Vermont

UNIFORM APPLICATION
FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/04/2019 3.33.54 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 8093761550

Expiration Date

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

Agency Name Vermont Department of Health

Organizational Unit Division of Alcohol and Drug Abuse Programs

Mailing Address 108 Cherry Street, P.O. Box 70

City Burlington

Zip Code 05402-0070

II. Contact Person for the Grantee of the Block Grant

First Name Cynthia

Last Name Thomas

Agency Name Vermont State Agency of Human Services, Division of Alcohol and Drug Abuse Programs

Mailing Address 280 State Drive

City Waterbury

Zip Code 05671-1000

Telephone 802-651-1550

Fax 802-651-1573

Email Address cynthia.seivwright@vermont.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Emily

Last Name Trutor

Telephone 802-651-1552

Fax 802-651-1573

Email Address emily.trutor@vermont.gov

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

Footnotes:

State Information

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

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: Martha Maksym

Signature of CEO or Designee[1]: _____

Title: Deputy Secretary

Date Signed: _____

mm/dd/yyyy

[1]If 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:

PHILIP B. SCOTT
Governor

State of Vermont
OFFICE OF THE GOVERNOR

April 26, 2019

Alex M. Azar, II, Secretary
Department of Health and Human Services
Hubert H. Humphrey Bldg.
200 Independence Ave., S.W.
Washington, DC 20201

Dear Secretary Azar:

This letter is to advise that as of December 11, 2018, Martha Maksym, Deputy Secretary of the Agency of Human Services, is my formal designee for all transactions required to administer the Vermont Human Services Plan Budget for FY19 and FY20, including each related block grant as listed below. The Agency of Human Services of the State of Vermont is designated to administer the grants or supervise their administration.

Application for Social Services Block Grant
Social Security Act, Sec. 2005 (42 U.S.C. 1397d). Regulations: 45 CFR Parts 96.70 - 96.74

Application for Preventative Health and Health Services Block Grant
U.S.C. 42 Chapter 6A Subchapter XVII Part A. Regulations: 45 CFR Part 75

Application for Maternal and Child Health Services Block Grant
Social Security Act, Sec. 501-513 (42 U.S.C. 701-713). Regulations: 45 CFR, Parts 96.1 - 96.112

Application for Substance Abuse Prevention and Treatment Block Grant
Title XIX, Part B of the Public Health Services Act (42 U.S.C. 300x). Regulations: 45 CFR Part 96

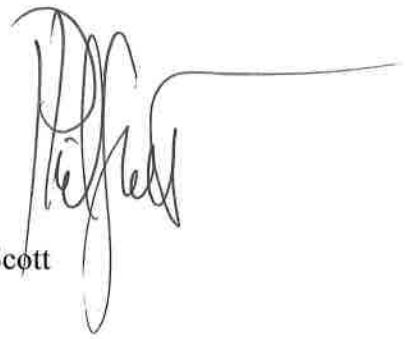
Community Mental Health Block Grant
P.L. 102-321 - Amendment to Title V created by ADAMHA Reorganization Act

Application for Low Income Home Energy Assistance Block Grant
P.L. 97-35. Regulations: 45 CFR, Parts 96.1 - 96.112

Applications for Community Services Block Grant
P.L. 970-35, the Omnibus Budget Reconciliation Act of l981 Regulations: 45 CFR, parts 96.l - 96.ll2

State Plan on Aging under the Social Security Title P.L. 97-35 of the Older Americans Act, as amended. Regulations III: 45 CFR, l32l-5, 45 CFR, l32l.7 - l32l.l9

Sincerely,



Philip B. Scott
Governor

PBS/kp

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:

This form is not applicable to Vermont.

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.

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Footnotes:

Strategic Plan 2017-2020

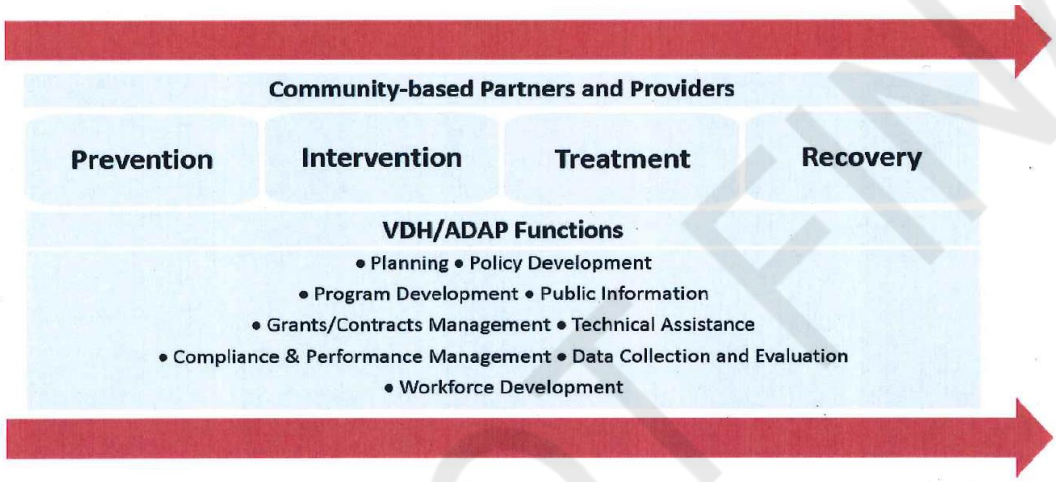
Motto

Prevention Works | Treatment is Effective | People Recover

Mission

ADAP's mission is to help Vermonters prevent and eliminate the problems caused by alcohol and other drug use. Working in partnership with other public and private organizations, ADAP plans, supports, and evaluates a comprehensive system of services.

Vermont's Continuum of Care



Performance Management and Public Accountability

ADAP's long-term substance misuse indicators are informed by the framework for Healthy People 2020, as well as Vermont data trends to reveal needs and gaps. Programs and initiatives aim to bend the curve on the following long-term indicators:

- % of persons age 12 and older who need and do not receive alcohol treatment.
- % of persons age 12 and older who need and do not receive illicit drug use treatment.
- % of adolescents in grades 9-12 who used marijuana in the past 30 days.
- % of adolescents in grades 9-12 binge drinking in the past 30 days.
- % of adults age 18-24 binge drinking in the past 30 days.
- % of adults age 65 and older who drink at a level of risk.

The above indicators can be found on the Vermont Department of Health's Performance Dashboard, together with performance measures for specific programs. For more information on the Performance Dashboard, please see the following link: healthvermont.gov/scorecard-alcohol-drugs.

Message from Division Director

Dear Staff and Partners

I am pleased to share the updated Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) strategic plan for 2017 – 2020. The plan outlines priorities for our work to ensure that Vermonters impacted by substance misuse get the information and help they need.

ADAP works collaboratively to support Vermont's Agency of Human Services' mission: strive to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves.

For more information, please visit the following link: healthvermont.gov/alcohol-drugs ■

Cynthia Thomas
Director, Vermont Department of Health, Division of Alcohol and Drug Abuse Programs

Strategic Plan 2017-2020

ADAP's Strategic Plan 2017-2020 sets out program and operational priorities for the next three years. In support of these priorities, ADAP has identified strategies that are informed by Vermont's Agency of Human Services (AHS) Strategic Plan and reflect ADAP's primary investments across the Department of Health's six goals. The strategies incorporate evidence-based practices, collaborative efforts and strong partnerships with local provider and community-based organizations to implement the most effective initiatives possible. For each strategy, quantifiable targets and measures are identified to help monitor progress, with the hope and determination of contributing to the ultimate outcome: to prevent and eliminate the problems caused by alcohol and drug misuse.

Goal 1: Effective and Integrated Public Health

Strategies:

- **AHS Substance Abuse Treatment Coordination (SATC):** Support AHS SATC to establish an integrated approach to serving Vermonters with substance abuse problems. This includes training of direct service staff to provide screening and implementation of regional pilots for service coordination across departments. (AHS)

  Targets: - Increase the # of regional pilots being implemented by 1 per year
  - Increase the # of AHS staff trained to provide screening

  Measures: - # of AHS regional pilots being implemented
  - # of AHS staff trained to provide screening

- **Linkages between Treatment and Recovery:** AHS will increase the percentage of individuals leaving treatment with more supports than when they started through adding additional recovery support and improving the linkages between treatment providers and recovery centers. (AHS)

  Targets: - Increase the # of individuals who have more social supports on discharge than on admission by 25%
  - 100% of treatment grants include requirement for referral to recovery by FY18

  Measures: - # of individuals who have more social supports on discharge than on admission
  - % treatment grants include requirements for referral to recovery centers

Goal 2: Communities with the Capacity to Respond to Public Health Need

Strategies:

- **Regional Prevention Capacity:** Increase and strengthen regional capacity by funding communities and schools through the Regional Prevention Partnerships (RPP) grant, School-based Substance Abuse Services (SBSAS) grant and the Prevention Consultant (PC) system.

  Targets: - Increase the # of VDH health district offices funded under the RPP from 6 to 12
  - At least 20 supervisory unions with functioning SBSAS grant program

  Measures: - # of VDH health districts funded under the RPP
  - # of supervisory unions with functioning SBSAS grant program

- **Trained and Qualified Prevention Workforce:** Increase the number of prevention practitioners in Vermont working toward ICRC (International Certification and Reciprocity Consortium) certification by providing training in ICRC competency areas and educating practitioners about certification resources.

  Targets: - 12 trainings in ICRC competency areas will be offered by the end of FY18

  Measures: - # of trainings in ICRC competency areas offered

- **ASAM Criteria:** Assure that individuals receive services at appropriate levels of care as defined by American Society of Addiction Medicine (ASAM) placement criteria.

  Targets: - 100% of treatment providers are utilizing ASAM placement criteria by FY18

  Measures: - # of treatment providers utilizing ASAM placement criteria as measured by site review documentation

- **Medication-Assisted Treatment (MAT):** AHS will increase access to Medication-Assisted Treatment (MAT) for opioid addiction by adding additional hub services and increasing the number of spoke providers. (AHS)

  Targets: - Increase the # of individuals receiving MAT per 10,000 Vermonters age 18-64

  Measures: - # of individuals receiving MAT per 10,000 Vermonters age 18-64

Goal 3: Internal Systems that Provide for Consistent and Responsive Support

Strategies:

- **Data Systems:** Improve data systems used to support ADAP reporting and service delivery.

  Targets: - Information Technology (IT) plan completed by 7/1/17
  - 12 Preferred Provider locations will use the updated Substance Abuse Treatment Information System (SATIS) by 7/1/17
  - 100% of new demonstration grant applications will include an analysis of the IT needs associated with the funding

  Measures: - IT Plan completed
  - # of preferred provider locations using updated SATIS

- **Policies and Procedures:** Improve coordination and consistency by developing internal and external policies and procedures for programs and operations.

  Targets: - Policy/procedure need areas and ADAP leads identified by 7/1/17
  - Guidance documents for at least 5 priority areas will be developed by 7/1/18

  Measures: - Policy/procedure need areas and ADAP leads identified
  - # of guidance documents developed

- **Monitoring:** Continuously improve and enhance quality of care through ongoing, objective, and systematic monitoring of providers and implementing an independent peer review process.

  Targets: - Increase the # of independent peer review site visits to preferred providers by 2 in CY17

  Measures: - % of treatment provider site visits in CY17 that were performed through an independent peer review process

- **Quality Improvement:** Develop a culture among providers to engage in continuous quality improvement by providing the services of a practice facilitator.

  Targets: - Minimum of 2 Preferred Providers will have implemented at least 1 quality improvement project in CY17
  - ADAP will implement at least 1 AIM project per calendar year

  Measures: - # of Preferred Providers implementing a quality improvement project
  - # of AIM projects implemented by ADAP

- **Evaluation:** Assess effectiveness of programs and initiatives by maintaining and increasing evaluation and data collection capacity.

  Targets: - A minimum of 10% of the federal demonstration grant budget, where allowable, will be allocated to evaluation

  Measures: - % of federal demonstration grant budget allocated to evaluation

Goal 4: A Competent and Valued Workforce that is Supported in Promoting and Protecting the Public's Health

Strategies:

- **Core Competency Trainings:** Increase provider access to training in core competencies. Priorities for this period are: Substance Abuse Prevention Skills (SAPST), American Society of Addiction Medicine (ASAM) placement criteria, co-occurring disorders, motivational interviewing, trauma-informed care at the individual and community level, Standards and Linguistically Appropriate Services (CLAS) and recovery coaching.

  Targets: - Increase or maintain the # of provider trainings in these areas

  Measures: - # of provider trainings offered

- **Evidence-based Practices:** Promote the adoption of evidence-based practices through learning collaboratives, including but not limited to environmental strategies, screening and brief intervention, adolescent and family treatment, co-occurring disorders, contingency management and medication-assisted treatment in primary care and community settings.

