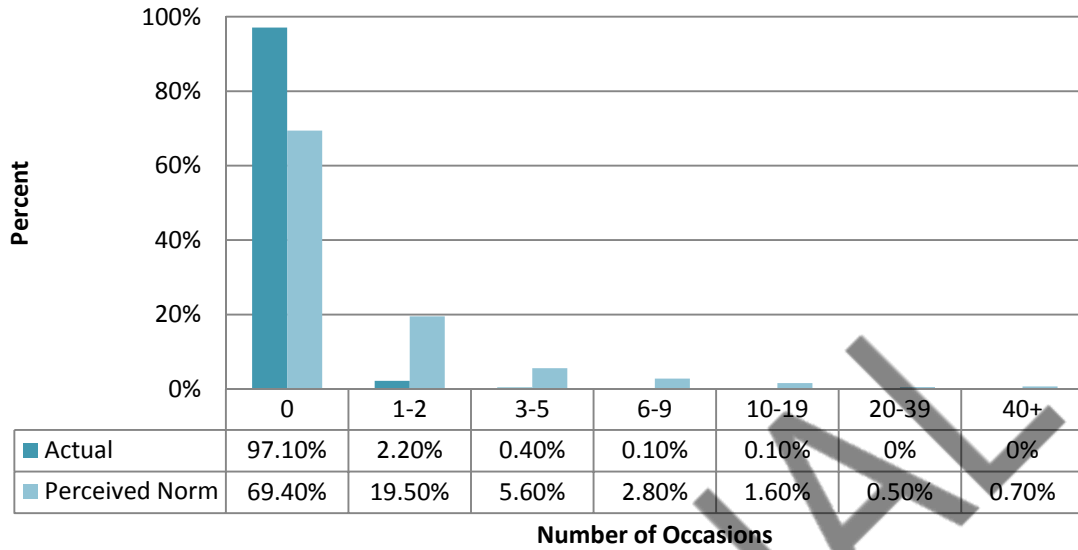
However, alcohol continues to be the most commonly reported substance used among all grade levels in the state. Underage drinking poses a range of risks and negative consequences. Early drinking onset has been associated with a range of social, emotional, behavioral, and health problems such as risky sexual behavior, car crash involvement, and unintentional injuries. Youth who start drinking before the age of 15 are four times more likely to develop alcohol dependence (NIAA, 2017).



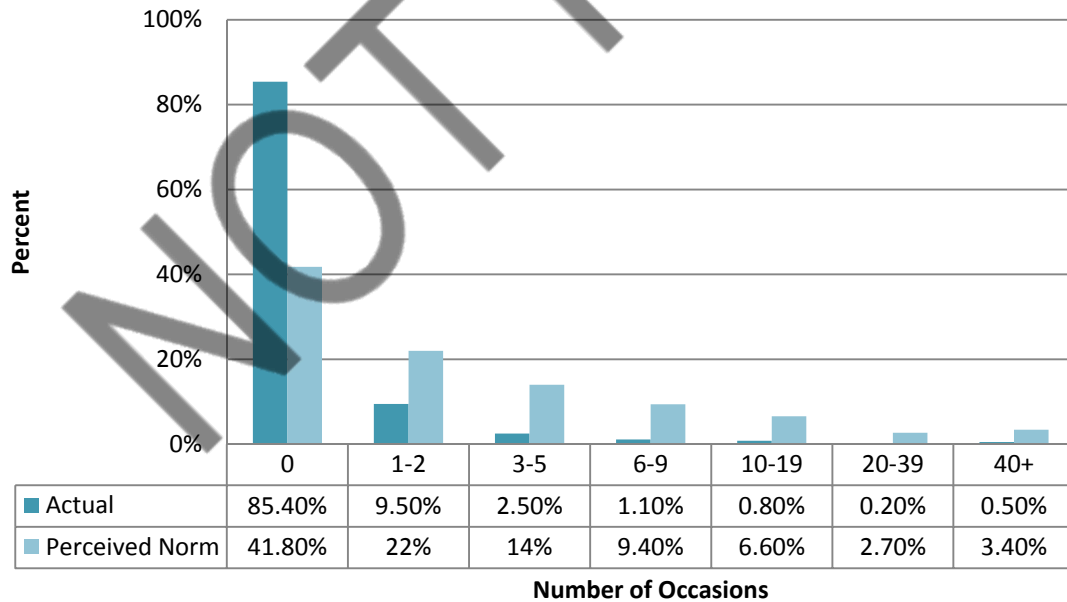
Perception of Alcohol Use

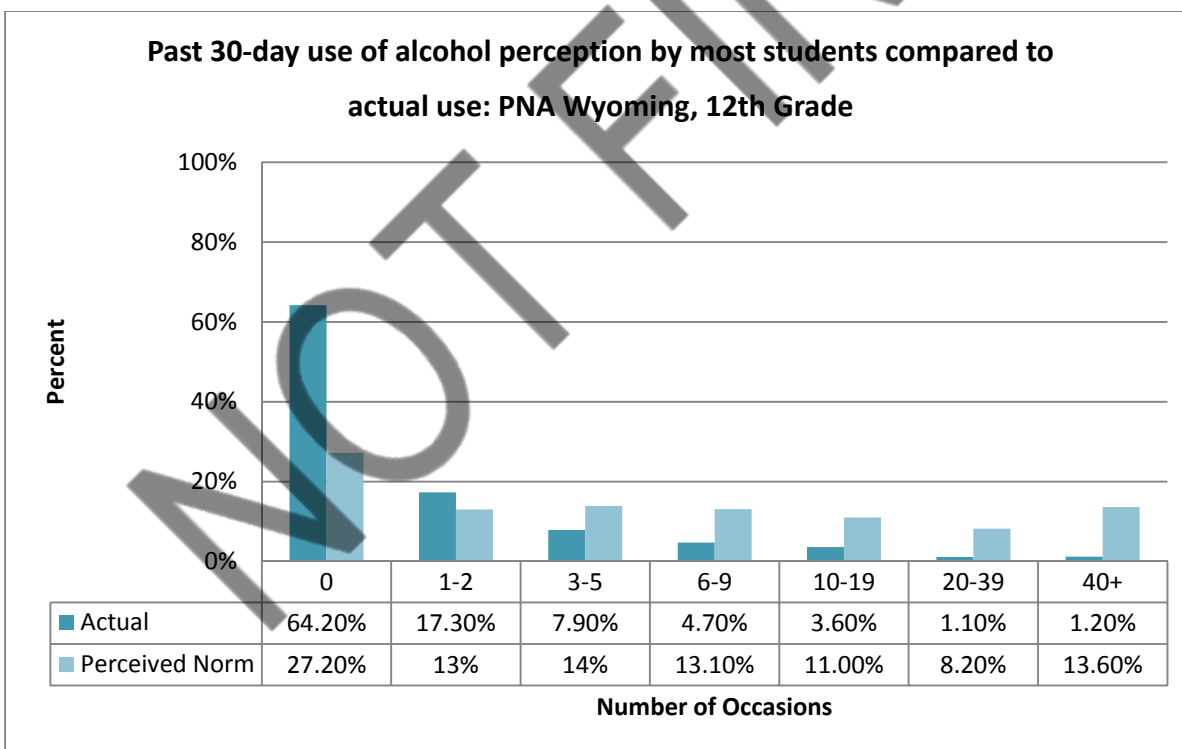
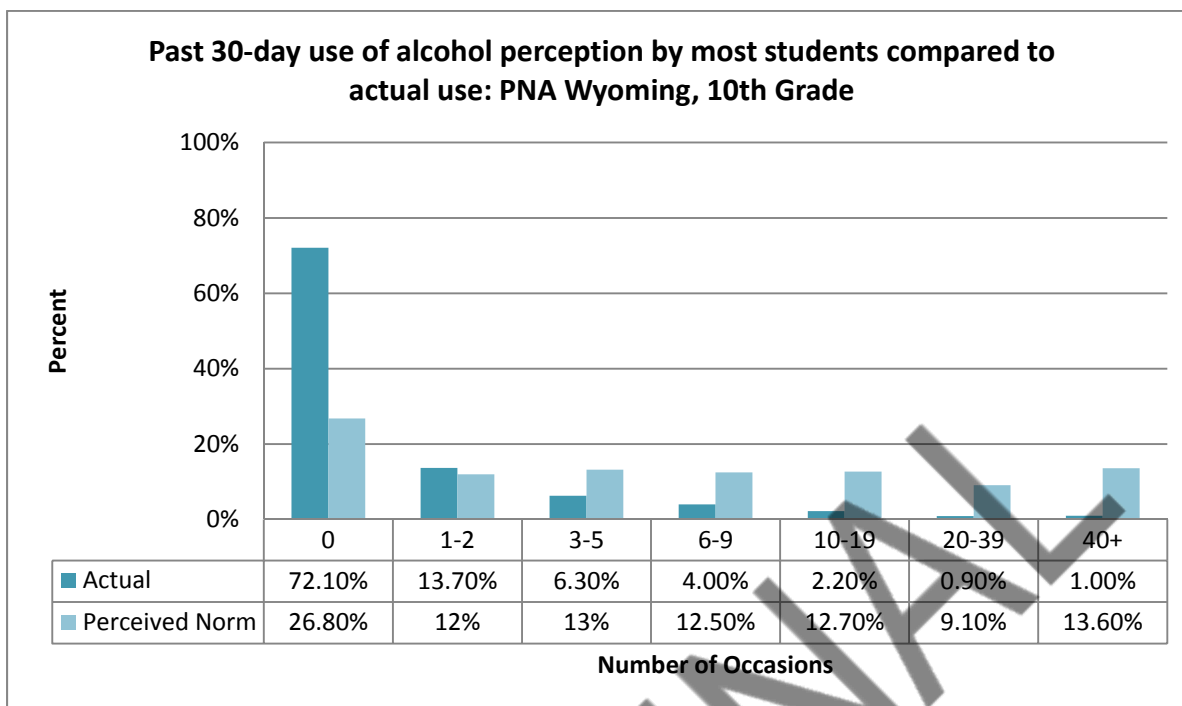
Based on social norms theory, the perception of how often and to what degree other students are using drugs and alcohol is a critical factor in whether a student decides to use drugs and alcohol. The perception of what most students are doing can either make substance use more or less likely. If the perception is that almost everyone is using alcohol, this exerts social pressure to join in drinking alcohol. If the perception is that most people do not use alcohol, then that perception exerts pressure on the student not to participate (PNA, 2016). As indicated by the data among 6th, 8th, 10th, and 12th graders in Wyoming, the actual percentage of students who have not used alcohol in the past 30 days is greater than the perceived norm. The higher perceived norm of alcohol use among youth may increase the likelihood of youth using alcohol.

