

Wyoming

UNIFORM APPLICATION

FY 2022 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 12/13/2021 3.18.29 PM)

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

A. State Information

State Information

State DUNS Number

Number 809915796
Expiration Date 4/20/2020 12:00:00 AM

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

Agency Name Wyoming Department of Health
Organizational Unit Behavioral Health Division
Mailing Address 122 W 25th Street Herschler Bldg 2W, Suite B
City Cheyenne
Zip Code 82002

II. Contact Person for the Grantee of the Block Grant

First Name Matthew
Last Name Petry
Agency Name Wyoming Department of Health
Mailing Address 122 W 25th Street Herschler Bldg 2W , Suite B
City Cheyenne
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III. State Expenditure Period (Most recent State expenditure period that is closed out)

From 7/1/2020
To 6/30/2021

IV. Date Submitted

NOTE: This field will be automatically populated when the application is submitted.

Submission Date 11/17/2021 12:09:48 PM
Revision Date 11/17/2021 12:09:54 PM

V. Contact Person Responsible for Report Submission

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Footnotes:

URS Tables Contact:

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B. Implementation Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

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 goal:

- 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

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Adult Binge Drinking Rates
Baseline Measurement: 18.6% (BRFSS 2018)
First-year target/outcome measurement: 17%
Second-year target/outcome measurement: 15%

New Second-year target/outcome measurement(if needed):

Data Source:

Behavioral Risk Factor Surveillance System

New Data Source(if needed):

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).

New Description of Data:(if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

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 goal:

- 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

Edit Strategies to attain the objective here:

(if needed)

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%

New Second-year target/outcome measurement (if needed):

Data Source:

Prevention Needs Assessment (PNA)

New Data Source (if needed):

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.

New Description of Data (if needed):

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

Indicator #: 2
Indicator: Alcohol Compliance Rate - Statewide
Baseline Measurement: 88.9% (2018)
First-year target/outcome measurement: 90%
Second-year target/outcome measurement: 91%

New Second-year target/outcome measurement(if needed):

Data Source:

Alcohol and Tobacco Sales Compliance Checks Report

New Data Source(if needed):

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.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

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 goal:

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.

Edit Strategies to attain the objective here:

(if needed)

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

New Second-year target/outcome measurement(if needed):

Data Source:

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

New Data Source(if needed):

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 420.75 days of individuals occupying a bed in the mental health housing facility.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None at this time.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The length of stay significantly increased to 524.84 days. COVID-19 could have effected these outcomes due to shutdowns and quarantine. Note: New goals coming next year. The MH goal will be closed out and new ones created.

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The length of stay significantly increased to 606.49 days. A large reason due to COVID-19 impact throughout the State.

How second year target was achieved (optional):

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 62.81%, underlining we have not quite met our goal for this year.

Strategies to attain the goal:

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

**Edit Strategies to attain the objective here:
(if needed)**

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%

New Second-year target/outcome measurement(if needed):

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.

New Data Source(if needed):

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%.

New Description of Data:(if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

Statewide methamphetamine treatment completion rate was 67.80%.

How second year target was achieved (optional):

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 goal:

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.

Edit Strategies to attain the objective here:

(if needed)

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%

New Second-year target/outcome measurement (if needed):

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.

New Data Source (if needed):

Description of Data:

Individuals treatment completion status is noted in their discharge information through WCIS. Target for FY19 is currently short at 58.33%.

New Description of Data (if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

Statewide Opioid Use Treatment Completion rate increased to 74.14%

Priority #: 6
Priority Area: Percent of individuals with a positive TB testing, whom completed Latent TB Infection (LTBI) treatment.
Priority Type: SAT
Population(s): TB

Goal of the priority area:

Improve access to TB treatments.

Objective:

Increase the percent of individuals whom test positive for TB; including completion of LTBI treatment.

Strategies to attain the goal:

Work closely with provider agencies to initiate individuals with TB.
Develop individual and/or standardized provider contract target; focusing on testing, admitting (residential only), and treating individuals with TB.
Provide technical assistance and training, upon request.
Improve reporting metric by bringing together two different systems; WCIS and TB Registry.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of individuals in the TB Program enrolled for LTBI/active TB disease treatment
Baseline Measurement: 2015: 77%
First-year target/outcome measurement: 2019: 80%
Second-year target/outcome measurement: 2020: 80%
New Second-year target/outcome measurement(if needed):
Data Source:

This source comes from the TB Patient Registry from the Public Health Divisions, Communicable Disease Program. Each Patient has a folder on a State HIPAA drive that includes their TB testing, treatment, and follow up records. In the TB Patient Registry in the "reason for test" numerous risk factors are included, including intravenous drug use. Data is collected from this.