  Targets: - Implement at least 4 learning collaboratives annually

  Measures: - # of learning collaboratives fully implemented by FY19

- **Staff Orientation:** Increase understanding of comprehensive system of care among ADAP staff by establishing an orientation process which is consistent across program areas and expose staff to best practices in operational management, prevention, treatment, recovery and performance management.

  Targets:
  - Orientation protocol developed in FY17
  - 100% of new staff complete orientation protocol within 6 months of hire in FY18
  - 100% of all staff complete orientation protocol in FY19

  Measures:
  - Orientation protocol completed
  - # of new staff who complete orientation protocol
  - # of all staff who complete orientation protocol

Goal 5: A Public Health System that is Understood and Valued by Vermonters

Strategies:

- **Public Information:** Increase the public's understanding of the substance abuse services system through development of resources that describe how to access substance abuse services, and promote substance abuse service outcomes.

  Targets:
  - Increase # of Health Department resources (e.g. publications, web-based tools) available to the public that describe how to access substance abuse services, or promote substance abuse service outcomes by 1/1/19

  Measures:
  - # of Health Department resources (e.g. publications, web-based tools) available to the public that describe how to access substance abuse services, or promote substance abuse service outcomes

- **Social Marketing:** Promote behavior change by conducting social marketing campaigns with high need populations including but not limited to young adults.

  Targets:
  - Increase the reach of social marketing initiatives (including % of target population reached, # of impressions, and # of active engagements)

  Measures:
  - % of target population reached, # of impressions, and # of active engagements

Goal 6: Health Equity for All Vermonters

Strategies:

- **Health Equity:** Improve substance abuse services for racial, ethnic, and underserved populations through provider training, and implementation of National Standards for Culturally and Linguistically Appropriate Services (CLAS) and expand the use of cultural brokers throughout the state.

  Targets:
  - Increase the # of providers trained in cultural competency
  - Increase the # of translations of key materials

  Measures:
  - At least 3 trainings completed by 7/1/19
  - At least 2 translations of priority materials completed by 7/1/19

Vermont PFS-2015 Evaluation Plan

A. Overview

Vermont has chosen to build upon progress already achieved through its previous PFS grant (PFS II) by extending the SPF model and associated PFS 2015 funding to all regions of the state. This new project, which is housed in the *Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP),* is titled the Vermont Regional Prevention Partnerships (RPP). The goal of the project is to strengthen the prevention infrastructure at the state, regional and community levels using VDH's existing health district structure as the primary mechanism to implement the RPP. More specifically, as reflected in the state's application for the PFS 2015 award, this goal was stated as follows:

Goal 1: Increase state, regional and community capacity to prevent underage and binge drinking, prescription drug misuse, and marijuana use through a targeted regional approach.

This broad process-oriented goal may be broken into three more specific goals corresponding to the PFS evaluation goals as stated in the SAMHSA PFS Evaluation Plan checklist. These are:

a) Implementing the SPF process at the state and community levels

b) Strengthening prevention capacity and infrastructure

c) Leveraging, redirecting, and aligning statewide funding streams and resources for prevention

To implement the RPP project, ADAP has decided to extend funding for a limited time to the six counties (or more precisely, the subrecipient organizations serving those counties) as funded through the 3-year PFS II grant awarded to the state in 2012. With RPP funding, they will now be supported (although at significantly reduced levels) through June of 2018. In addition, RPP will support six new subrecipients, thereby extending PFS funding to most of the remainder of the state for the duration of the RPP project. The new subrecipients are still in their planning phase as of September 2016; intervention activities are expected to begin by early 2017.

Grantee services areas for the initial six subrecipients, with one minor exception, are aligned with county boundaries. Service areas for the six new subrecipients will also generally follow county boundaries, although the exact service areas for some grantees are yet to be finalized. One deviation from this overall approach is that Windsor County, which was served under PFS II, will continue to be served for the duration of the RPP project, but by a different subrecipient organization. Table 1 lists both the previously funded and the new subrecipient organizations, along with the primary county in which they will focus their efforts.

With respect to outcomes targeted, Vermont's application specified these three objectives:

Goal 2: Reduce underage and binge drinking among persons aged 12 to 20

Goal 3: Reduce prescription drug misuse and abuse among persons aged 12 to 25.

Goal 4: Reduce marijuana use among persons aged 12 to 25.

Table 1. Continuation and New Subrecipients: Vermont RPP Project

Subrecipient Organization	Cohort	Primary County(ies) Served
Youth Services, Inc.	Continuation	Windham
Mt. Ascutney Hospital and Health Center	Continuation	Windsor
Lamoille Family Center	Continuation	Lamoille
Rutland Community Programs, Inc. and Rutland Regional Medical Center	Continuation	Rutland
Chittenden County Regional Planning Comm.	Continuation	Chittenden
Washington County Youth Services Bureau and Boys and Girls Club	Continuation	Washington
The Collaborative – Bennington Office	New	Bennington
The Collaborative – Springfield Office	New	Windsor
United Way of Addison County	New	Addison
North Country Hospital	New	Orleans and Essex
Franklin County Caring Communities	New	Franklin and Grand Isle
Northeastern Vermont Regional Hospital	New	Caledonia

The following evaluation plan, which was developed and will be implemented by the Pacific Institute for Research and Evaluation (PIRE), describes the data sources that will be used to document and assess how, and the extent to which, these goals were achieved, along with the planned analysis and reporting activities that will translate the data into useful findings. Because one requirement of the evaluation is to support the national cross-site evaluation of PFS 2015, the following plan includes a section (see Section B below) devoted specifically to describing the data elements we will submit to PEP-C for cross-site evaluation purposes.

B. Data to be Submitted to PEP-C for Cross-Site Evaluation

In this section we specify the data elements for both process and outcome evaluation purposes that we will submit to PEP-C in support of the national cross-site evaluation. For our own state-level evaluation, we may not use all of these data elements, and will also use additional data not required for submission to PEP-C (see Section C for details).

B.1 Process Data

State-level process data needed for submission to PEP-C will be based on information obtained from the state RPP project coordinator, ADAP's prevention consultants, and our contracted TTA provider/coordinator (CHL). In addition, aggregated data from subrecipient

responses to the CLI will also be used to inform the state-level process evaluation. Community-level process data will be provided directly by the subrecipients via the CLI. A list of the CSAP-required state-level and community-level process measures, as specified in the PFS 2015 RFA, and their data sources is provided in Table 2. As the state evaluator, PIRE will provide trainings and resources for our subrecipients as needed (e.g., help with interpretation of CLI items and instructions, standardized attendance logs for individual-focused programs, census data files to estimate reach of environmental strategies, etc.) to ensure that CLI data are complete and accurate.

Table 2. Required Process Measures and Data Sources for submission to PEP-C

State-Level:	**Data Source**
Number of training and technical assistance activities per funded community provided by the grantee to support communities	State Project Coordinator, augmented by records from CHL and records from Vermont's Prevention Consultant Data System
Reach of training and technical assistance activities (numbers served) provided by the grantee	TTA attendance and contact logs prepared by CHL and the Prevention Consultants
Percentage of sub-recipient communities that have increased the number or percent of evidence-based programs, policies, and/or practices	Roll-up of sub-recipient-level data from CLI (item #36a)
Percentage of sub-recipient communities that report an increase in prevention activities supported by leveraging of resources	Roll-up of sub-recipient-level data from CLI (item #34)
Percentage of sub-recipient communities that submit data to the grantee data system	State evaluator records showing submission of CLI and CGRS data (see section C below)
Community-Level:	**Data Source**
Number of active collaborators/partners supporting the grantee's comprehensive prevention approach	CLI (item #25)
Number of people served and/or reached by IOM category (universal, selective, indicated), six strategies, demographic group and targeted population	CLI (multi-items), based on attendance logs and census data for target populations
Number and percent of evidence-based programs, policies, and/or practices implemented by sub-recipient communities	CLI (#36a)
Number of prevention activities at the sub-recipient level that are supported by collaboration and leveraging of funding streams	CLI (#34)
Number, type and duration of evidence-based interventions by prevention strategy implemented at the community level	CLI (#33)

B.2 Outcome Data

Because the outcome data submission requirements for PFS grantees have been updated and more precisely defined by PEP-C since the PFS 2015 RFP was released, our plans for outcome data submission follow the current PEP-C requirements as posted on the MRT website. Vermont will not submit substitute state-level outcome measures, as we believe it makes sense for PEP-C to use the standardized sources (e.g., NSDUH) it has already identified for state-level outcomes. For community-level outcomes, the intervening variable,

consumption, and consequence measures we plan to submit for each of the state's three priorities are listed in Table 3. Per prior agreement with PEP-C on our PFS II outcome data, we will use measures derived from the National Poison Data System (NPDS) to fulfil the annual measure requirement for UAD and prescription drug misuse related measures.

As indicated in the above table, two important sources of outcome data are the Youth Risk Behavior Survey (YRBS) and the Vermont Young Adult Survey (YAS). The YRBS is administered in nearly all public middle schools and high schools in Vermont as well as many private schools. No sampling is involved, as all students in grade levels 6 through 12 who are capable of completing the survey are invited to participate unless parents withhold consent. Overall response rates for the YRBS statewide typically range from 75 to 85 percent. The YRBS items are thoroughly tested by CDC for reliability and have also been shown to track closely with estimates from other surveys such as NSDUH and MTF in terms of trends over time (convergent validity).

Table 3. Community Outcome Data Planned for Submission to PEP-C

Target Behavior	Type of Measure	Measure	Target population	Source	Frequency Collected	Level of Data[1]
UAD	Intervening variables	Perceived parental disapproval of alcohol	Students in grades 6-12	YRBS	Bi-annual	SD
		Perceived peer disapproval of alcohol	Students in grades 6-12	YRBS	Bi-annual	SD
		Perceived risk of binge drinking	Students in grades 6-12	YRBS	Bi-annual	SD
		Perceived likelihood of UAD party enforcement	Students in grades 6-12	YRBS	Bi-annual	SD
	Consumption	Past 30-day alcohol use	Students in grades 6-12	YRBS	Bi-annual	SD
		Past 30-day binge drinking	Students in grades 6-12	YRBS	Bi-annual	SD
	Consequence	Calls to Poison Center Information Center regarding alcohol by persons aged 12-20 per capita	Persons aged 12 to 20	NPDS	Annual	County[2]
Rx Misuse	Intervening variables	Perceived ease of obtaining Rx pain relievers	Persons aged 18 to 25	YAS	Bi-annual	Zip code
		Perceived risk of misusing Rx pain relievers	Persons aged 18 to 25	YAS	Bi-annual	Zip code
	Consumption	Past year any Rx drug misuse	Persons aged 18 to 25	YAS	Bi-annual	Zip code
	Consequence	Calls to Poison Center Information Center regarding Rx drugs by persons aged 12-25 per capita	Persons aged 12 to 25	NPDS	Annual	county
Marijuana Use	Intervening variables	Perceived risk of binge drinking	Students in grades 6-12	YRBS	Bi-annual	SD
	Consumption	Pasts 30-day use of marijuana	Students in grades 6-12	YRBS	Bi-annual	SD
	Consequence	TBD	--	--	--	--

[1]Data at the school district (SD) and zip code levels may be rolled up to the PFS grantee (i.e., subrecipient) level.
[2]NPDC data may be disaggregated into PFS and non-PFS zip codes, where needed.

The YAS is an online survey in which participants are recruited through ads on Facebook. Because there is no sampling frame, a response rate cannot be calculated. State-level estimates for key outcome measures from the 2014 and previous administrations of the YAS, however, have been similar to state-level estimates from NSDUH. A sufficient N of young adult respondents (n=3200) was obtained for the 2014 survey such that county-level estimates of reasonable precision were obtained for each of Vermont's PFS II subrecipients (which were defined geographically by county; the average n of respondents per county was 260 after two pairs of particularly small adjoining small counties were combined into single units). As long as recruitment procedures remain similar across the years of administration, and we continue to recruit approximately 3000 (or more) respondents statewide, we believe the YAS provides a useful and cost efficient tool for detecting community-level intervention effects on young adults. The YAS was conducted again earlier this year (data are still being analyzed) and we plan to continue conducting the survey on a bi-annual basis through 2020. YAS items were borrowed largely intact from well-respected ongoing national surveys such as the YRBS and NSDUH, and therefore can be safely assumed to have acceptable levels of reliability and validity.

Both the YRBS and the YAS data sets are weighted in order to better reflect the underlying demographics of the areas for which estimates are produced. For the YRBS, the weighting variables are school district, sex, and grade level. For the YAS the variables are county, sex, and age group (18-20 vs. 21-25).