Past 30-day use of alcohol perception by most students compared to actual use: PNA Wyoming, 6th Grade



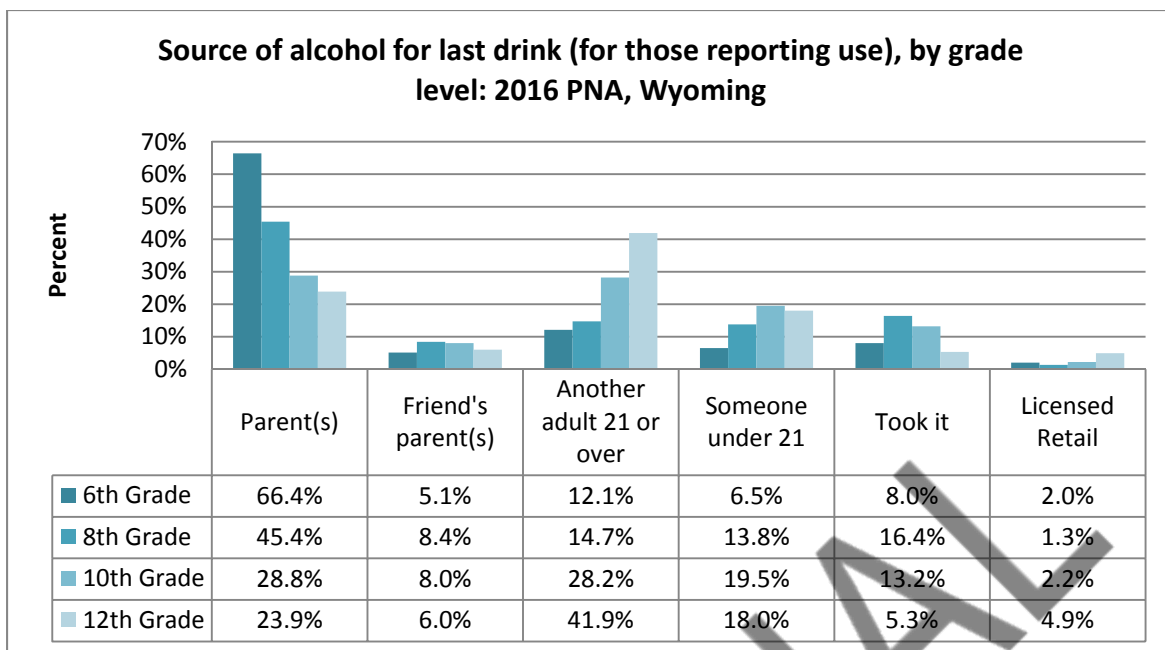
Past 30-day use of alcohol perception by most students compared to actual use: PNA Wyoming, 8th Grade





Youth Access to Alcohol

Regulations on the availability of alcohol are used to reduce underage drinking in Wyoming. Despite regulations, youth are still able to access alcohol.



Alcohol Compliance Checks

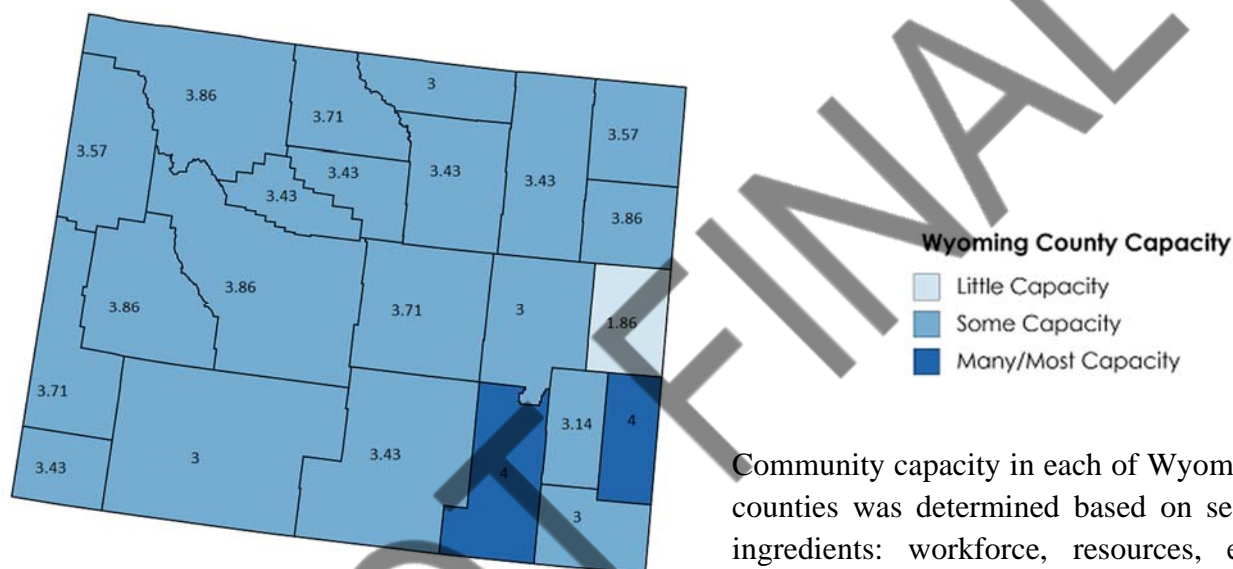
Alcohol compliance checks are a proven, best-practice strategy for reducing the sale of alcohol to persons under the age of 21. A very low percentage of youth report their most recent source of alcohol being a licensed retailer. In 2016, a total of 1,410 valid alcohol compliance checks were conducted across Wyoming. Overall, 2016 alcohol sales compliance for all reporting counties was 86%.

County	Valid Alcohol Compliance Checks	No Infractions	Prohibited Sales Violation	Prohibited Sales Warning	Closed or Does not Sell Alcohol	Compliance Rate
Albany	68	58	10	0	0	85.3%
Big Horn	38	17	0	21	2	44.7%
Campbell	106	76	14	16	5	71.7%
Carbon	15	12	3	0	0	80.0%
Converse	81	69	2	0	21	85.2%
Fremont	89	85	4	0	0	95.5%
Goshen	40	38	2	0	0	95.0%
Johnson	95	87	8	0	23	91.6%
Laramie	160	133	27	0	2	83.1%
Lincoln	56	53	1	2	0	94.6%
Natrona	173	152	19	2	11	87.9%
Niobrara	10	10	0	0	0	100.0%
Park	87	77	9	1	0	88.5%
Sheridan	107	87	20	0	12	81.3%
Sublette	55	53	2	0	4	96.4%
Sweetwater	116	107	9	0	0	92.2%
Teton	55	46	7	2	5	83.6%
Uinta	59	53	6	0	1	89.8%
Wyoming	1410	1213	153	44	86	86.0%

Community Capacity to Address Alcohol Misuse

According to SAMHSA's Strategic Prevention Framework, capacity refers to the "various types and levels of resources available to establish and maintain a community prevention system that can identify and respond to community needs." Intentional capacity building at all levels helps ensure that successful programs are sustained within the community. Effective capacity building also increases a community's ability to respond to changing issues with innovative solutions.

Wyoming conducted a baseline report in 2016, at which time the state average capacity score was 3.44. A score of 1 or 2 indicates that a county has no or little capacity. A score of 3 indicates that a county has some capacity. Of the 23 counties, only six (26%) counties were below an average score of 3.2. Two counties scored a 4 or higher, which indicates a county has many/most capacity. Each county and their rankings are shown below.



Community capacity in each of Wyoming's 23 counties was determined based on seven key ingredients: workforce, resources, effective communication, community engagement, active leadership, readiness for change, and sustainability.

The seven key ingredients were evaluated through 1) interviews with the Community Prevention Specialists, 2) focus group with key prevention stakeholders, and 3) a survey of local coalition members. Each key ingredient is defined below:

Workforce (Key Components: knowledge, skills, experience, social validity)

Successful implementation requires staff, leaders, and coalition members who are familiar with prevention and have received training in the evolving aspects of prevention including the public health approach and the strategic prevention framework. Individuals should also possess management, facilitation, and personal and professional skills, and have experience in their field and positions. Additionally, they should understand the unique cultural characteristics of their community and have a willingness and ability to embrace those cultural differences.

Resources (Key Components: people, funding, space, time, access)

Resources are the infrastructure of program implementation. All successful prevention programs require adequate monetary resources, staff, physical space, time, and connections with the served community. In addition, a thorough knowledge of and relationship with the various aspects of the local prevention infrastructure must be developed.

Effective Communication (Key Components: internal and external communication)

Regular exchange of information and data is critical, both internally within the various segments of the organization and externally between the coalition and the multitude of community sectors involved in prevention efforts.

Community Engagement (Key Components: shared vision, diverse and inclusive representation)

Broad and diverse representation from the community is key to successful prevention implementation. To effectively engage the community, the coalition must ensure that all members involved feel included in the process. This inclusion starts when the coalition shares a vision and when members have defined roles and a voice in the process. It is also important that coalition members have an understanding of the needs of the community gained through their involvement in different segments.

Active Leadership (Key Components: involvement, commitment to prevention)

Active leaders are personally committed to achieving prevention goals in their communities. They are able to articulate and share a vision in a way that inspires others to follow, they have the knowledge and commitment to pursue their prevention goals, and they have the skills to communicate their vision to stakeholders. Active leaders are also able to negotiate and coordinate conflicting interests between the coalition and community and/or business leaders while prioritizing their prevention aims.

Readiness for Change (Key Components: community climate, history of effectiveness)

Positive change in prevention communities is unlikely to occur unless the community is ready. The best indicator of readiness is a past record of successful prevention implementation. Communities that are open to new ideas and that have a commitment to tackle prevention issues may be ready too. Additionally, prevention communities with strong connections among stakeholders and implementing organizations are better positioned to tackle prevention changes.

Sustainability (Key Components: buy-in, training)

Project funders and stakeholders want to see programs continue and improve. Project sustainability is more likely when the project strategies match the needs of the community and when staff, leaders, and community members are invested in the process, receive ongoing training, and institutionalize the knowledge gained and efforts put forth during the project.

Conclusion

Wyoming substance abuse prevention efforts focused on reducing alcohol misuse/abuse have been effective. Wyoming continues to see a decrease in students reporting drinking underage and adults

reporting binge drinking. The Wyoming Department of Health currently funds substance abuse prevention efforts in all 23 counties with a focus on using data-driven environmental strategies to create healthier environments.

Alcohol is still the most commonly misused/abused substance in the state carrying some of the highest societal consequences. With a comprehensive and coordinated strategy across organizations to prevent the misuse/abuse of alcohol throughout Wyoming, we will continue to see the negative consequences associated with alcohol decrease.

NOT FINAL

Wyoming Department of Health Alcohol Prevention Plan

Preventing alcohol misuse/abuse requires a comprehensive and coordinated strategy across organizations throughout Wyoming. The Wyoming Department of Health, in collaboration with the Statewide Epidemiological Outcomes Workgroup, completed a coordinated statewide alcohol misuse and abuse prevention plan with specific state benchmarks.

Goal 1: Reduce alcohol misuse/abuse and associated harmful consequences

Objective 1.1: Decrease the percent of adult binge drinking to 13% or lower by 2020, from a 2016 baseline of 18.4% and compared to a 2016 national average of 16.9%.

Data source: Wyoming Behavioral Risk Factor Surveillance System

Objective 1.2: Increase the percentage of youth reporting no alcohol use in the past 30 days to more than 72% in high school, from a 2016 baseline of 68.37%, and more than 92% in middle school, from a baseline of 91.29% in 2016, by 2020.