New Data Source(if needed):

Description of Data:

CY 2017 - Actual: 90% - 3 patients identifying as IDU; 1 completed LTBI treatment, 1 initiated but lost to follow up (pregnant), 1 did not initiate treatment (no data)
CY 2018 - Actual: 80% - 5 patients identifying as IDU; 4 initiated treatment; 3 completed treatment; 1 discontinued due to pregnancy;
CY 2019 - Goal: 80% - 5 patients thus far identifying as IDU; no treatment records received yet.
CY 2020 - Goal: 80%

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Treatment regimens can take nine (9) or longer months to complete. Data reported will lag until the individual completes treatment. Due to this, the CY is used as a calendar year, making it difficult to break down FFY and SFY. Also, a high percentage of individuals enrolled are in corrections. Often they do not have a set discharge date and will be transferred or released without much warning, the correction facilities staff generally do not follow up with Public Health or include a discharge plan. Therefore individuals are lost to follow-up through treatment. There is a special project set on addressing TB in corrections.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

120%

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Footnotes:

Only the Priority 3 was completed in the Wyoming - 2022 Mental Health Block Grant Report. The remaining priorities are within the Substance Abuse Report.

Global Revision request sent on 2021/12/06 - Please find that the document "COVID Mitigation Report_MH_Wyoming21" has been uploaded into the attachments as requested. No funds have been expended, as the State has been awaiting approval to use the funds per the guidance letter sent titled "COVID19 Testing & Mitigation Guidance Ltr.pdf" on August 10, 2021, "States can start utilizing the resources as soon as the states' plans are approved by SAMHSA" found on page four (4) of five (5).

**for the Community Services Mental Health Block Grant (MHBG)
for Federal Fiscal Year Ending September 30, 2021
Due Date: December 31, 2021**

For the Federal Fiscal Year ending September 30, 2021, please upload a Word or PDF document in Table 1 of the FY22 MHBG Report on the COVID Testing and Mitigation activities and expenditures by providing the following information, due by December 31, 2021:

List the items and activities of expenditures completed by September 30, 2021. (if no activities were completed, note here with Not Applicable)

| COVID Testing and Mitigation Program Report for STATE | |
|---|-----------------------|
| Item/Activity | Amount of Expenditure |
| Not Applicable | Not Applicable |
| | |
| | |

FOOTNOTE:

Global Revision request sent on 2021/12/06 - Please find that the document "COVID Mitigation Report_MH_Wyoming21" has been uploaded into the attachments as requested. No funds have been expended, as the State has been awaiting approval to use the funds per the guidance letter titled "COVID19 Testing & Mitigation Guidance Ltr.pdf" sent on August 10, 2021, "States can start utilizing the resources as soon as the states' plans are approved by SAMHSA" found on page four (4) of five (5).

C. State Agency Expenditure Reports

MHBG Table 3 - Set-aside for Children's Mental Health Services

Reporting Period Start Date: 7/1/2020 Reporting Period End Date: 6/30/2021

| Statewide Expenditures for Children's Mental Health Services | | | |
|--|-----------------|---------------------------|---|
| Actual SFY 1994 | Actual SFY 2020 | Estimated/Actual SFY 2021 | Expense Type |
| \$173,144 | \$3,169,513 | \$2,572,290 | <input checked="" type="radio"/> Actual <input type="radio"/> Estimated |

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

States and jurisdictions are required not to spend less than the amount expended in FY 1994.

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Footnotes:

Decrease in services majorly impacted due to COVID-19. For example, many Wyoming referrals for children's mental health services derive from the school system. Due to COVID-19 and safety measures to reduce the spread, schools across Wyoming closed, were given the option for online schooling, or resumed in-person with mask requirements and social distancing. Since the SGF 21 was majorly impacted by the changes in guidance to school's openings, closures, and protocols, not as many students were referred for mental health services. Another example, due to budget cuts from COVID-19, a larger provider reduced their children's services.

(21,435.75 hours * \$120 = \$2,572,290.00) Hours determined from the SMI - SED MOE from WCIS, multiply that by the hourly rate, get the expenditures.

C. State Agency Expenditure Reports

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

| Period (A) | Expenditures (B) | <u>B1 (2019) + B2 (2020)</u> 2 (C) |
|-----------------|---------------------|--|
| SFY 2019 (1) | \$23,884,797 | |
| SFY 2020 (2) | \$23,809,458 | \$23,847,127 |
| SFY 2021 (3) | \$23,885,035 | |

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

| | | | | |
|----------|-----|----------|----|-------|
| SFY 2019 | Yes | <u>X</u> | No | _____ |
| SFY 2020 | Yes | <u>X</u> | No | _____ |
| SFY 2021 | Yes | <u>X</u> | No | _____ |

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

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Footnotes:

Provided whole number above; actual number is \$23,885,034.94