C. Other Data to be Collected in Support of Vermont's Evaluation

Several other data sources will also be utilized to inform our evaluation. Specifically, we will collect additional process data from subrecipients through the Community Grantee Reporting System (CGRS) developed under Vermont's PFS II grant, additional information and perspectives on RPP implementation through interviews and focus groups with VDH District Office Staff, subrecipient agencies and key partners, and possibly additional survey and archival data elements not listed in Section B above. Each of these sources is described below.

C.1 CGRS

CGRS was initially developed to collect a variety of process evaluation measures from Vermont's PFS II subrecipients, pending finalization of the CLI. When the CLI was finally operational, CGRS was reduced considerably to include only those elements that were not obtained through the CLI but were still seen as important subrecipient-level implementation measures needed for our monitoring and process evaluation efforts. In particular, CGRS collects information on the implementation status of each intervention and the process objectives achieved to date. Implementation status is determined by subrecipients' progress ratings on each of the core activities identified in their intervention work plans. The work plans were developed by PIRE using multiple sources to determine the key steps necessary to implement various interventions effectively and with fidelity. CGRS also collects brief narrative reports on successes, challenges, and TTA needs specific to each intervention. All sub-recipients are trained on its purposes and how to use CGRS, and are required to submit data to CGRS on a quarterly basis.

C.2 Interviews and Focus Groups

For PFS II, PIRE conducted a qualitative study to collect and synthesize perceptions and experiences of key community stakeholders involved with the project. Interviews were conducted with all six VDH District Directors (DDs) involved with PFS. Focus groups were held with VDH Prevention Consultants (PCs) and representatives from both lead community agencies and community partner organizations from PFS regions. Recordings of the interviews and focus groups were transcribed and analyzed, and findings and recommendations were organized into four central themes: roles of state staff and community partners, changes to regional and community capacity, successes and challenges of regional strategy implementation, and training and technical assistance needs. Key findings and recommendations were submitted to ADAP and have been used to inform subsequent development of guidelines disseminated to both continuation and new subrecipients regarding roles and processes conducive to effective implementation of the SPF model at the regional and community levels. A study using similar methods is planned for RPP; the specific themes to be explored are still under development.

C.3 Additional Outcome Measures

The YRBS and YAS contain a number of measures in addition to those planned for submission to PEP-C. Examples of these include measures of the frequency of binge drinking and marijuana use, specific categories of misused prescription drugs, and sources where misused prescription drugs are obtained. All these measures are potentially relevant to the focus of various intervention strategies that may be implemented, and therefore will be examined for evidence of intervention effects and also shared with state and subrecipient stakeholders for assessment and planning purposes.

Previous efforts to use certain archival sources of outcome data for evaluation purposes have been set aside due to concerns over the reliability and/or usefulness of these sources for evaluation purposes. For example, wide variations have been noted across years and/or jurisdictions in indicators such as treatment admissions, alcohol-related car crashes involving young drivers, and ATOD-related emergency room visits. Such variability can be due to very small numbers of events in the numerators, variations in admission procedures and other policies, and variations in how events are recorded or categorized. Time permitting, however, we will explore further these and other archival data sources to see if concerns noted previously have either lessened over time or can somehow be addressed. If found to be useful, we will certainly be willing to also include them in the community outcome data submitted to PEP-C.

D. Analysis Plan

D.1 Process Data

Analyses of process data will focus on the three sub-goals of RPP goal #1 and will be primarily descriptive. Specifically, we will summarize the data elements listed in Table 2 above, along with other process data described in Section C, in the form of one or more narrative reports. The summaries will pay particular attention to key focal points and objectives of the SPF and the PFS grants, including evidence of:

- increased community capacity and partnership building
- increases in services provided to subgroups prone to health disparities
- the expansion and leveraging of funding sources for community-based prevention, and
- effective implementation of intervention strategies as guided by the intervention work plans.

For the qualitative data collected through interviews and focus groups, we will sift through and synthesize the information in the transcripts using qualitative analysis software as was done for the PFS II evaluation (Atlas.ti software was used for this purpose).

D.2 Outcome Data

The primary analysis approach to be used for the outcome evaluation will be to examine changes over time (i.e., from a designated “baseline” year” to one or more later years during and/or at the end of the RPP funding) in all of the outcome measures previously identified in Sections B and C above. Because the continuation and new subrecipients received funding for different time frames, the baseline and follow-up years for these two subgroups will differ. This situation offers the advantage of each subgroup being able to serve as the comparison group for the other, depending on the time period examined.

Two fundamental outcome evaluation questions will be addressed:

1. To what degree did the counties served by RPP-funded subrecipients experience improvements between baseline and follow-up (i.e., between 2013 and 2018 for continuation subrecipients and between 2017 and 2020 for new subrecipients) in the outcome measures examined?

2. Collectively, did the RPP-funded communities experience greater improvements in the outcome measures examined relative to non-funded communities during the time period they were funded?

Although question #1 is addressed through a pre-post design only, and therefore is not particularly well-suited to attributing positive change specifically to RPP, it is still informative to examine change over time just within the counties where the RPP-funded interventions are delivered. In consideration of the goals of the RPP project, it is useful to assess whether key

outcome measures are headed in the desired direction over the time frame of the funding. If they are, this indicates that programmatic goals are being achieved, which is important in and of itself. Although it is not justified using these findings alone to attribute such success specifically to the RPP grant, it nevertheless can be reassuring to policymakers and to grantees to see that, for whatever reasons, desired outcomes are heading in the right direction. If so, the possibility that favorable trends in the outcomes may have been influenced in part by the RPP-funded activities remains a viable, although tentative, interpretation of the findings.

The rationale for examining pre-post change in the RPP-funded counties is bolstered by the recognition that there were many other prevention activities being implemented in communities throughout the state. If unfunded counties tended to have more of some other ATOD prevention activities in their areas, that could be a reason for not observing greater impacts in the funded counties, rather that concluding that PFS funding had no effect. More generally, it has become virtually impossible to find “pure” comparison groups in community-based prevention research where there are no competing prevention efforts underway.

The pre-post analyses will be largely descriptive, in which baseline and follow-up means for each outcome measure are presented in a manner that depicts changes in these measures over duration of the RPP funding period. Statistically significant differences between years will be noted.

In addition to the pre-post analyses (which focus only on funded counties), the analyses will also compare changes over time among funded counties to those counties that were not funded (or receiving reduced funding only) during the same period. Regression models using software specifically designed for survey data that incorporate unequal respondent weights and stratification (e.g., SAS Proc SURVEYLOGISTIC) will be used to statistically test whether changes in outcome measures over time are more pronounced in funded counties compared to the comparison counties (as evidenced by a significant time by condition interaction effect). We will also examine and summarize overall patterns observed in these comparisons, regardless of statistical significance, in light of the limited statistical power provided by the small numbers of counties involved in the analysis.

D.3 Analyses Focused on Behavioral Health Disparities.

For CLI reporting, subrecipients will track the number of persons reached through individually-focused interventions, broken down by characteristics including race/ethnicity, gender, age, disability status, primary spoken language, and arm forces affiliation (of either the participant or a family member). The percentages of participants in various categories prone to experiencing health disparities will be calculated and tracked over time to see if participation from these vulnerable subgroups increases, and also to determine whether participation rates are in line with the population-level percentages of these subgroups, if known.

Additionally, a number of interventions include core activities that specifically focus on increasing outreach to and participation by vulnerable subgroups. Because CGRS captures progress on these core activities, the data will be examined to determine the extent to which

these particular activities are being implemented. Follow-up as needed with the subrecipients can then be initiated to address obstacles to carrying out these activities.

With respect to outcome measures, both the YRBS and YAS capture subgroup membership on a number of characteristics linked with health disparities. These include sex, sexual orientation, gender identity, race/ethnicity, and (for the YAS) military status, disability, and primary spoken language. Disaggregation of the data by these various subgroups will be used to examine changes over time in disparities for key outcome measures. These analyses will be conducted collectively for the subgroups of counties identified above (i.e., as served by either continuation or new subrecipient organizations), as the subgroup sample sizes for individual counties will likely be too small to analyze separately.

With respect to leveraging, redirecting and aligning state wide funding streams and resources for prevention, VDH will utilize the evaluation results and reports to justify the continued need for prevention services statewide through a state funded allocation. This dedicated fund will be requested from the legislature and justification for such a request will be based on the success of the PFS II and PFS 2015 as detailed from the evaluation results. In addition, the funding of all 12 districts under the PFS 2015 will establish and build capacity for prevention services throughout the state enabling VDH to utilize block grant funds to continue successful programmatic and environmental prevention strategies. Redirection of prevention resources will be developed and initiated based on the evaluation results of PFS 2015 strategies, or combination of strategies, that are shown to provide positive impact on identified outcomes.

E. Reporting

PIRE will prepare an annual Evaluation Brief each year of the RPP that will summarize the process data collected during the preceding year. The report will provide descriptions of subrecipient activities, focusing in particular on the four process evaluation issues identified in Section D.1 above. Additionally, findings from the YAS at both the statewide and county level will be disseminated each year the survey is conducted (note: YRBS statewide and county-level findings are also disseminated directly by the Vermont Department of Health). A final RPP evaluation report, which will include the findings from both the process and outcome evaluation, will be submitted to ADAP at the conclusion of the evaluation contract, which if extended for a full five years will coincide with the conclusion of the RPP project.

Beyond the reporting activities just described, PIRE team members meet formally on a monthly basis with the state-level project director, and (for our on-site Evaluator) even much more frequently whenever the need arise, to discuss both programmatic and evaluation activities and issues. PIRE evaluation team members also participate regularly in subrecipient trainings and other events, site visits with the subrecipients, and ADAP-sponsored presentations to various audiences that may include PFS evaluation updates.

VERMONT SABG 2020-2021
NARRATIVE PLAN – STEP 1
Step 1 Narrative

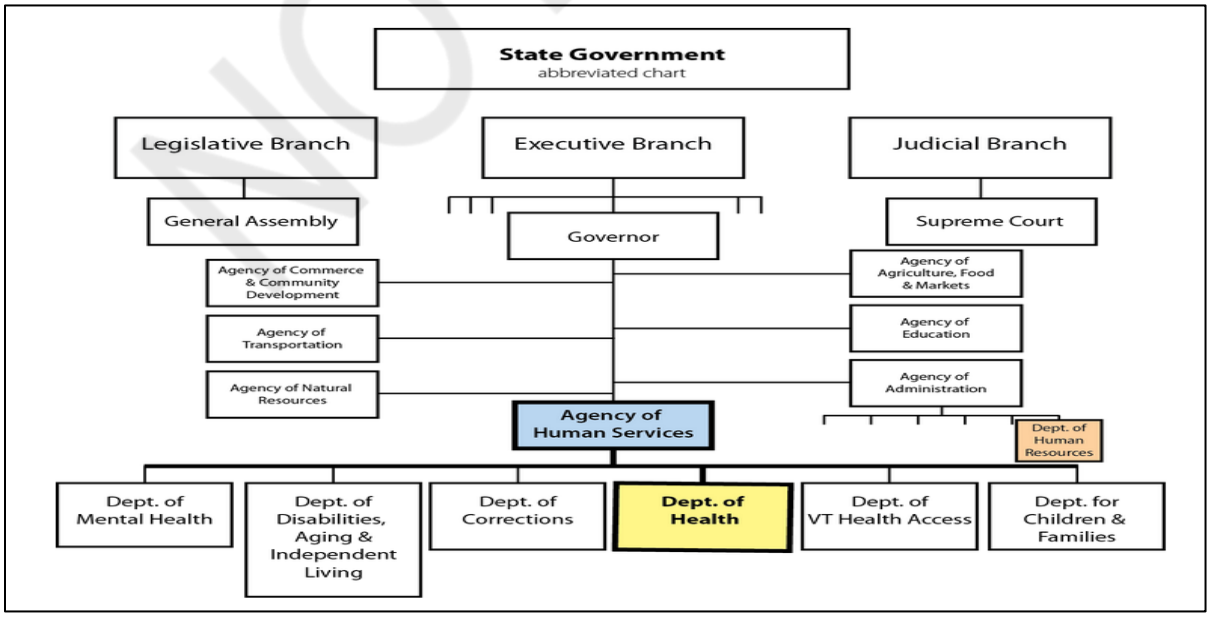
Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the 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.

STRUCTURE

AGENCY OF HUMAN SERVICES (AHS)

The mission of the Agency of Human Services is to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves. The Agency of Human Services includes the Departments of: Health (VDH), Mental Health (DMH), Disabilities, Aging and Independent Living (DAIL), Corrections (DOC), Vermont Health Access (DVHA), and Children and Families (DCF). Vermont's State Mental Health Authority (SMHA) resides in DMH and the Single State Authority (SSA) resides within VDH.