Data Source: Wyoming Prevention Needs Assessment

Objective 1.3: Decrease the percent of alcohol-related fatal crashes to 30% by 2020, from a 2014 baseline of 34% and compared with a national average of 31% in 2014.

Data source: Wyoming Department of Transportation, Fatality Analysis Reporting System

Goal 2: Strengthen capacity across the state to address the problem of alcohol misuse

Objective 2.1: Overall capacity in at least 17 counties will increase by 2020 from baseline report in 2016.

Data source: Comprehensive Capacity Assessment Report

Objective 2.2: All counties will have a functioning coalition to include a charter or bylaws, with representation from at least ten sectors of the community, and completed training in basic prevention science.

Data source: Comprehensive Capacity Assessment Report

Goal 3: Reduce the availability of, and access to alcohol by persons under the age of 21

Objective 3.1: Increase the counties participating in Alcohol compliance checks annually from 18 to 23.

Data source: Alcohol and Tobacco Sales Compliance Checks Report

Objective 3.2: Increase the alcohol compliance rate statewide to 90% or higher by 2020, from a baseline of 86% in 2016.

Data source: Alcohol and Tobacco Sales Compliance Checks Report

Objective 3.3: Increase the percent of counties reporting an alcohol compliance rate of 90% or higher to 50% by 2020, from a baseline of 33% in 2016.

Data source: Alcohol and Tobacco Sales Compliance Checks Report

Objective 3.4: Increase the percent of middle school students reporting that they have never had a drink of alcohol in their lifetime to 76% from a 2016 baseline of 73.45% by 2020, and high school students to 50% from a 2016 baseline of 39.93%.

Data source: Wyoming Prevention Needs Assessment

Objective 3.5: Among high school students who report ever having an alcoholic beverage, decrease youth reporting accessing alcohol from parents to less than 13% of students by 2020, from a baseline of 15.8% in 2016.

Data Source: Wyoming Prevention Needs Assessment

Objective 3.6: Among high school students students who report ever having an alcoholic beverage, decrease youth reporting access to alcohol from another adult, 21 and over, to less than 17% for high school students by 2020, from a baseline of 21.0% for high school students in 2016.

Data Source: Wyoming Prevention Needs Assessment

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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.

Community Mental Health Centers (CMHC)

CMHC are able to provide community services to support patients functioning outside of inpatient or residential institutions. CMHC include mental health and co-occurring outpatient treatment services, individual, group and family therapy, case management, wrap around services, rehabilitation services, housing/residential, medication management, recovery support, and (increasing through the state) peer support services. CMHC assist individuals in connection to primary health care, educational resources, and other various community resources.

Gatekeeper Services

Designed to ensure individuals are receiving the least restrictive services based on needs.

Medication Assisted Treatment

Use of medications in combination with counseling and behavioral therapies for treatment of substance use disorders. Several CMHCs do offer this service in Wyoming.

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

Memorandum of Understanding (MOU)

Hospitals and community mental health centers are contractually obligated to have an MOU. This MOU lists expectations for coordination of care and communication regarding discharge plans of individuals receiving services.

Title 25 (Wyo. Stat. Ann. 25-10-101 - 129)

The Division coordinates many activities to address the high number of involuntary hospitalization in the state. The Clinical Services Unit Manager is the coordinator 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 coordinate the following services under comprehensive community-based mental health service systems?

- | | |
|----------------------------|---|
| a) Physical Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) Mental Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Housing services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services | <input checked="" type="radio"/> Yes <input type="radio"/> 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 or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

By virtue of CMHCs and Public Health Nursing within the centers, physical health services can be provided. Through Quality of Life funding, medical and dental services can be provided. Services provided by local school systems under IDEA have the ability to provide community resources to those in need.

3. Describe your state's case management services

All state funded CMHCs provide case management; services include advocacy, linkage, monitoring, and follow-up services. Case managers serve as primary links between basic needs, community resources, family, legal, primary care services, and recovery support.

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

Gatekeeper services - Designed to ensure individuals are receiving the least restrictive services based on needs.

Alternatives include: LOCUS and Lighthouse. LOCUS is the Level of Care Utilization System for Psychiatric and Addiction Services providing a system for assessment of service needs for adult clients, describe continuum service intensities, create a methodology for quantifying assessment of service levels, and facilitate clinical management and documentation. Cloud Peak Counseling Center, a provider in Wyoming, operates a Lighthouse inpatient treatment facility, made up of six beds, it ranges from voluntary walk-ins to patients admitted under Title 25.

NOT FINAL

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 M/SUD 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	7685	8981
2.Children with SED	4530	2660

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 estimate for planning purposes (<https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Wyoming-2018.pdf>). The Statewide incidence rate was determined using WCIS as providers are required to input information such as, "SMI Clients Served/Hours Provided" and "SED at Transaction Date". National data and evidence based practices for mental health treatment are taken into account when considering what providers will be awarded with State funding.

(47 Percent of Client who meet Federal SMI definition from Uniform Reporting System at 16,352 clients served (WCIS) = 7685 prevalence. Statewide incidence of "SMI Clients Served" from WCIS shows 8981 clients served).

(27 Percent of Ages 17 and under at 16,352 clients served = 4530 prevalence. Statewide incidence of "SED at Transaction Date" from WCIS shows 2660 clients served).

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

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 | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) | Educational services, including services provided under IDE | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) | Juvenile justice services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) | Substance misuse preventiion and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) | Health and mental health services | <input checked="" type="radio"/> Yes <input 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 |

NOT FINAL

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

- a. Describe your state's targeted services to rural population.

Wyoming is a rural and frontier State, all services are individually based on availability and accessibility.

- b. Describe your state's targeted services to the homeless population.

PATH Grant - The State applies for this grant each year. Allowing the State to provide outreach and PATH case management services for adults 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, disability providers, and others) to utilize the SOR process for people who are literally homeless or at risk of homelessness to apply for SSI and/or SSDI. CMHCs/SACs work to preempt unnecessary crisis/emergency detention of persons with SMI who are homeless. Further, CMHCs provide community based services in each county to adults and children.

- c. Describe your state's targeted services to the older adult population.

Wyoming is a rural and frontier state, all services are individually based on availability and accessibility.

NOT FINAL

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.

Function is on the local communities; providers are required to submit emergency action plans including training documents, resources, and plans. Providers can access MHTTC/TTC for training opportunities.

The Division requests emergency plans from the providers. In using these plans, the Division hopes to create a safety net of communication if/when an emergency arises. For example, if there is a need for mental health services for an event (e.g. tornado) and one provider was impacted, the communication exists for a close-by provider to assist where needed. Emergency preparedness training could be offered, as most Federal Emergency Management Agency (FEMA) through the United States Department of Homeland Security training and classes are free and online. The state may find training available in regards to the emergency health services regarding SMI and SED, until these resources are located, discussed, and a plans, funds will be reserved as TA funds.

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

10. 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 | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ii) Education | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iii) Brief Intervention | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iv) Assessment | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| v) Detox (inpatient/social) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vi) Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vii) Intensive Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| viii) Inpatient/Residential | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ix) Aftercare; Recovery support | <input checked="" type="radio"/> Yes <input type="radio"/> No |

b) Services for special populations:

- | | |
|--------------------------------------|---|
| Targeted services for veterans? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| Adolescents? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Other Adults? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| Medication-Assisted Treatment (MAT)? | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Criterion 2

NOT FINAL

Criterion 3

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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ 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. Has your state identified a need for 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, and custody issues? ☐ Yes ☒ No
 - g) Providing employment assistance ☒ Yes ☐ No
 - h) Providing transportation to and from services ☒ Yes ☐ No
 - i) Educational assistance ☐ Yes ☒ 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 ☒ 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. Has your state identified a need for 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 (e.g., military families, veterans, adolescents, older adults)? ☐ Yes ☒ 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? ☒ Yes ☐ No
2. Has your state identified a need for 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
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. If agencies identify a client who needs TB services, the client is referred to the WDH TB program.

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

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ☐ Yes ☒ No
2. Has your state identified a need for 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
N/A

NOT FINAL

Criterion 8,9&10**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
2. Has your state identified a need for 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. Has your state identified a need for 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, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, 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
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries ☐ Yes ☒ No
 - b) An organized referral system to identify alternative providers? ☐ Yes ☒ No
 - c) 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. Has your state identified a need for 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

1. Does your state have an agreement to ensure the protection of client records? ☒ Yes ☐ No
2. Has your state identified a need for 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.

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

FY19 has eight (8) block grant sub-recipients identified to undergo the peer review.

FY20 has eight (8) block grant sub-recipients identified to undergo the peer review.

FY21 has eight (8) block grant sub-recipients identified to undergo the peer review.

3. Has your state identified a need for 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) Development of 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, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? ☒ Yes ☐ 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)

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? ☐ Yes ☒ No
2. Has your state identified a need for 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
 - b) 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:
 - 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. Has your state identified a need for 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
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? ☒ Yes ☐ No
 - b) Mental Health TTC? ☒ Yes ☐ No
 - c) Addiction TTC? ☒ Yes ☐ No
 - d) State Targeted Response TTC? ☒ 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
 - b) Early Intervention Services Regarding HIV ☐ Yes ☒ No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment ☐ Yes ☒ No
 - b) Professional Development ☐ Yes ☒ No

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

<http://rules.wyo.gov>

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. 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 2018-FFY 2019?

☐ Yes ☒ No

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

None at this time.

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NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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 Trauma⁵⁸ paper.

57 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.

58 Ibid

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 M/SUD 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 M/SUD providers? ☒ Yes ☐ No
3. Does the state have a plan to build the capacity of M/SUD 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.
None at this time.
Please indicate areas of technical assistance needed related to this section.
None at this time.

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NOT FINAL

Environmental Factors and Plan

13. 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.⁵⁹

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.⁶⁰

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 the Health Insurance 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.

⁵⁹ 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 Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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 has implemented LOCUS-5, Lighthouse services, and has attempted to implement an Emergency Room pilot program.
Please indicate areas of technical assistance needed related to this section.
None at this time.

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14. Medication Assisted Treatment - Requested (SABG only)

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? ☒ Yes ☐ 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? ☐ 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 abuse use disorders are used appropriately*? ☐ Yes ☒ No
5. Does the state have any activities related to this section that you would like to highlight?

The Division has contracted with the University of Wyoming (UW), Washington, Wyoming, Alaska, Montana, Idaho (WWAMI), Rural and Underserved Opportunities Program (RUOP), to give students the ability to explore MAT with professionals. The funding comes from the SOR Grant. Students live in rural or urban underserved communities throughout Washington, Wyoming, Alaska, Montana, or Idaho for a four-week, elective immersion experience. They work side-by-side with local physicians providing healthcare to underserved populations. Administered by the UW Department of Family Medicine, RUOP is a collaborative effort of the UW School of Medicine, WWAMI campuses and the Area Health Education Centers. Once students graduate, several may stay within the state, utilizing their experience in MAT where appropriate.