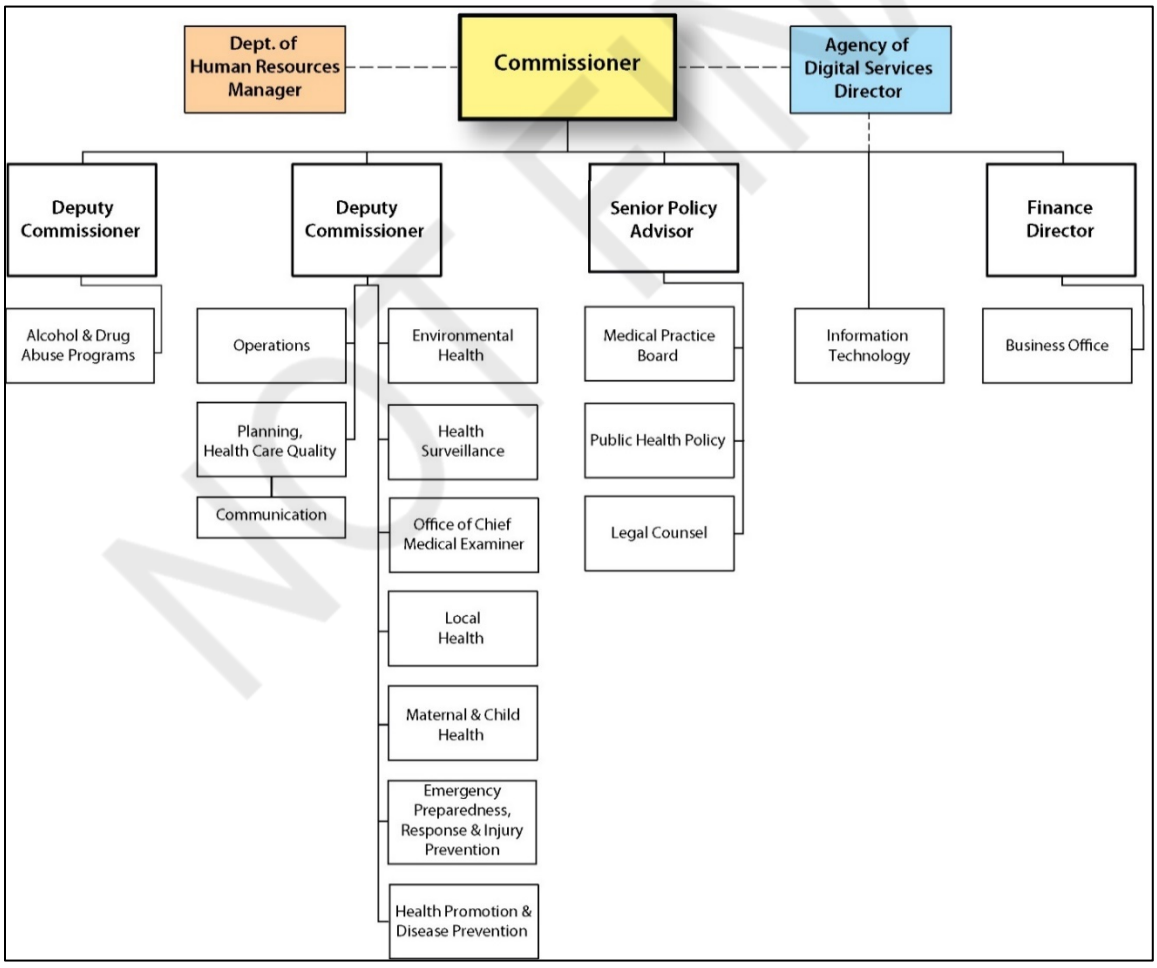


VERMONT DEPARTMENT OF HEALTH (VDH)

The Vermont Department of Health (VDH) is organized under the leadership of a Governor-appointed Commissioner and two Deputy Commissioners, as well as a Senior Policy Advisor and Finance Director to oversee the various Divisions, Units, and Offices. One of two Deputy Commissioner oversees the Division of Alcohol and Drug Abuse Programs (ADAP) and rural health, and supervises the ADAP Division Director, who serves as the Single State Authority (SSA). Essential public health services are carried out across the state by the Office of Local Health through 12 District Offices. All Vermont residents have a local health office they can access for a range of public health services such as information, disease prevention and emergency response services.

The local health offices work in partnership with health care providers, volunteer agencies, schools, businesses and coalitions and organizations in their communities to improve health and extend public health initiatives across the state.

STATE AUTHORIZATION



Vermont Statute establishes that the Department of Health shall have power to supervise and direct the execution of all laws relating to public health and substance abuse. Reference [Title

18: Health § 1. General powers of department of health (Amended 2005, No. 174 (Adj. Sess.), § 34a; 2007, No. 15, § 8.)] available at:
http://legislature.vermont.gov/statutes/section/18/001/00001

DIVISION OF ALCOHOL AND DRUG ABUSE PROGRAMS (ADAP)

The Division of Alcohol and Drug Abuse Programs (ADAP) is designated as the Single State Authority (SSA), with all its duties, responsibilities and authorities carried out and exercised by and within the Vermont Department of Health. By statute, ADAP is authorized to plan, operate and evaluate substance use/misuse programs, and establish a regional system of opioid addiction treatment. Reference [Title 18: Health; Chapter 094: § 4806. Vermont Department of Health, Division of Alcohol and Drug Abuse Programs] available at:
http://legislature.vermont.gov/statutes/section/18/094/04806

ADAP, as SSA representative, oversees the following list of statewide system of care functions for prevention, intervention, treatment and recovery:

- Grants/Contracts Management
- Data Collection and Evaluation
- Public Information
- Compliance and Performance Management
- Planning
- Policy Development
- Program Development
- Technical Assistance
- Workforce Development

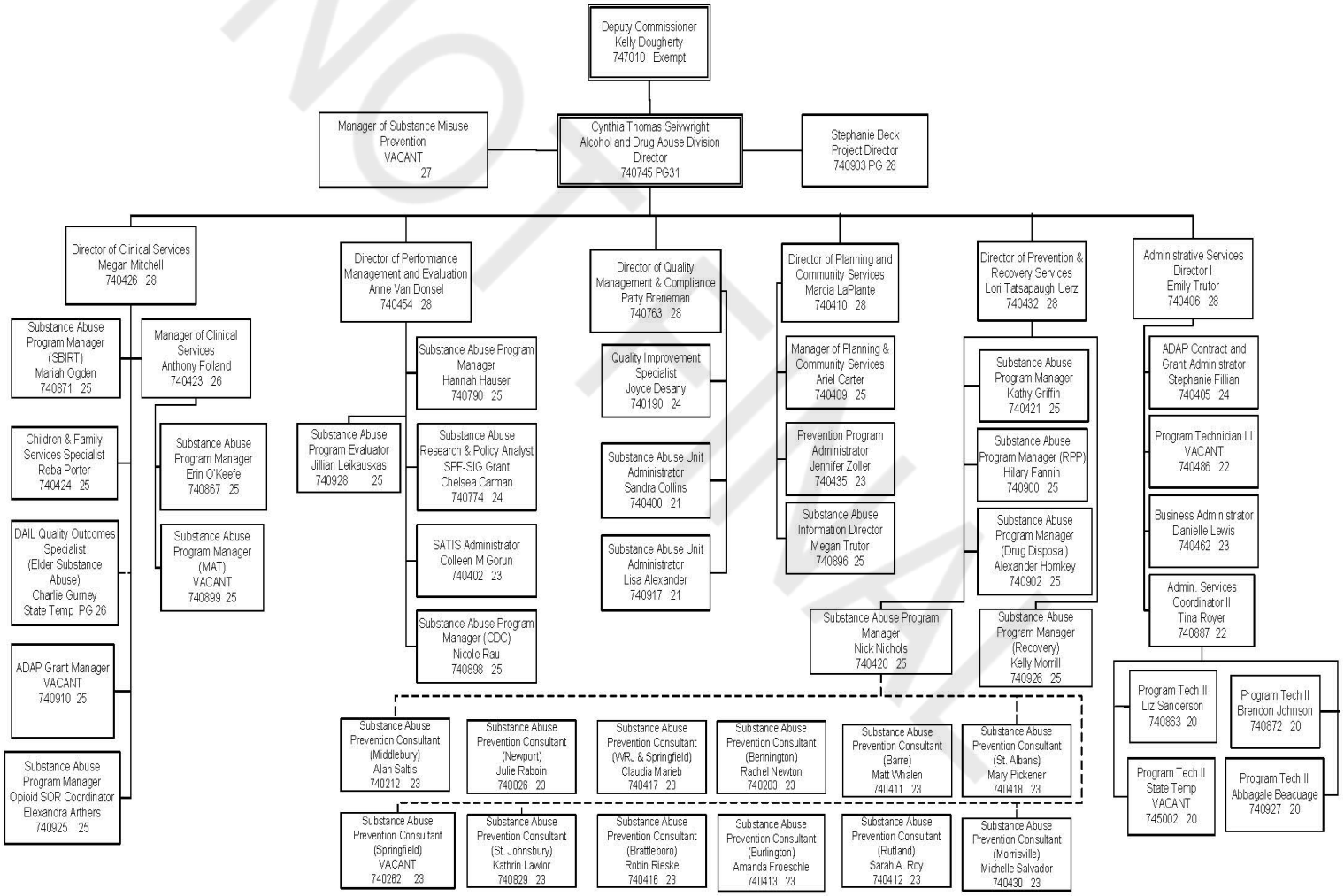
Each function is overseen by a unitdirector who reports to the Division Director. The Clinical Services Director supervises the Manager of Clinical Services who serves as the State Opioid Treament Authority (SOTA).

The following is ADAP's organizational chart.

VERMONT
DEPARTMENT OF HEALTH

Division of Alcohol & Drug Abuse Programs

July 2019



STRATEGIC PLANS

HEALTHY VERMONTERS 2020

The Vermont Department of Health (VDH) led an extensive stakeholder review of Healthy People 2020 goals and identified "Alcohol and Other Drug Use" as one of a short list of priorities for Healthy Vermonters 2020. This plan and additional review of data on needs and gaps has informed Vermont's long-term substance misuse indicators. The Healthy Vermonters 2020 Plan is available at: http://www.healthvermont.gov/about/reports/healthy-vermonters-health-status-reports

Programs and initiatives aim "to bend the curve" on the following long-term indicators:

- Percent of persons age 12 and older who need and do not receive alcohol treatment.
- Percent of persons age 12 and older who need and do not receive illicit drug use treatment.
- Percent of adolescents in grades 9-12 who used marijuana in the past 30 days.
- Percent of adolescents in grades 9-12 binge drinking in the past 30 days.
- Percent of adults age 18-24 binge drinking in the last 30 days.
- Percent of adults age 65 and older who drink at a level of risk.

More detail on the above indicators, together with short and mid-term performance measures for specific programs, is available at: http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

An Opioid Performance Scorecard has also been established to track progress on the Vermont's Opioid Strategy and is available at: http://www.healthvermont.gov/scorecard-opioids

State Health Improvement Plan (SHIP) 2019–2023

Vermont's latest State Health Improvement Plan (SHIP) focuses on the reduction of health disparities. The SHIP is informed by the 2018 State Health Assessment (SHA). Substance use has been identified as one of six priority health and social conditions. Development of action plans and performance measures is in process. More detail included: For more information reference: *Special Populations* section of this document.

ADAP's Strategic Plan 2017-2020

ADAP's Strategic Plan will be further informed by Vermont's new State Health Improvement Plan (SHIP) and is structured around and informed by the Vermont Department of Health (VDH) Strategic Plan. Both the VDH and ADAP Strategic Plans drive the building of internal and external capacity to carry out work on health improvement priorities. Goal areas include:

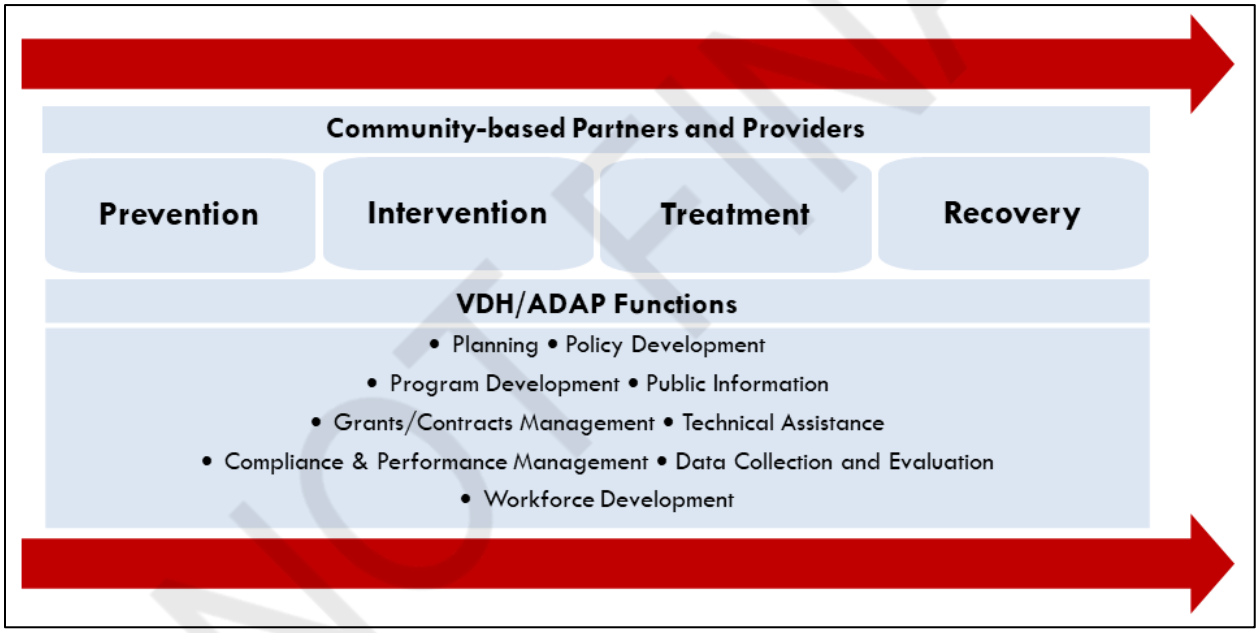
- Effective and Integrated Public Health
- Communities with the Capacity to Respond to Public Health Need
- Internal systems that Provide for Consistent and Responsive Support – Data Systems, Policies and Procedures, and Quality Improvement

- Competent and Valued Workforce
- Public Health System that is Understood and Valued by Vermonters
- Competent and Valued Workforce
- Health Equity for All

Work has commenced on the ADAP Strategic Plan for 2020- 2022, to be completed in January 2020. The ADAP Strategic Plan is available at: http://www.healthvermont.gov/alcohol-drugs The VDH Strategic Plan is available at: http://www.healthvermont.gov/about-us/reports/strategic-plan

SYSTEM OF CARE - STATE, REGIONAL and LOCAL LEVELS

Vermont's system of care reflects the continuum of care: prevention, intervention, treatment and recovery in conjunction with ADAP functions and an extensive network of community-based partners and providers.



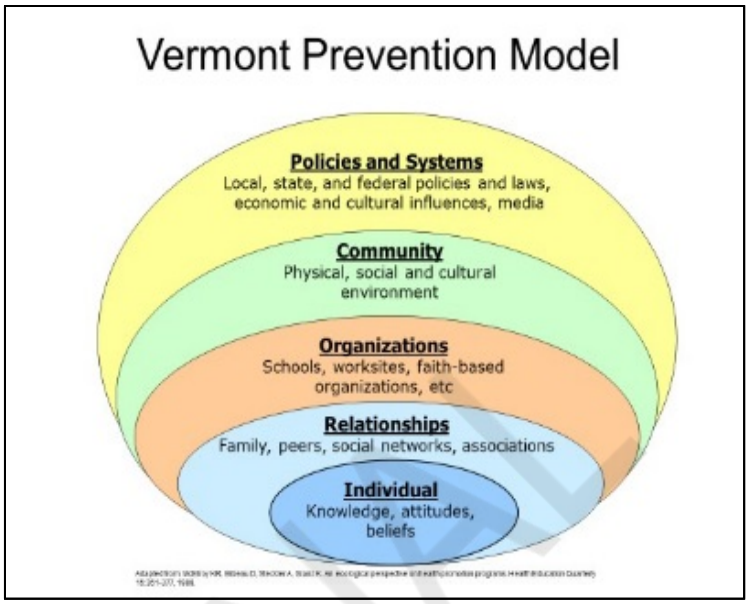
PREVENTION SYSTEM

Prevention of substance use disorders involves reducing the risks that contribute to alcohol, tobacco or other drug misuse while promoting factors that support healthy lifestyles and communities. In support of achieving the core outcomes prevention efforts aim to:

- Reduce underage drinking
- Reduce high-risk drinking
- Reduce adolescent marijuana use
- Reduce prescription drug misuse and abuse

Vermont Prevention Model

Prevention strategies are most likely to succeed if they reach people where they live, work and play, such as in their community, school, family and individual environments. It takes a combination of actions, sustained over time, to promote health, prevent and reduce alcohol and other drug misuse.



The Vermont Prevention Model shows the different levels of ADAP communities, partners and stakeholders work to implement evidence-based prevention strategies and services across these various environments.

Strategic Prevention Framework (SPF)

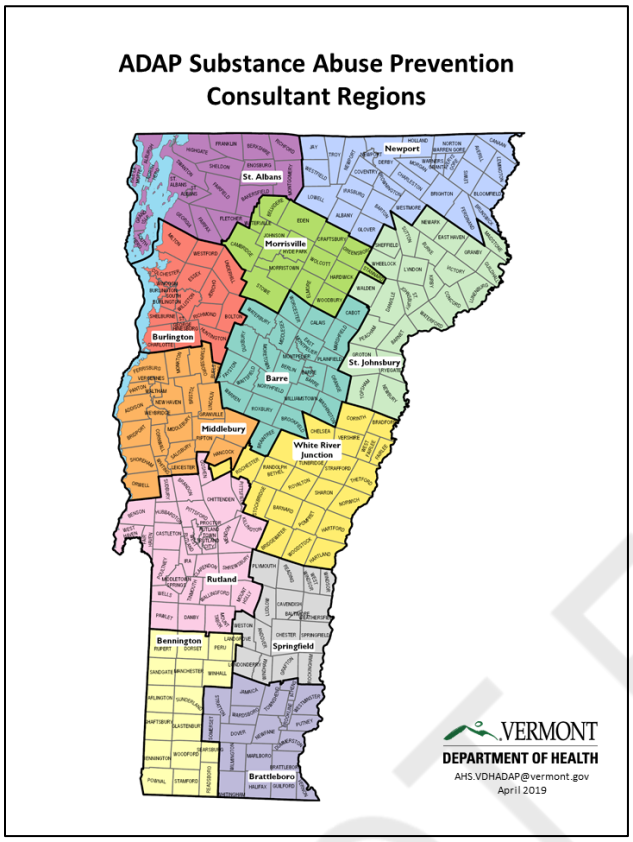
The Strategic Prevention Framework (SPF) has been adopted across the Department of Health as a means of facilitating and communicating about prevention strategies across disciplines. The SPF involves five processes:

1. Assessment – profile population needs, resources and readiness to address needs and gaps;
2. Capacity – mobilize and build capacity to address needs;
3. Planning - develop a comprehensive strategic plan;
4. Implementation – implement evidence-based prevention programs and activities; and
5. Evaluation – monitor, evaluate, sustain and improve or replace things that fail.

Prevention Strategies

Vermont implements a comprehensive prevention program statewide, with emphasis on information dissemination, education, alternative programs, problem identification, community-

based processes and environmental strategies as defined in the Six Strategies for Prevention (for more detail, click on this external link). More information on Vermont's prevention strategies is available at: http://www.healthvermont.gov/alcohol-drug-abuse/programs-services/how-prevention-works.



Regional Prevention Consultant System

Vermonters have access to one of 12 regional prevention consultants (PCs). These health professionals are alcohol and drug misuse prevention experts located in the 12 local health offices in Vermont. They support community efforts to lead and carry out prevention efforts. Prevention consultants help with:

- Community organizing
- Program planning and consultation
- Presentations and training
- Community grants information and guidance
- Information & referral

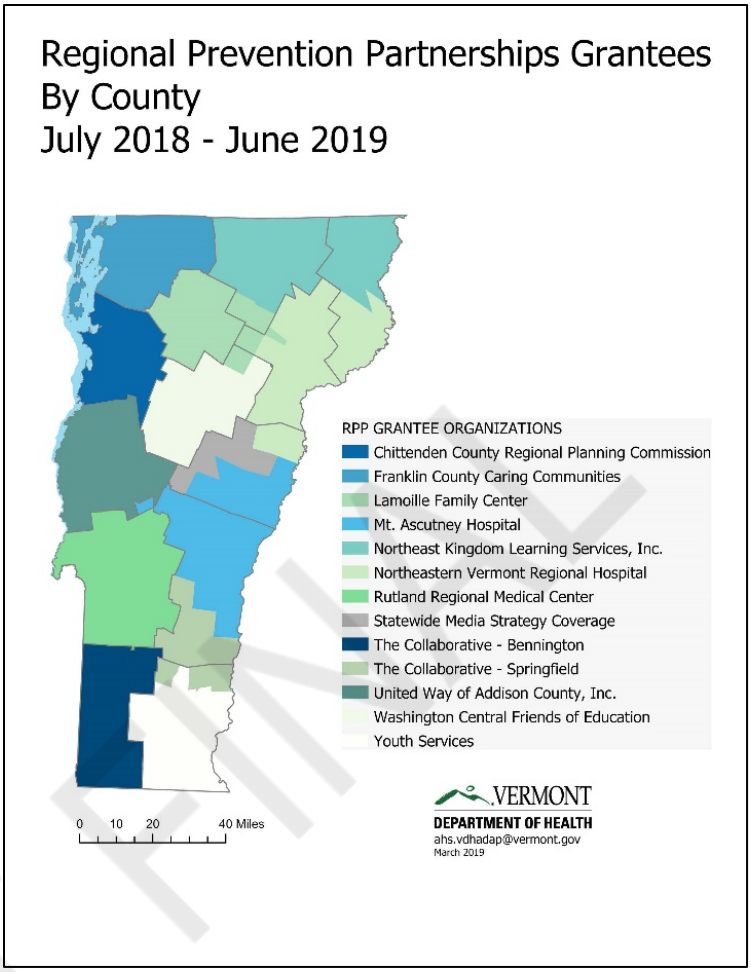
Community Partnerships and Mobilization

Programs and services that help communities become healthy and involved are a key part of alcohol and drug use prevention in Vermont. Bringing communities together is a job for many people from all walks of life, including law enforcement, the news media, parents, students, community coalitions, and doctors. Alcohol and drug prevention programs help support communities to grow in wellness and health. Vermont's emerging challenge is to address capacity of its substance misuse prevention system – and specifically its need for statewide coverage. The following are some of the investments ADAP is making to address community prevention capacity.

Regional Prevention Partnership (RPP)

The Regional Prevention Partnership (RPP) is a five-year cooperative agreement with the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of the RPP is to apply the Strategic Prevention Framework

(SPF) to reduce underage and binge drinking among persons aged 12-20, and marijuana use and prescription drug misuse amount young people 12-25.



The purpose of the RPP is to strengthen the prevention infrastructure at the state, regional and community levels using VDH's existing health district structure as the primary mechanism for implementation. At present all twelve of Vermont's District Office regions are implementing the SPF model and employ strategies suchy as underage drinking policy approaches, parenting programs, electronic screening and brief intervention, community mobilization, enhanced law enforcement, and targeted media campaigns.

The long-term vision for the RPP is for a fully functioning statewide system for prevention services that is coordinated at the regional level and respectful of the regional and cultural diversity that exists across Vermont. This system will build upon existing structures at the state, regional, and community level to support this vision. In developing the vision, the state recognizes that a community-level structure in which individual communities are funded to plan and implement their own prevention efforts is inefficient and not sustainable. The longer-term goal is to have effective regional prevention structures that collectively cover the entire state, along with centralized support and services.

Prevention Expansion Grants (PEG)

The Prevention Expansion Grants (PEG) supports the expansion of community-based substance misuse prevention strategies targeting a high need population experiencing health disparities such as low socioeconomic status (SES), LGBTQ, military and their families, refugees etc. across the lifespan. Required activities include expanding an evidence-based or promising strategy, the use of data to identify need, goals and objectives, a plan to achieve the objectives identified and an evaluation component. Nine (9) projects are being funded this year across the state located in the Burlington, Brattleboro, Barre, and Windsor Health District Office catechment area and one statewide grant to Outright Vermont focused on the LGBTQ population.

Prevention Infrastructure Grant (PIG)

The Prevention Infrastructure Grant (PIG) supports substance misuse prevention organizations that have demonstrated a high level of organizational capacity, experience and previous performance. Funds are utilized to maintain local and regional levels of capacity to implement substance misuse evidence-based and/or promising practices using the Strategic Prevention Framework (SPF) process and model. Two (2) organizations are supported in the Morrisville and Windham Health Districts.

Young Adult High Risk Substance Use College Pilot Project

The Young Adult High Risk Substance Use College Pilot Project supports a partnership between Healthy Lamoille Valley Coalition and Johnson State College to assess readiness and capacity, develop a plan utilizing the AHS Improvement Model (AIM) guidelines/model (continuous quality improvement) and implement a comprehensive approach to reduce alcohol and/or marijuana use both on and off campus.