**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.*

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Environmental Factors and Plan

15. 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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ 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 M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"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 M/SUD 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.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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) ☒ Peer Support/Peer Bridgers
- b) ☒ Follow-up Outreach and Support
- c) ☐ Family-to-Family Engagement
- d) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis

- e) ☐ Follow-up crisis engagement with families and involved community members
- f) ☒ Recovery community coaches/peer recovery coaches
- g) ☒ Recovery community organization

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

Not at this time.

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

Not at this time.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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? ☒ Yes ☐ No
- b) Required peer accreditation or certification? ☐ Yes ☐ No
- c) Block grant funding of recovery support services. ☒ Yes ☐ 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 ☐ 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?
Not at this time.
Please indicate areas of technical assistance needed related to this section.
Not at this time.

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Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

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:

Please respond to the following items

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

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 (WDH) is currently updating the Olmstead Plan. Both the 2017 report and the 2019 updates will be available to review in the attachments.

In regards to reducing volume and demand in Wyoming's "Title 25" system for involuntary commitments: On track for continued reduction in total volume and total costs from previous biennia related to Title 25 involuntary hospitalizations. There is currently a forecasted 28% chance of exceeding all Title 25 funds available in the 2019-2020 biennium. This is up from the previous quarterly projection, primarily due to a temporary capacity limitation at the Wyoming State Hospital (WSH) regarding ligature risk modifications, required by CMS.

In regards to decreasing the average length of stay (ALOS) at the WSH and Title 25 "designated hospitals": ALOS is down as compared to the three previous fiscal years, and continues to be monitored daily through the new WSH data tracking system. Note: the WDH monitors ALOS for short-term (acute) and the facility writ-large separately to assist in managing operations (e.g., admission/discharge flows). The WDH expects ALOS to further reduce when construction of the new WDH facilities (WSH and Wyoming Life Resource Center (WLRC)) is complete in 2020-2021.

In regards to Wyoming's Comprehensive and Supports (DD/ID) waivers: The WDH continues to see an upward trend in the number and percent of individuals on the wait list for more than 18 months. The WDH will bring as many individuals off the wait list as possible, but it is heavily dependent on the budget forecast for the 2019-2020 biennium.

In regards to the expansion of healthcare coverage options for Wyoming's uninsured population experiencing, or at-risk of institutionalization: No progress on expanded healthcare coverage options (e.g., Medicaid expansion).

After legislation passed in the 2018 Budget Session, the WDH has expanded the Wyoming Medicaid Donation program. The program has moved to a new location, with the ability to process increased volume of donated medication to be distributed to communities and individuals in need in Wyoming.

The Joint Labor, Health, and Social Services interim committee will be taking up "mental health" as a 2019 interim topic. It is possible the committee will discuss expanded coverage options (e.g., Medicaid expansion, adult mental health waivers, etc.) as well as system reforms (e.g., Title 25) that may impact this goal and metric.

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

Not at this time.

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Footnotes:

Attachments for this section:

1. Wyoming-Department-of-Health_Olmstead-Primer-and-Plan
2. WDH Olmstead_data update_04.2019

NOT FINAL

WYOMING OLMSTEAD GOALS, 2017-2021

April, 2019 Updates

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.

April, 2019 update: On track, pending 2019 Legislative Session actions.

2. Continue to implement operational changes needed to meet new missions – as defined by the Wyoming Legislature – at the Wyoming State Hospital and the Wyoming Life Resource Center.

April, 2019 update: On track.

3. Reduce volume and demand in Wyoming’s “Title 25” system for involuntary commitments.

April, 2019 update: On track for continued reduction in total volume and total costs from previous biennia related to Title 25 involuntary hospitalizations. There is currently a forecasted 28% chance of exceeding all Title 25 funds available in the 2019-2020 biennium. This is up from our previous quarterly projection, primarily due to a temporary capacity limitation at the Wyoming State Hospital due to ligature risk modifications, required by CMS.

Figure 1: Cumulative Title 25 costs and projected costs, SFY 2012-2020 (projected), updated April, 2019

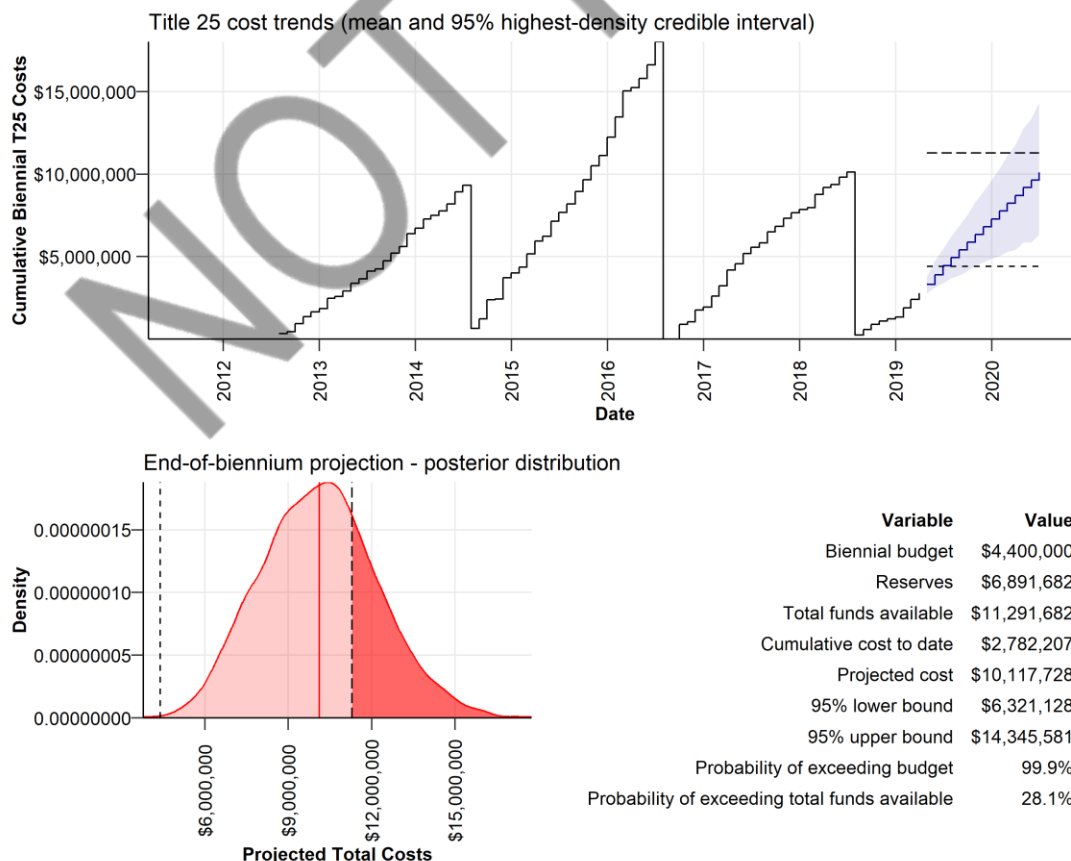
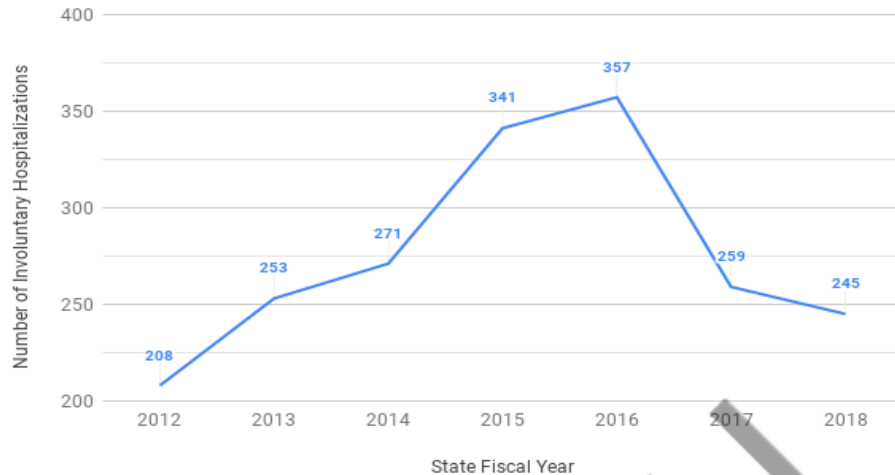


Figure 2: Involuntary hospitalization orders (after a ‘110’ hearing), by state fiscal year



**Note that there have been 185 involuntary hospitalizations statewide in SFY 2019 to date. There are 228 involuntary hospitalizations projected for SFY 2019 (straight line monthly average).*

4. Decrease the average length of stay (ALOS) at the Wyoming State Hospital and Title 25 “designated hospitals.”

April, 2019 update: ALOS is down as compared to the three previous fiscal years, and continues to be monitored daily through the new State Hospital data tracking system (shown in Figures 4, 5, and 6, below). Note that the Department monitors ALOS for short-term (acute) and the facility writ-large separately to assist in managing operations (e.g., admission/discharge flows). The Department expects ALOS to further reduce when construction of the new WDH facilities (Wyoming State Hospital and Wyoming Life Resource Center) is complete in 2020-2021.

Figure 3, below, shows ALOS for the Adult Psychiatric Services (APS) unit at the Wyoming State Hospital. Figure 4, on the next page, shows the wait list and population mix for the APS unit. Note the downward trend in the “long term” population over the previous 18 months.

Figure 3: ALOS at the Wyoming State Hospital, by state fiscal year

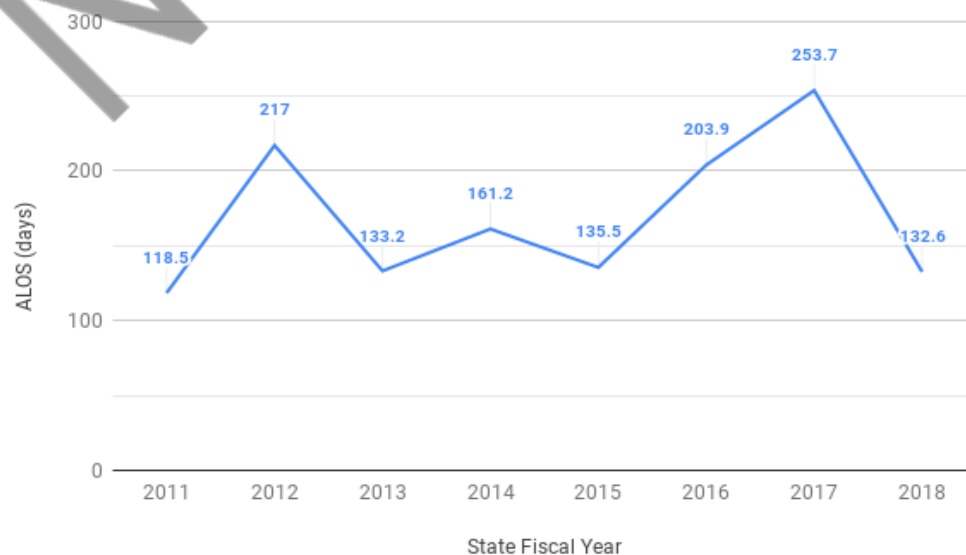


Figure 4: State Hospital census and wait list, by population type, through April, 2019