Public Information and Messaging

The Vermont Department of Health (VDH) produces public information materials to promote and protect the health of Vermonters and visitors – at home, at school, at work, at play, or out in the community. Public Information Campaigns are a key component in ADAP's Strategic Plan to ensure that the public health system is understood and valued by Vermonters, and to increase the public's understanding of the continuum of care (see Goal 5), including how to access those services, and to promote substance misuse service outcomes. Public information campaigns are also an effective means to enhance other prevention programs or build on existing public awareness efforts. The following are some of Vermont's on-going campaigns.

CAMPAIGN OVERVIEWS & MESSAGING STRATEGIES

VERMONT DEPARTMENT OF HEALTH

Campaign	Audience	Behavioral Objective	Messaging Strategy	Tactical Implementation
OUTLAST	High-risk youth ages 13-17	Prevent marijuana use and underage alcohol use	Currently in development	Currently in development; anticipated implementation via targeted social and digital media
OVER THE DOSE	Young adults ages 18-25 at risk of prescription opioid misuse	Prevent prescription opioid misuse	Correct misperception that opioid use or misuse is risk-free; highlight similarities between prescription opioids and heroin	Prompt interaction with educational content via social and digital media, and interactive web-based experiences
-CHECK- YOURSELF	Young adults ages 21-25 at risk of binge drinking	Reduce binge drinking	Provide realistic tips to reduce binge drinking while still participating in social activities	Target high-risk young adults via social media
CDC Centers for Disease Control and Prevention	Adults ages 25-54 who have, or who may in the future have, an opioid prescription	Increase knowledge of the risks associated with opioid use	Emphasize extreme risks and consequences of opioid use through personal stories	Promoted via digital media, radio, and TV ad buys to drive traffic to Health Department webpage
Responsible Use Campaign	Young adults and adults ages 18-54 who have, or who may in the future have, an opioid prescription	Increase knowledge of the risks associated with opioid use	Address audience gaps in knowledge through clear educational content blocks	Currently promoted via social and digital media, directing people to the Health Department's RxAware page
DO YOUR PART Rx	Adults ages 18+ who have, or have previously had, an opioid prescription	Increase safe storage and disposal of prescription and over-the-counter medications	Educate on the risks of unsafe storage and disposal; emphasize ease with which Vermonters can protect themselves and others	Based on research findings, existing campaign was expanded to enhance Rx storage and proper disposal messaging
SUD Outreach (TBD)	Youth, young adults and adults seeking substance use disorder treatment	Increase ability to find and engage in treatment services	To be developed with Centralized Intake system development	Call center, appointment board, website, waitlist management, interim services
Responsible Prescribing	Primary Audience: Prescription opioid prescribers; Secondary Audience: End user for prescriber knowledge (patients)	Increase best practice opioid prescribing and patient knowledge of the risks associated with use	5 health communications videos and handouts currently in development	Health Department web resource library and collateral, direct VPMS affiliated outreach, partnerships, public campaign crossover
PARENT UP	Parents whose children are at risk of substance use	Increase proactive conversations between parents and youth about risks of substance use	Empower parents to talk with children; empower parents as the number one influence on youth behaviors; substance-specific messages; address parent isolation	Enhancement of existing messaging and new messaging in development

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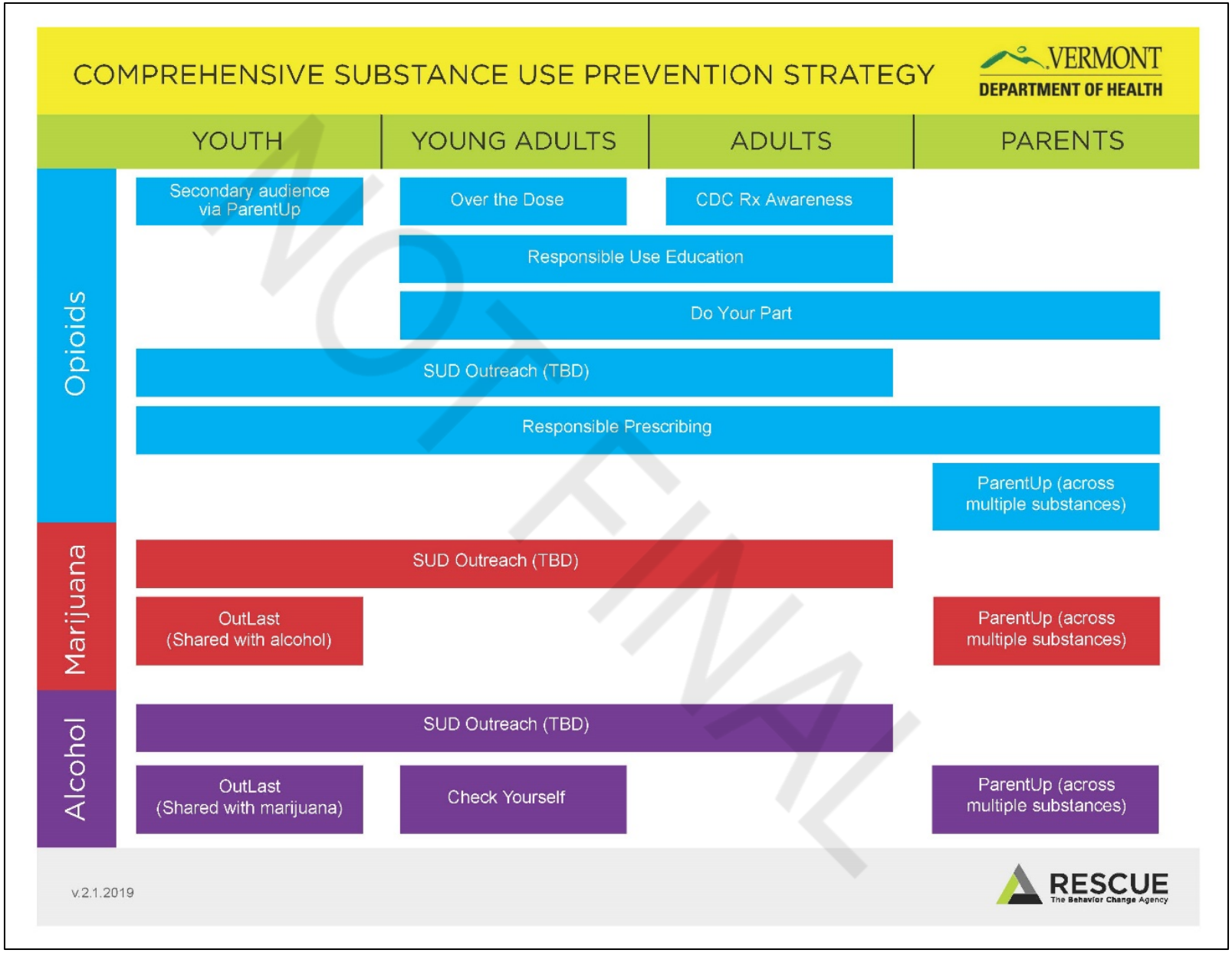
RESCUE The Behavior Change Agency



PLANNED ENHANCEMENTS TO PUBLIC INFORMATION STRATEGY

Messaging to Support the Reduction of Stigma

Vermont has a robust public messaging strategy on the consequences of opioid misuse with layered campaigns targeted to the public, young adult high risk users and physicians. Assessments conducted by Vermont's Opioid Coordinating Council and Vermont's Alcohol and Drug Abuse Council – both representing stakeholders across the continuum of care – have identified the stigma of opioid use disorder and medication assisted treatment as a barrier to treatment. They identified public messaging to address stigma as a gap to fill to improve outreach to those needing treatment, their family members and friends. Strategic planning sessions are being conducted in 2019 to inform stigma reduction messaging strategies.

Outreach Materials to Increase Awareness of Vermont's Good Samaritan Law

In June 2013, a new law granted immunity from prosecution (in most cases) if a person calls for help during an opioid overdose emergency. With the number of fatal opioid overdoses increasing in the state, Vermont is planning to promote messaging to increase knowledge of the law, therefore increasing the number of calls for help in an overdose situation. Outreach strategies are intended to reach high-risk opioid users, as well as first responders. Finalized materials and outreach strategies are planned for late summer 2019.

INTERVENTION/EARLY IDENTIFICATION

Impaired Driver Intervention Program (IDRP)

The Impaired Driver Rehabilitation Program (IDRP) is a program of the Department of Health, Division of Alcohol and Drug Abuse Programs that provides screening, education, and treatment services for individuals throughout Vermont who have received an impaired driving conviction. Individuals are not eligible to have their driving privileges reinstated by the Department of Motor Vehicles until they have successfully completed the IDRP. The curriculum includes lectures, reading materials, videos and small group discussions. For individuals with one impaired driving conviction, or who are court ordered to attend the IDRP, a clinical evaluator will determine if counseling is necessary.

The IDRP educational curriculum has been updated. Prime For Life©, developed by the Prevention Research Institute, is an evidence-based motivational prevention, intervention and pretreatment curriculum specifically designed for people who might be making high-risk choices. It is designed to change drinking and drug use behaviors by changing beliefs, attitudes, risk perceptions, motivations, and the knowledge of how to reduce their risk of alcohol- and drug-related problems throughout their lives. Because Prime For Life© includes both prevention and intervention content, it is also designed in a way that serves universal, selective, and indicated audiences with program delivery options for each.

Schools

The School-based Substance Abuse Services (SBSAS) grants support alcohol and drug use/misuse prevention and mental health promotion in selected supervisory unions throughout the state, and focus on the following priorities:

- Reduce past month use of alcohol, marijuana and other illicit substances among adolescents (12-17)
- Reduce binge drinking among adolescents (12-17)

Through grants awarded to 20 supervisory unions (selected based on need, readiness and their plan) schools implement substance use/misuse prevention strategies, including:

- Substance use/misuse and mental health screening and referral services
- Initiatives that support the CDC Whole School, Whole Community, Whole Child Framework available at: https://www.cdc.gov/healthyschools/wscc/index.htm
- Classroom health curricula
- Peer leadership groups
- Parent education
- Teacher and support staff alcohol and other drug training
- Educational support groups

The long-term goal is to achieve statewide coverage so all supervisory unions would benefit from the best practices in substance abuse prevention.

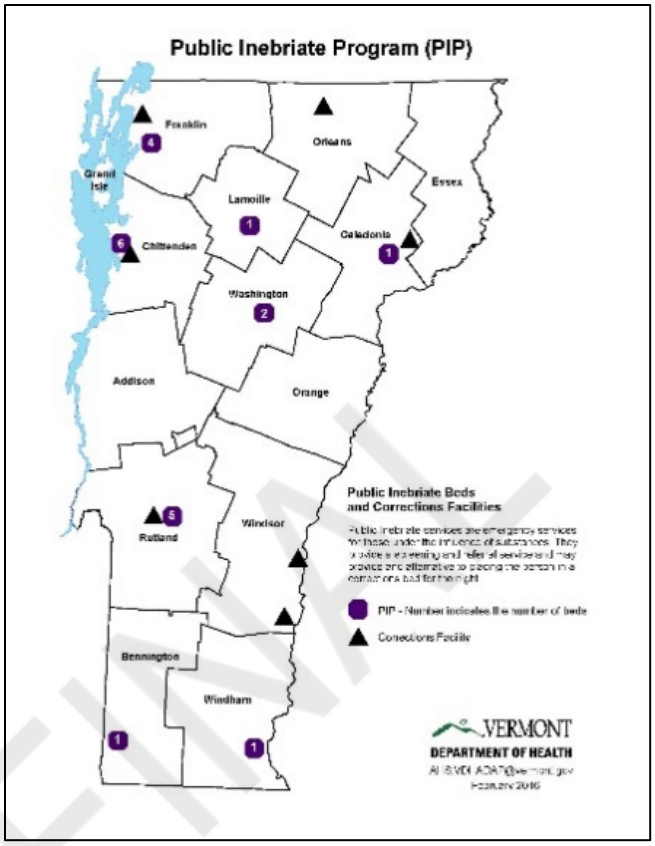
Screening in Primary Care Settings

In 2013, the Department of Health's Division of Alcohol and Drug Programs was awarded a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide screening, brief intervention, & referral to treatment (SBIRT) at 13 sites, including emergency departments, primary care offices, a women's health clinic, and free clinics. Trained clinicians and medical providers used evidence-based tools to screen for risk of substance misuse. If a person screened at a high-risk level, the clinician made an assertive referral to a treatment option in which the individual is interested. 91,711 people were screened – more than the original program goal - by the conclusion of the SBIRT grant in 2017.