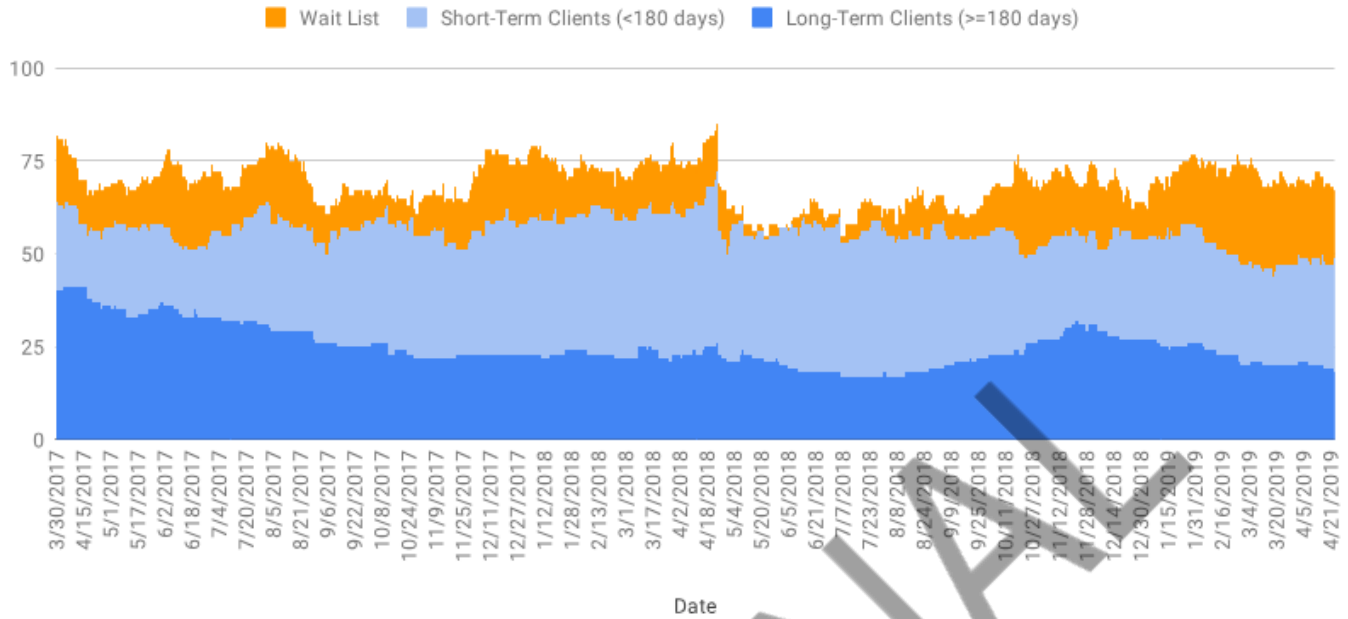
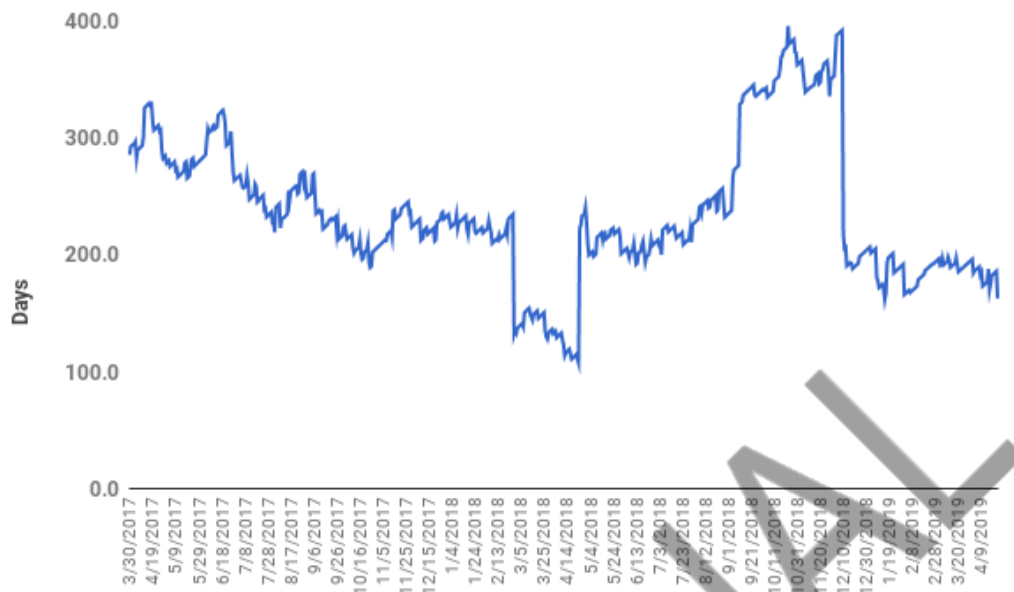


Figure 5: State Hospital average length of stay (ALOS) for short-term clients (e.g., <180 days)



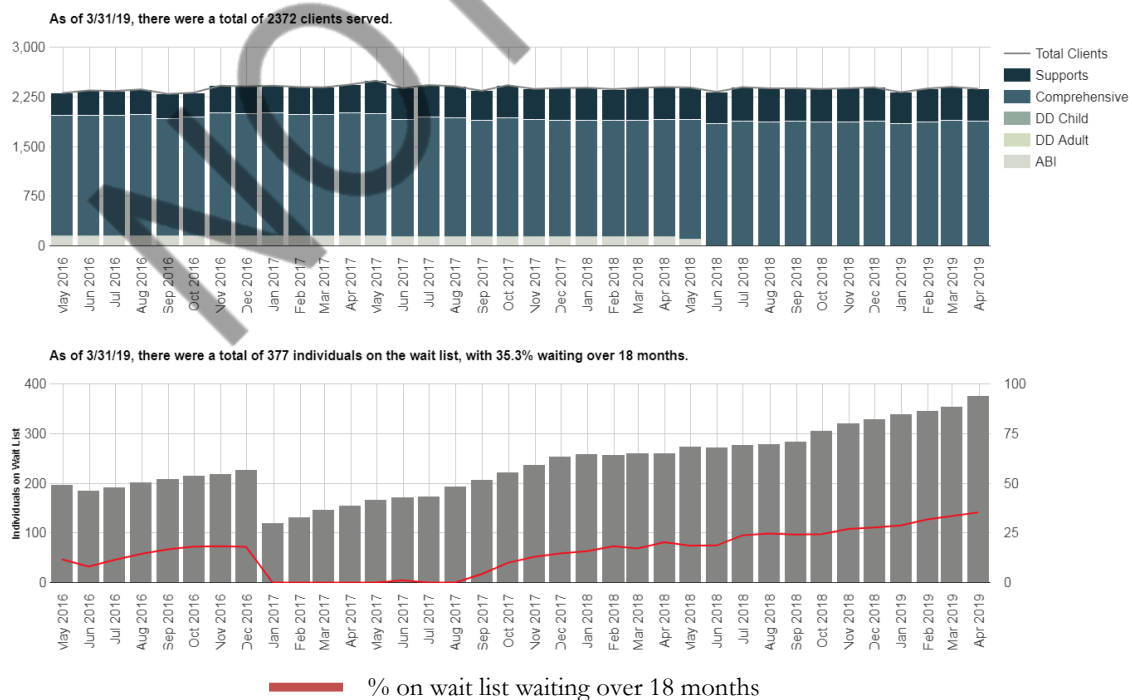
Figure 6: State Hospital average length of stay (ALOS) for all clients, excluding Carbon Hall¹



- 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.

April, 2019 update: The Department continues to see an upward trend in the number and percent of individuals on the wait list for more than 18 months. The Department will bring as many individuals off the wait list as possible, but it is heavily dependent on the budget forecast for the 2019-2020 biennium.

Figure 7: DD waiver dashboard screenshot, through March, 2018

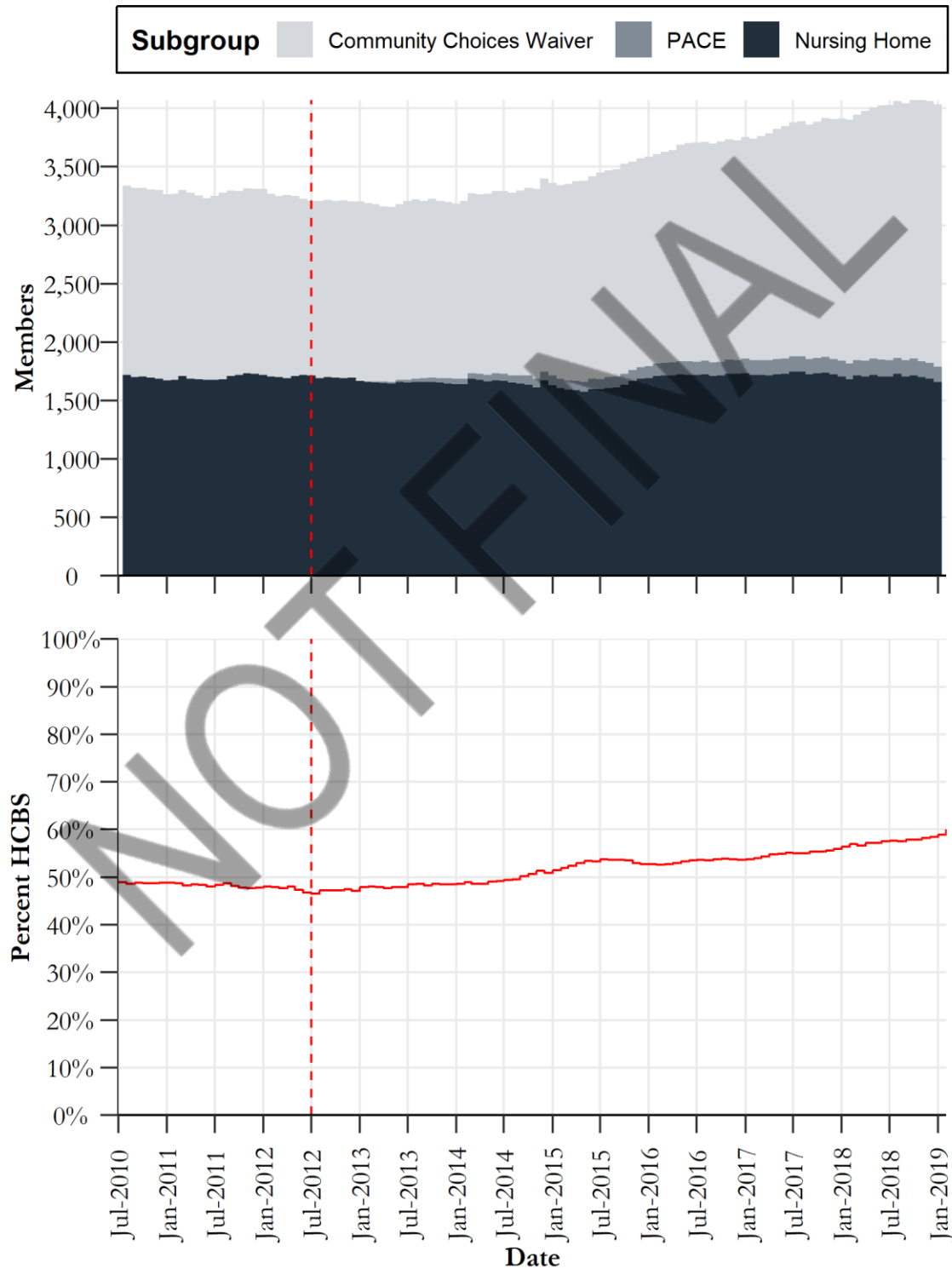


¹ Carbon Hall is a unit at the Wyoming State Hospital that cares for elderly patients with psychiatric needs (e.g., gero-psych). This unit is scheduled to be phased out after the construction is complete for the new State Hospital buildings in Evanston and the new Wyoming Life Resource Center buildings in Lander.

- Continue to increase the percentage of Medicaid long-term care recipients served in home and community-based settings, as opposed to institutional settings.

April, 2019 update: On track. Percent of long-term care recipients served in home and community-based settings continues to increase.

Figure 6: Medicaid Long-term care members, by setting, by month and fiscal year



7. Continue to maintain a “zero waitlist” policy for Medicaid Long-term Care Waivers (Community Choice Waiver).

April, 2019: On track.

8. Expand healthcare coverage options for Wyoming’s uninsured population experiencing, or at-risk of institutionalization.

April, 2019 update: No progress on expanded healthcare coverage options (e.g., Medicaid expansion).

- After legislation passed in the 2018 Budget Session, the Department has expanded the Wyoming Medicaid Donation program. The program has moved to a new location, with the ability to process increased volume of donated medication to be distributed to communities and individuals in need in Wyoming.
- The Joint Labor, Health, and Social Services interim committee will be taking up “mental health” as a 2019 interim topic. It is possible the committee will discuss expanded coverage options (e.g., Medicaid expansion, adult mental health waivers, etc.) as well as system reforms (e.g., Title 25) that may impact this goal and metric.

NOT FINAL

WYOMING AND *OLMSTEAD*

A PRIMER ON DEPARTMENT OF HEALTH INITIATIVES AND POLICIES



Wyoming Department of Health

Updated July, 2017

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EXECUTIVE SUMMARY

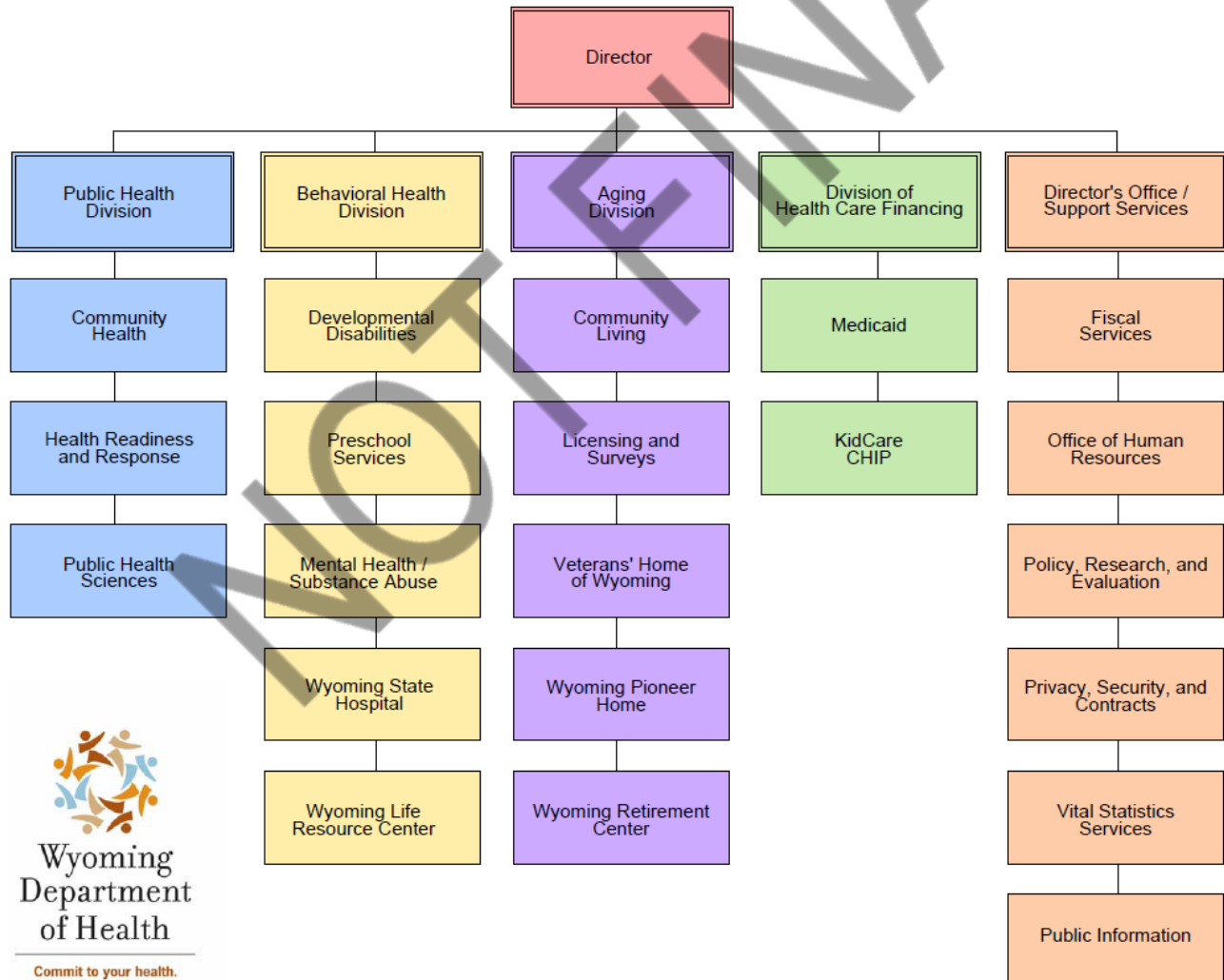
Purpose

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.

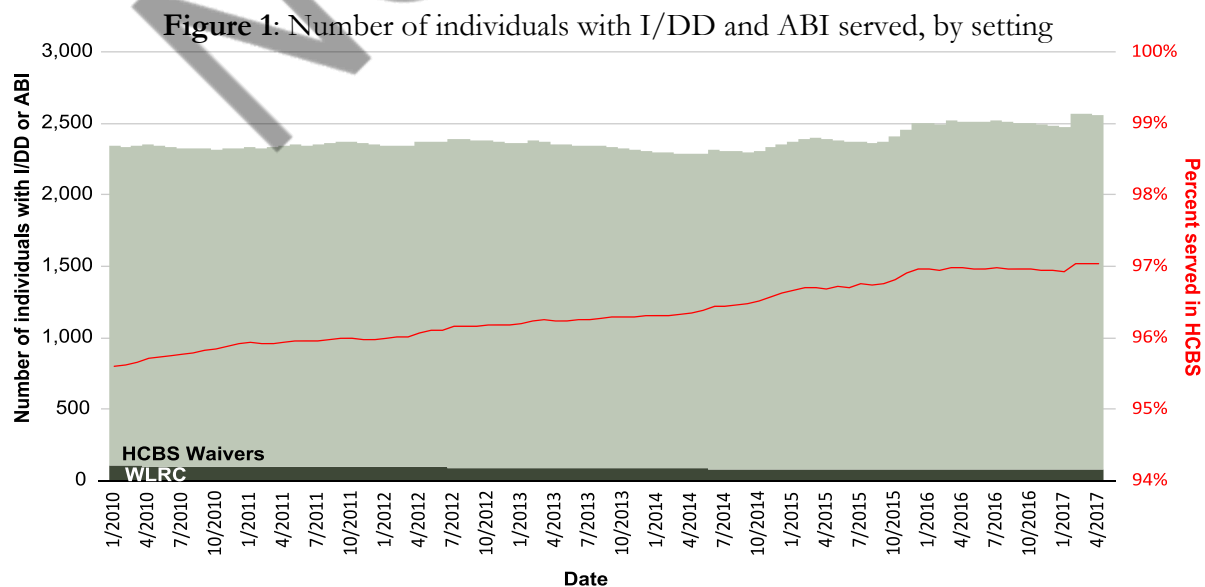
The State, as well as the WLRC, must comply with many federal and state codes, statutes and regulations, as well as the interpretations of these laws by U.S. courts.

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

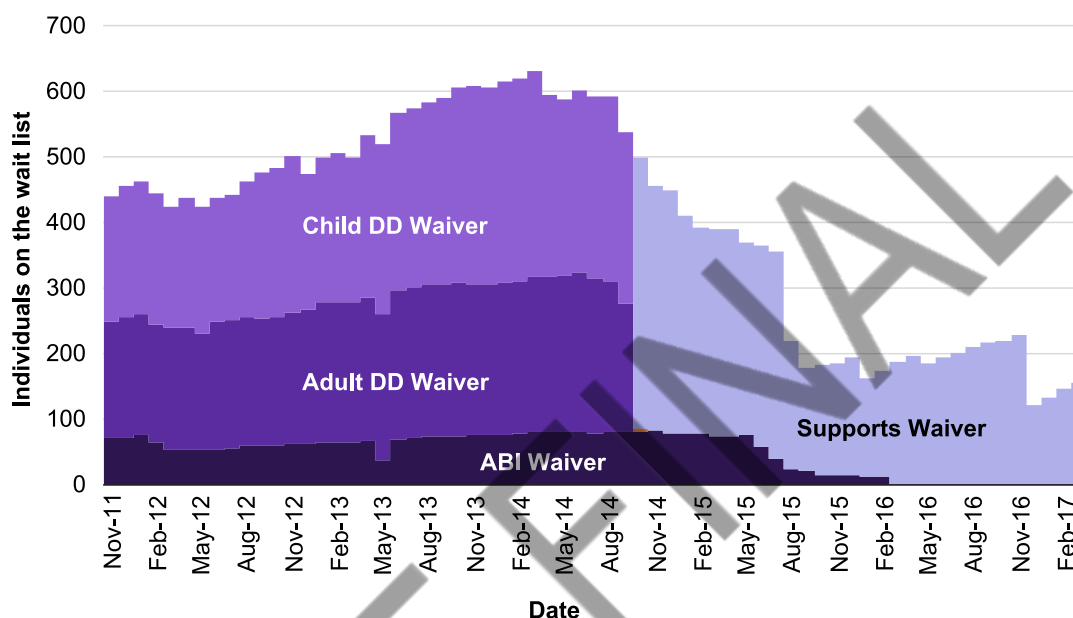
When compared with the significantly higher number of people served in home- and community-based settings, the fraction of individuals with I/DD or ABI in an institution has declined as well. This is illustrated in Figure 1, below. Note that the percent served in HCBS has increased from approximately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