This intervention is being continued by the Blueprint for Health (Blueprint) as a new program, called Screening, Brief Intervention, and Navigation to Services (SBINS). The Blueprint is currently designing a program of SBINS supports that will be available to every Blueprint primary care practice and all emergency departments in the state. Medicaid will fund new staff, with staffing levels adjusted for practice and department patient volume. The new staff will provide the brief interventions for patients and navigation services in collaboration with other Community Health Team members. More information on the Blueprint for Health and SBINS is available at: blueprintforhealth.vermont.gov/program-design-development

Public Inebriate Program (PIP)

ADAP has designated qualified organizations to provide 24-hour, 7-day-per-week community-based alcohol and drug crisis stabilization and detoxification programs, including for incapacitated individuals taken into protective custody by law enforcement for public inebriation. The process of screening and determining appropriate placement for individuals meeting criteria for incapacitation, due to either the intoxication or withdrawal from alcohol or other drugs, is defined in 18 V.S.A. Chapter 94, 4808 available at:



https://legislature.vermont.gov/statutes/section/18/094/04808

Results of the screening process may include individuals being referred for further medical assessment, alternative placements to incarceration, or placement within restrictive facilities. The period of protective custody ends when the person is released to one of the designated PIPs or, if not available in the vicinity, to the emergency department of a licensed general hospital for treatment. If an approved PIP is unavailable, or where assistance is actively refused or resisted by the incapacitated person, then protective custody can be continued by lodging the person in a lock-up or community correctional center, not to exceed 24 hours.

TREATMENT– All Modalities

Substance use disorder treatment services, including Medication Assisted Treatment, are provided in accordance with evidence-based best practice and the most recent version of the American Society of Addiction Medicine (ASAM) Criteria.

Vermont's substance use disorder treatment system includes ADAP's Approved and Preferred Provider treatment programs. Preferred Providers are treatment organizations that have attained a certificate from ADAP and have an existing contract or grant from ADAP to provide treatment. Certification standards (updated in August 2018) serve as the basis for certification and can be found at: http://www.healthvermont.gov/alcohol-drugs/professionals/treatment-provider-certification

Preferred Providers are essential to delivering direct clinical programs and services into their local communities. Currently, there are 24 Preferred Providers serving multiple sites. Vermonters across the state have access to all levels of care. Most providers are non-profit and a few are for-profit. This system includes some but not all community mental health centers (designated agencies).

Outpatient Programs

Outpatient programs provide treatment at a program site, but the person lives elsewhere (usually at home). There are 24 outpatient treatment programs statewide, with treatment services offered in a variety of settings: health clinics, community mental health clinics, counselors' offices, hospital clinics, local health department offices, or residential programs with outpatient clinics. Many meet in the evenings and on weekends so participants can go to school or work. People who do best in an outpatient program are able to attend counseling sessions regularly, have supportive friends or family members, have a place to live, and have some form of transportation to get to treatment sessions.

Intensive Outpatient Programs

As with outpatient programs, intensive outpatient programs also provide treatment at a program site, but the person lives elsewhere (usually at home). There are 14 intensive outpatient treatment programs statewide, and require a person to attend 9 to 19 hours of treatment activities per week consisting of a combination of assessment, care coordination, individual, group, and/or family therapy sessions. Intensive outpatient programs can last up to several months with continuing care afterward.

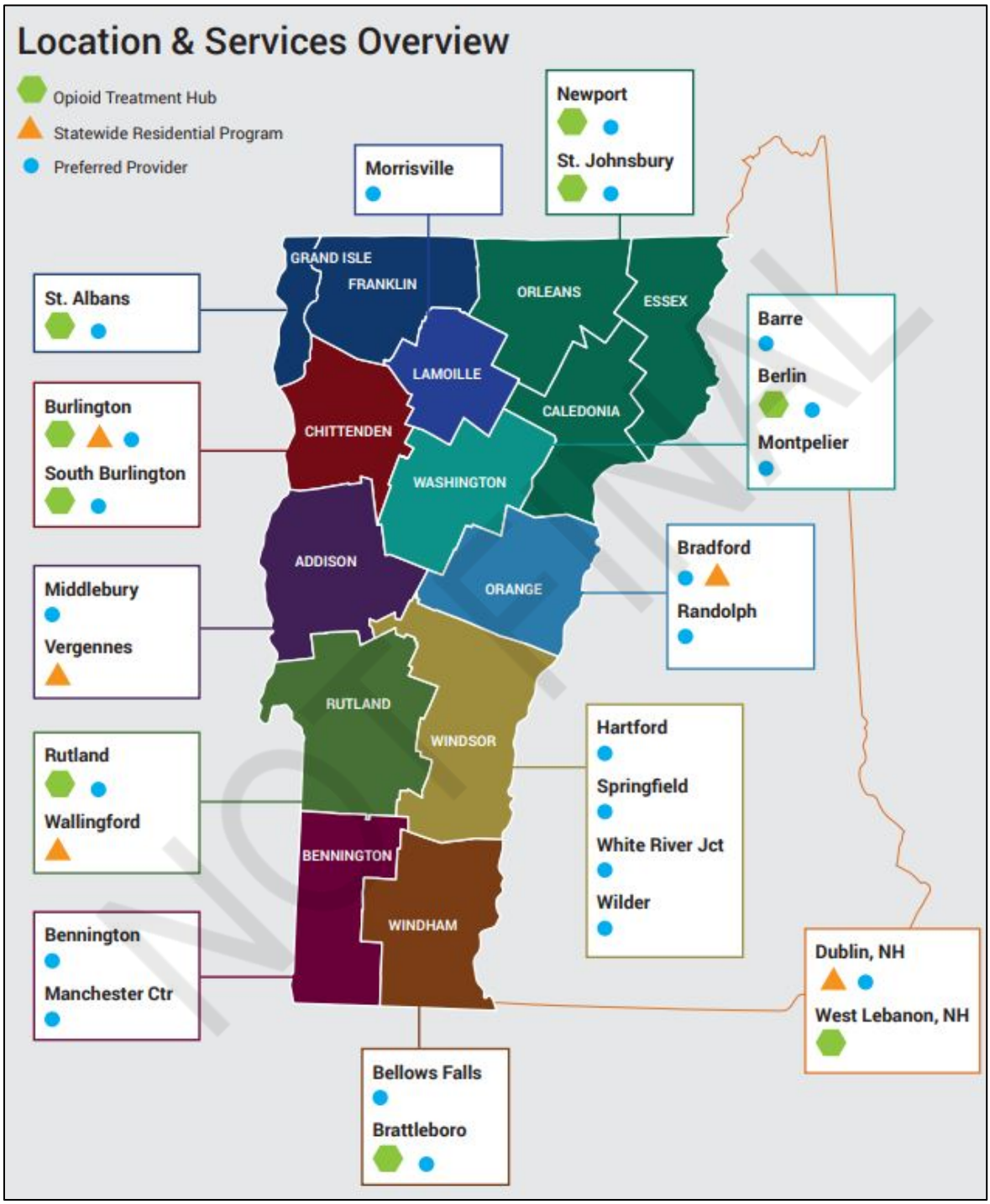
Inpatient Treatment

Inpatient treatment, provided in special units of hospitals or medical clinics, offers both detoxification and acute medical and/or mental health services. People who have a severe mental disorder or serious medical problems in addition to a substance use disorder are most likely to receive inpatient treatment. The length of stay varies by condition but rarely exceeds seven days.

Short-term Residential Treatment Programs

Short-term residential programs provide a living environment with treatment services. Several models of residential treatment (such as the therapeutic community) exist in Vermont. Treatment is determined by medical need, and usually lasts 30 days or less. There are three short-term residential specialty treatment programs in Vermont, including one women's specialty program. Residential treatment may help people with very serious substance use disorders who have been unable to get and stay sober or drug free in other treatment. Medically monitored inpatient withdrawal management services are also available through an organized service delivered by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical

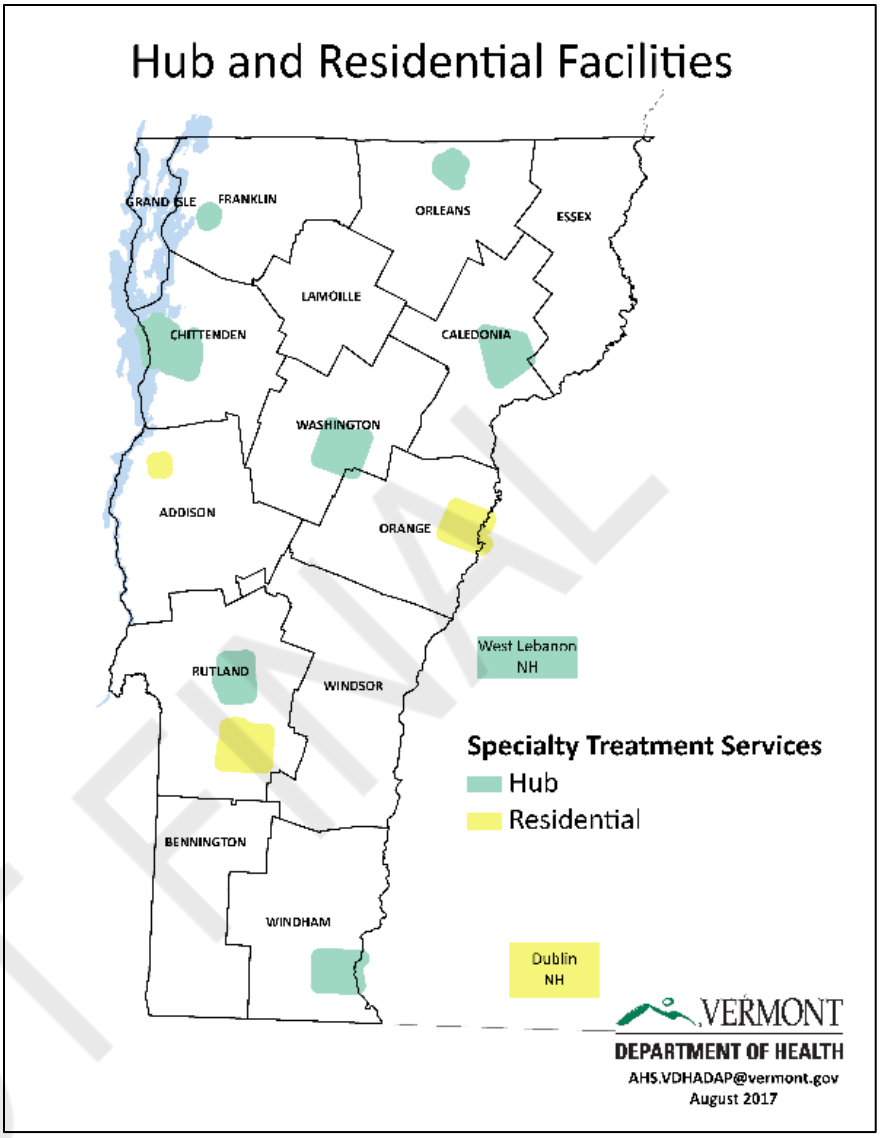
protocols that comply with the requirements of ASAM, with Opioid Treatment Hubs guided by the Medication Assisted Treatment Rules.



Hub and Spoke

Vermont's Hub and Spoke system of care is a statewide partnership of specialty treatment centers and medical practices that provide comprehensive medication assisted treatment (MAT)

services to Vermonters who are diagnosed with opioid use disorder (OUD). Regional specialty treatment centers (Hubs) are federally accredited Opioid Treatment Programs (OTPs). Hubs treat patients, primarily individuals who are using substances intravenously, with complex needs. Spokes are office-based opioid treatment (OBOT) providers staffed by a three-person care team with a care coordinator/clinician, nurse and physician for every 100 patients administering MAT in medical practice settings such as primary care, OB-GYN, or psychiatry. Spokes can also be comprised of several physicians sharing the support team.