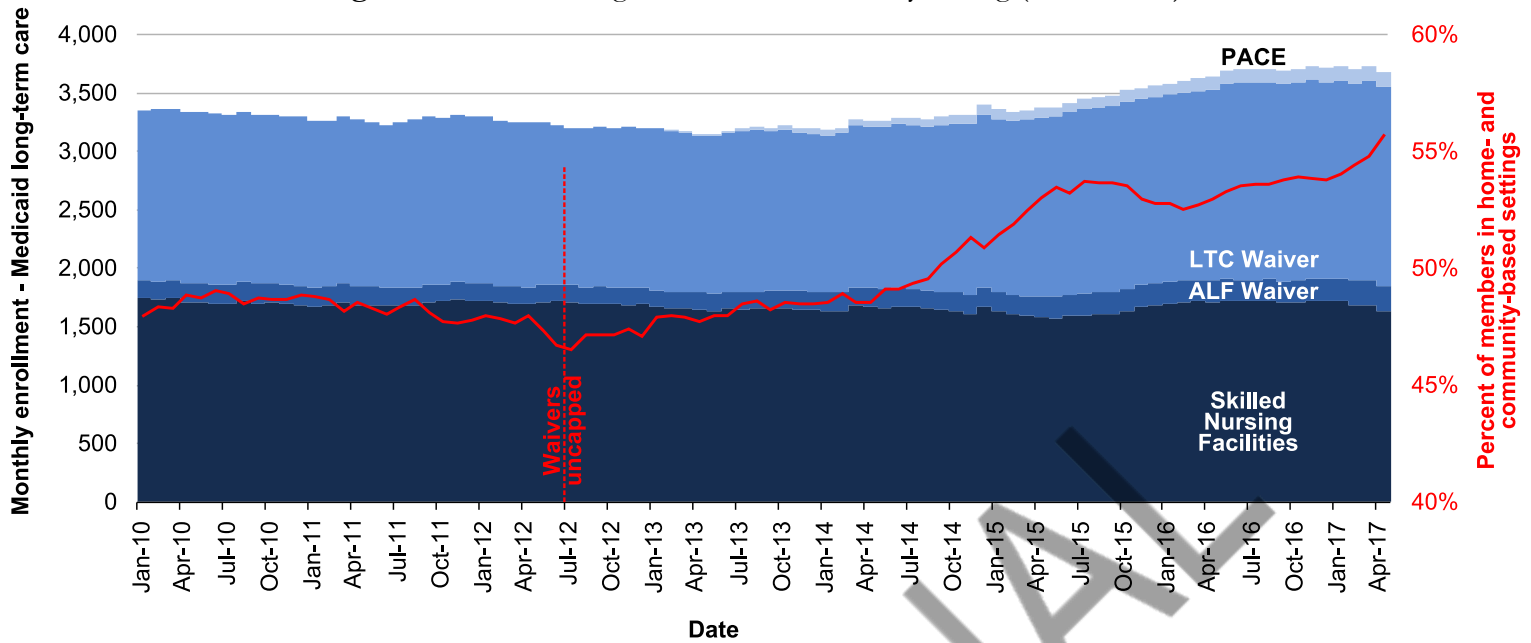
Of note in the tables:

- 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)

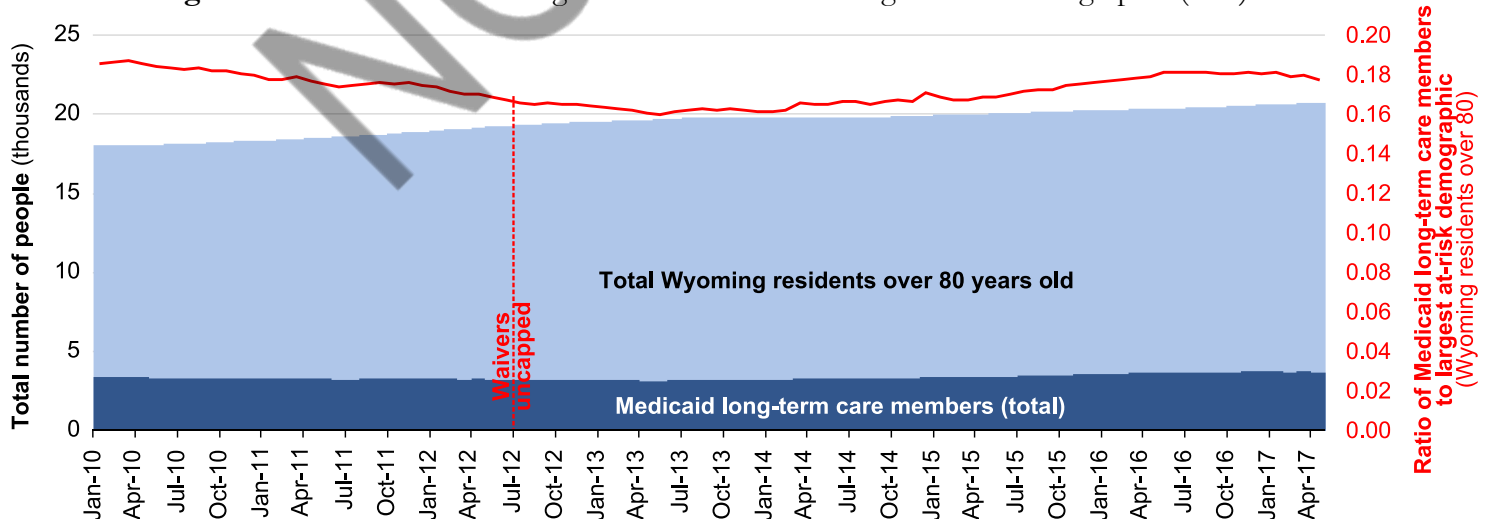


Note on Figure 3, above, the legislative decision to “uncap” the LTC and ALF waivers in SFY 2013. This has led to a gradual increase in the percentage of individuals served in HCBS settings, from approximately 47% to over 56% today. This trend is beneficial both to members (who would much prefer to remain 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.

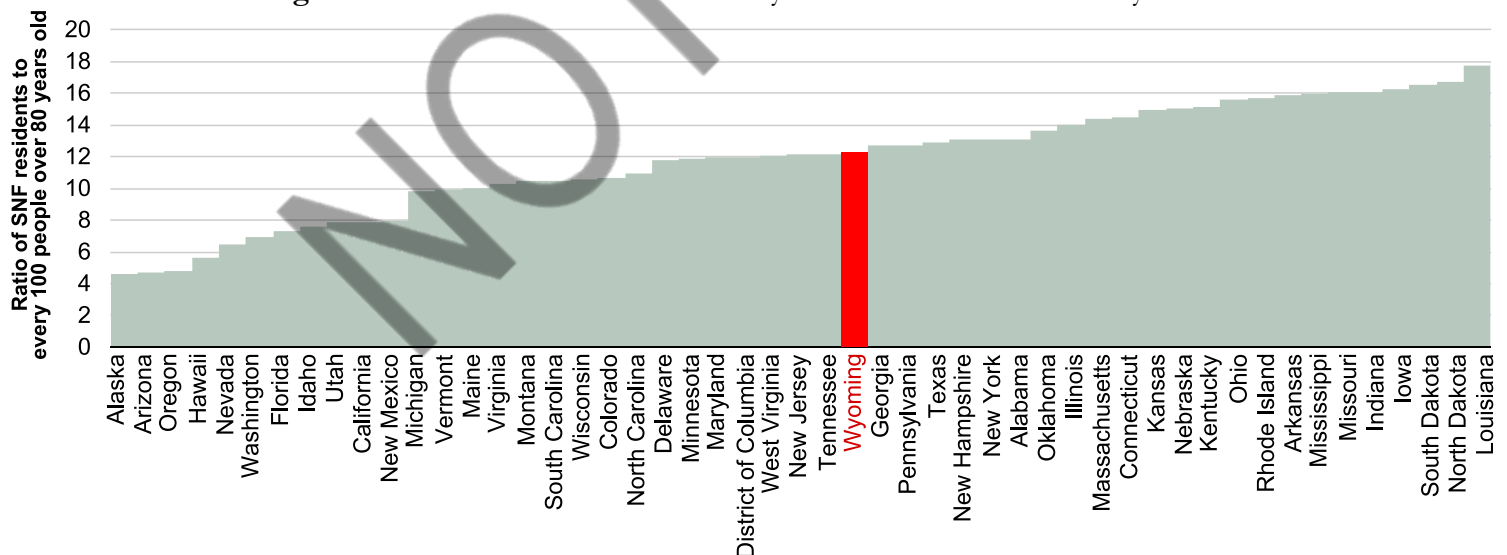
Table 5: ALF/LTC vs. SNF average number of points¹⁶

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

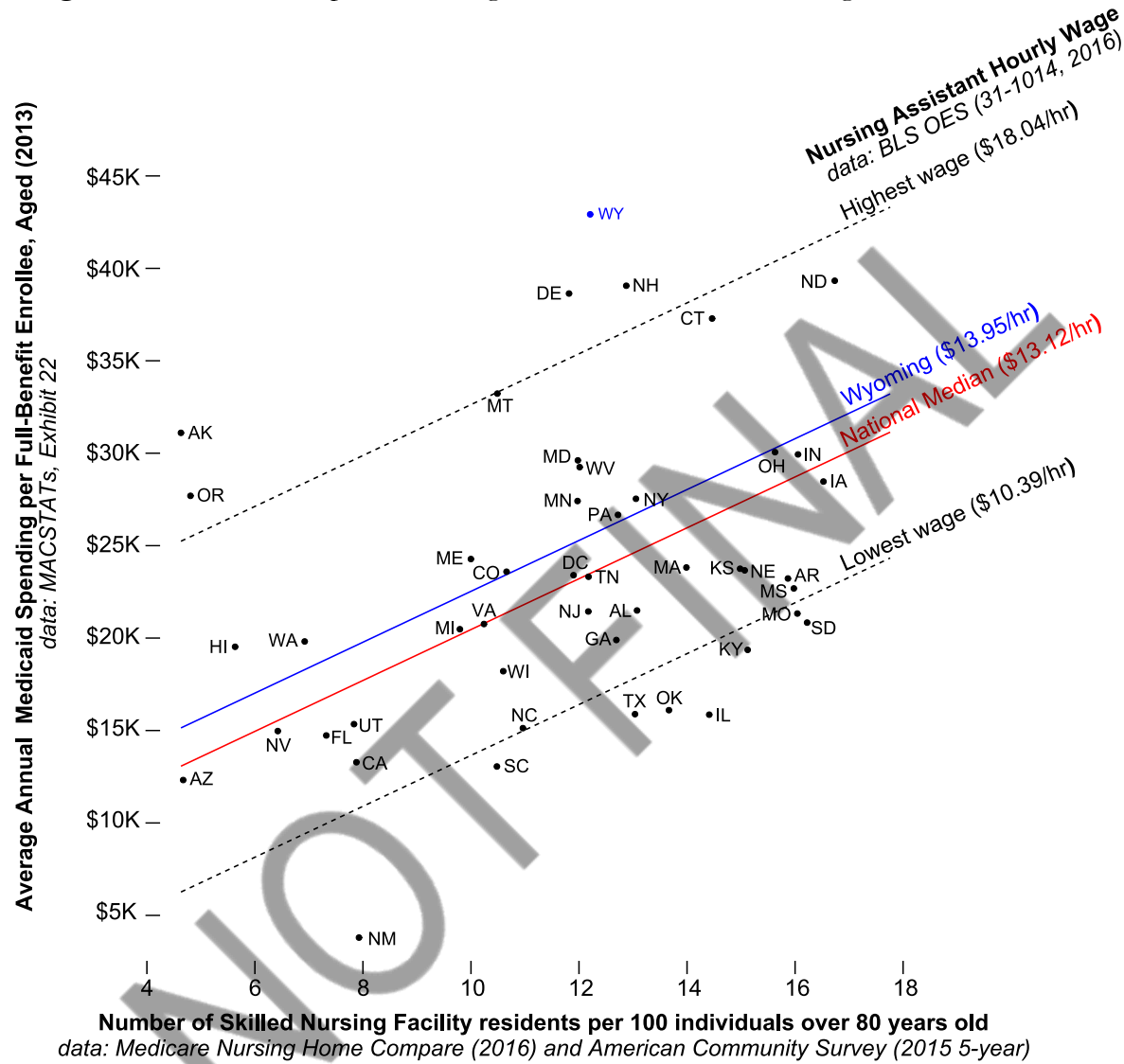


Because SNF settings are so expensive, this degree of institutionalization is partly responsible for the fact that Wyoming has the highest Medicaid cost per aged full-year equivalent enrollee. The scatterplot in Figure 6,

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	
"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.

NOT FINAL

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

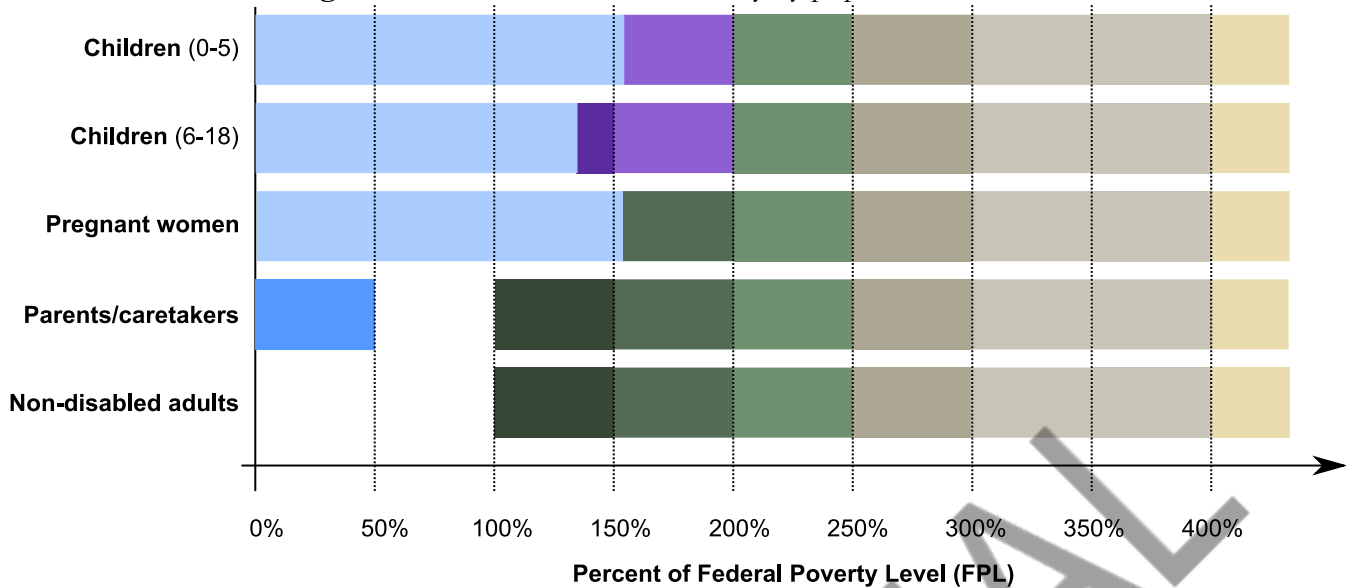
Wyoming's economy depends heavily on mineral extraction and tourism. Low prices for oil and gas, along with decreasing demand for coal have depressed output, increased unemployment, and reduced State government revenues by an estimated 23 percent for 2017-18. The Governor and Legislature have, accordingly, 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



Insurance Coverage

Public		Medicaid -No cost sharing -No premiums
		Medicaid -De minimis cost sharing -No premiums
		CHIP Plan B -MOOP: Med: \$200 / Pharm: \$100 / Dental: \$15 -No premiums
		CHIP Plan C -MOOP: Med: \$300 / Pharm: \$200 / Dental: \$75 -No premiums
Individual coverage on Federally-facilitated marketplace		Cost Sharing Reduction - 94% AV + APTC Avg. MOOP: \$879 / Avg. deductible: \$229 Premium limit: 6.3 - 8.05% of income
		Cost Sharing Reduction - 87% AV + APTC Avg. MOOP: \$1,691 / Avg. deductible: \$737 Premium limit: 6.3 - 8.05% of income
		Cost Sharing Reduction - 73% AV + APTC Avg. MOOP: \$4,622 / Avg. deductible: \$2,078 Premium limit: 6.3 - 8.05% of income
		Silver - 70% AV + APTC Avg. MOOP: \$5,824 / Avg. deductible: \$2,559 Premium limit: 8.05 - 9.5% of income
		Silver - 70% AV + APTC Avg. MOOP: \$5,824 / Avg. deductible: \$2,559 Premium limit: 9.5% of income
		Silver - 70% AV Avg. MOOP: \$5,824 / Avg. deductible: \$2,559

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

18. Children and Adolescents M/SUD 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 community.⁶³ 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 24.⁶⁴ 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 death.⁶⁵

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 21.⁶⁶ 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 costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ 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 M/SUD 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).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, 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.

⁶⁵Centers 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.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department 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 <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? ☐ Yes ☒ No
 - The recovery and resilience of children and youth with SUD? ☐ Yes ☒ No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - Child welfare? ☐ Yes ☒ No
 - Juvenile justice? ☐ Yes ☒ No
 - Education? ☐ Yes ☒ No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? ☒ Yes ☐ No
 - Costs? ☐ Yes ☒ No
 - Outcomes for children and youth services? ☒ Yes ☐ No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
 - Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? ☐ Yes ☒ No
 - for youth in foster care? ☐ Yes ☒ No
- 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.
- Does the state have any activities related to this section that you would like to highlight?
 Not at this time.
 Please indicate areas of technical assistance needed related to this section.
 Not at this time.

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19. Suicide Prevention - Required for 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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; 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 2018-FFY 2019 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 Wyoming counties have a 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.

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

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20. Support of State Partners - Required for 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

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 CMHC 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. Memorandum of Understanding between hospitals and community mental health centers.
b. Behavioral Health Advisory Council
c. Gatekeeping and Diversion grants
d. Early Intervention and Education Program- Ensures that services are provided to eligible children birth through five with Developmental Delays and disabilities in accordance with the IDEA and Wyoming state laws.

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

None at this time.

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21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and 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 an Advisory/Planning Council (PC). 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 PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf).⁶⁹

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 M/SUD 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.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

- a) 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 Wyoming Association of Mental Health and Substance Abuse Centers (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

3. 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; two times annually is the minimum with the flexibility to have a meeting every two months in a twelve consecutive month period. These meetings focus on addressing concerns identified by the membership. 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 collected to help the Council understand behavioral health issues in a broader perspective.

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

None at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There 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.

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Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
HEATHER BABBITT	State Employees	WY DEPT OF HEALTH - MHSA		
AMANDA BIALAS	State Employees	DIVISION OF VOC REHAB		
SAM BORBELY	State Employees	DEPT OF CORRECTIONS		
LORI BURNS	Others (Advocates who are not State employees or providers)	HOUSING AUTHORITY		
KATHRYN CAMPBELL	Parents of children with SED/SUD			
TAMMY COOLEY	Youth/adolescent representative (or member from an organization serving young people)			
CASSANDRA CRUMPTON	Others (Advocates who are not State employees or providers)			
PAUL DEMPLE	Providers	NORTHERN WYOMING MENTAL HEALTH CENTER		
SCOTT ERICKSON	Others (Advocates who are not State employees or providers)			
TRUDY FUNK	Providers	CURRAN-SEELEY FOUNDATION		
KYLE GAMROTH	Youth/adolescent representative (or member from an organization serving young people)			
SUNNY GOGGLES	Representatives from Federally Recognized Tribes			
WAYNE GRAVES	Others (Advocates who are not State employees or providers)			
LAURA GRIFFITH	Persons in recovery from or providing treatment for or advocating for SUD services			
ROBERT JOHNSTON	Others (Advocates who are not State employees or providers)		WY,	
CHERI KREITZMANN	Youth/adolescent representative (or member from an organization serving young people)			
SHERRY MERCER	Family Members of Individuals in Recovery (to include family members of adults with SMI)			

CHRISTY MISPLAY	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
JO ANN NUMOTO	State Employees	DEPT OF EDUCATION		
SHARON PUCILLO	State Employees	DEPT OF FAMILY SERVICES		
DONNA SEDEY	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
BRENDA STOUT	State Employees	DEPT OF HEALTH - HEALTHCARE FINANCING		
MICHAELA TSCHIRHART	Persons in recovery from or providing treatment for or advocating for SUD services			
JEFF WASSERBURGER	State Employees	SENATE DISTRICT 23		
KELLY WEBB	Representatives from Federally Recognized Tribes			
JESSI WESTLING	Others (Advocates who are not State employees or providers)			
CHASSITY WIEDERSPAHN	Youth/adolescent representative (or member from an organization serving young people)			
SUE WILSON	State Employees	LEGISLATURE/HOUSE		
CAROLYN YEAMAN	Others (Advocates who are not State employees or providers)			

*Council members should be listed only once by type of membership and Agency/organization represented.

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BEHAVIORAL HEALTH DIVISION STAFF:

MEGAN NORFOLK, BLOCK GRANT COORDINATOR / BHAC LIAISON (NON-VOTING MEMBER)

MARLA SMITH, COMMUNITY SYSTEM UNIT MANAGER (NON-VOTING MEMBER)

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Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	28	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	1	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	3	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	2	
Total Individuals in Recovery, Family Members & Others	18	64.29%
State Employees	8	
Providers	2	
Vacancies	0	
Total State Employees & Providers	10	35.71%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Youth/adolescent representative (or member from an organization serving young people)	4	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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22. 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? ☒ Yes ☐ No
- b) Posting of the plan on the web for public comment? ☒ Yes ☐ No
- If yes, provide URL:
<https://health.wyo.gov/behavioralhealth/mhsa/grants/>
- c) Other (e.g. public service announcements, print media) ☒ Yes ☐ No

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