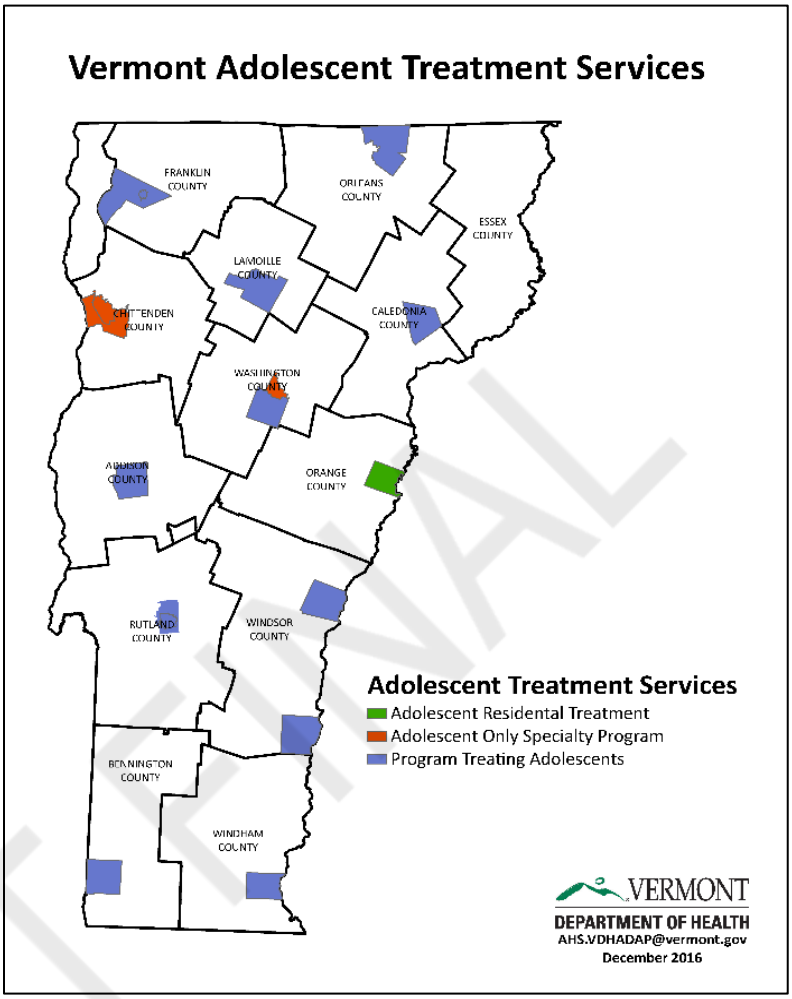
A primary aspect of the Spokes is the wrap-around services provided to the patients based on a customized treatment plan overseen by a doctor and buttressed by the nurses and counselors who connect the patient with community-based support services, whether referral to mental health treatment, job placement, and/or family and recovery support.

The Hub and Spoke system supports bi-directional patient transitions between the Hubs and Spokes to replicate other medical specialties, where Hubs stabilize people with complex needs who require the most care, and physicians (Spokes) manage more stable patients' ongoing needs over the long term.

The Hub and Spoke system has dramatically increased the number of people who receive MAT services. There are six Hubs, with a total of nine locations serving the state; some Hubs have multiple locations. Hub and Spoke learning collaboratives on psychosocial treatments, co-occurring disorders, contingency management, and MAT in primary care and community settings are offered to clinicians to strengthen workforce skills and improve coordination.

More information is available at: healthvermont.gov/alcohol-drug-abuse/how-get-help/find-treatment

Adolescent and Family Services



There are 11 treatment programs that provide adolescent treatment services statewide and there are three adolescent-only specialty programs. ADAP supports youth substance use disorder treatment providers to provide effective and developmentally appropriate services:

- Use of evidence-based and age appropriate treatment models (e.g. Seven Challenges, Brief Challenges and Seeking Safety)
- Offer services in emotionally and physically accessible environments for adolescents. This means offering services outside of the agency, in the school, community and homes of the youth- important especially for low-income youth
- Define the service not as substance use disorder treatment, but as a service that is there to help them meet their life goals as they envision them
- Offer a menu of treatment options (group, individual, and treatment approaches) to avoid a one size fits all approach
- Integrate with mental health services
- Employ clinicians skilled in adolescent treatment
- Involve the family in the adolescent's treatment
- Address generational substance misuse within the family
- Support adolescents in promoting their own health and healthy development, including encouraging them to share insights, take leadership roles, get involved with their community, build organizational leadership skills and self-esteem, and create and share important information with their peers and others who serve youth

TB/HIV Services

In Hubs (OTPs) and residential programs, patients are provided with testing for TB and HIV upon admission and referrals are coordinated with primary care to infectious disease programs/clinics at partner hospitals such as Rutland Regional Medical Center and the University of Vermont (UVM) Medical Center. Preferred Providers across the levels of care

offer psychoeducation regarding TB and HIV transmission risks, prevention strategies and resources for clients including but not limited to needle exchange programs.

PLANNED ENHANCEMENTS TO TREATMENT SYSTEM

Centralized Intake and Resource Center

ADAP is working to implement a statewide substance use disorder centralized intake and resource center (CIRC) in 2019 to improve equitable access to treatment resources across regions. The CIRC will include a call center and website where Vermonters and treatment professionals can find information on substance use disorder prevention, intervention, treatment and recovery services. Vermonters will be able to call one number to schedule an assessment with a substance use disorder treatment provider, get information and referrals to other services (transportation, mental health, economic resources), and receive counseling and education to reduce the adverse health effects of substance use and promote personal health.

Medical Director

ADAP will support the services of a part-time medical director through a partnership with the University of Vermont Health and Wellness Center. The Medical Director will focus on the aspects of policies and procedures, quality assurance, care, case and systems issues that pertain to individual or groups of physicians.

RECOVERY SERVICES AND SUPPORTS

Vermont has a strong commitment to recovery supports as a critical component of the system of care and this program area will be a capacity enhancement priority over the next two years.

Increasing the capacity of the recovery support system will be a strategic priority over the next two years. Vermont will increase the number of trained recovery coaches and support a system for coach certification which will align with the International Certification & Reciprocity Consortium (IC&RC) Peer Recovery credential with the support of State Opioid Response (SOR) funds. Additional training will be provided for coaches who are seeking to work in areas of specialization such as medication assisted treatment, pregnant and parenting women and employment readiness. These coaches will be needed to bring the Recovery Coaches in the Emergency Department, Employment Services in Recovery and the New Mom's in Recovery programs to scale.

Recovery Centers

Vermont has a system of 12 community-based recovery centers located throughout the state, with one center located in each health district. The recovery centers offer a wide variety of supportive services, including peer support and referral, substance-free recreation, and educational opportunities.

Vermont Recovery Network (VRN)

The Vermont Recovery Network (VRN) provides technical assistance, training and data collection services to several recovery centers. Through the ongoing relationship with the VRN, the recovery centers, and the Vermont Association for Mental Health and Addiction Recovery (VAMHAR), there is emphasis on the need to have peers, family members and other supporters staffing recovery centers and guiding the Vermont Department of Health on appropriate language and techniques to use to be more welcoming and supportive of those looking to engage with treatment and recovery services.

Recovery Coaching

Many recovery support services are provided by recovery coaches located in and deployed by recovery centers. The Vermont Recovery Coach Academy trains people in recovery from substance use disorder, family members and other supporters on the tools, skills and resources necessary to becoming an effective recovery coach. The training, provided by the Vermont Association of Mental Health and Addiction Recovery (VAMHAR) is a 4 day, 32-hour training to prepare an individual to become a recovery coach, with an eye towards overall professional development.

Recovery / Sober Housing

ADAP contracts with community housing and/or recovery organizations to provide transitional, sober supported housing for Vermont residents. The majority of referrals are made by residential substance use disorder treatment providers, though not exclusively, with the primary goals of supporting the individuals transition to permanent housing, supporting their recovery efforts and increasing their recovery capital.

There are some women's transitional housing services, as well as family transitional housing services. Work has been done to expand the availability of transitional, sober housing. In the last year a home was opened in Caledonia County and has begun housing individuals discharging from treatment.

The Vermont Alliance of Recovery Residences (VTARR), Vermont's state affiliate of the National Association of Recovery Residences (NARR), has adopted a set of standards for four levels of sober housing ("Recovery Residences"). VTARR requested and is in receipt of technical assistance for the systems, processes, procedures, and trainings related to transitional, sober housing, and has compiled data related to the status and needs of transitional, sober housing into a formal needs assessment.

Recovery Coaches in Emergency Departments

Recovery centers send trained recovery coaches to the emergency departments (ED) of area hospitals to provide support and connection to additional services. These coaches meet with people who come into the hospital due to an overdose or other substance use-related issue, and help them to move from crisis to recovery. Coaches are first trained at the Recovery Coach

Academy, and then receive a second level of training specific to working in the ED. Coaches work with people during their hospital visit and after discharge, helping them identify treatment and other services and recovery supports. They also provide guidance on obtaining and using naloxone.

The Recovery Center meets with local hospitals to identify need and capacity of the hospital for the program and currently, there are six sites up and running 1090 individuals were seen in the EDs from July 1, 2018 – June 30, 2019. Four additional sites and five hospitals are in the planning stage (with one Recovery Center serving 2 hospitals).

Employment Services in Recovery

The Employment Services in Recovery Program has been launched with employment consultants working out of three (3) Hubs, one (1) Spoke and one (1)recovery center. Through this program, people in recovery from substance use disorder have access to employment consultants. These consultants help with building resumés, mock interviews, job search and placement assistance and more. Employment consultants also work directly with Vermont businesses and employers to reduce barriers to hiring people who are in recovery. This program is a collaboration of the Departments of Health, Labor, Disabilities, Aging and Independent Living. Quality improvement work and expansion to additional communities is in planning phase.

New Mom's in Recovery

Recovery Coach Pregnant and Parenting Women's Specialists specialize in serving pregnant and parenting women seeking substance use disorder treatment and recovery services, as well as the development of a family-friendly environment at recovery centers. Vermont will expand a pilot program initiated at one recovery center to three (3) additional recovery centers that have demonstrated the capacity and readiness for this program.

SPECIAL POPULATIONS

Treatment/Referral

In Hubs (OTPs) and residential programs, patients are provided with testing for TB and HIV upon admission and referrals are coordinated with primary care to infectious disease programs/clinics at partner hospitals such as Rutland Regional Medical Center and the University of Vermont (UVM) Medical Center. Preferred Providers across the levels of care offer psychoeducation regarding TB and HIV transmission risks, prevention strategies and resources for clients including but not limited to needle exchange programs. Vermont is implementing a Substance Use Disorder Centralized Intake and Resource center to better facilitate access to treatment and resources for special populations, improve capacity management, and allow for data and reporting on the provision of interim services and referrals to resources.

Prevention Education Partnerships

The Vermont Department of Health (VDH) has established a partnership with Vermont CARES, a statewide organization serving Vermonters affected by HIV/AIDS. This works includes prevention, education and support services for people who are using drugs intravenously. Vermont Cares will train first responders on reducing stigma, and working with people who have experienced an opioid overdose. The VDH will partner with the Departments of Mental Health, and Disability, Aging, and Independent Living to expand opioid overdose prevention training for community partners in 2019.

Syringe Service Programs

Syringe Service Programs, known as SSPs, are community-based programs that provide access to sterile needles, free of cost. SSPs also provide overdose education and prevention, naloxone (Narcan®) distribution, case management, referrals to health services, HIV and HCV testing, and facilitate safe needle disposal. As of January 2018, four SSP organizations oversee seven fixed locations, and one mobile unit. Possession of syringes and injection equipment as part of an SSP does not violate Vermont's paraphernalia law according to State Statutes 18 V.S.A. § 4475, 18 V.S.A. § 4476, and 18 V.S.A. § 4478. SSP services are free, legal, and anonymous.

Pregnant and Parenting Women and Children

The Hubs (opioid treatment programs - OTP) include pregnancy testing and screening for pregnancy risk as part of their admission protocol. This is part of a full physical with labs at admissionand annually thereafter in addition to testing for pregnancy as needed. Hubs manage pregnancies that occur by providing increased internal supports, providing referrals to prenatal care and services, and participating in community empaneled teams to wrap services around complex patients. Female patients are also referred to their primary care provider or Planned Parenthood for contraception. Hubs have been trained by Planned Parenthood to improve contraceptive counseling and active referrals for women to access long acting reversible contraception (LARC).

As part of the Blueprint for Health's Women's Health Initiative, many Spokes (office-based opioid treatment – OBOT) receive training on screening and brief intervention with women related to health disparities and pregnancy risk. Follow-up is supported through a bi-directional referral relationship with women's health specialty providers. The women's health specialty providers are providing enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long acting reversible contraception (LARC).

Improving Care for Opioid-exposed Newborns (ICON)

The Improving Care for Opioid-exposed Newborns (ICON) project, housed within the Vermont Child Health Improvement Program, partners with the Vermont Department of Health, Divisions of Alcohol and Drug Abuse Programs and Maternal and Child Health, and the University of Vermont Children's Hospital to improve health outcomes for opioid-exposed newborns. Improved health outcomes are achieved by provision of educational sessions on up-to-date

recommendations and guidelines to health care professionals who provide care for opioid-dependent pregnant women and their infants. The objectives are:

- Improved availability of, and access to prenatal and postnatal care for opioid-dependent, pregnant women and opioid-exposed infants
- Coordination of services for women to connect them with substance use disorder treatment providers, housing, newborn care, and resources to support and achieve a healthy family
- Promotion of evidence-based guidelines for use by health care practitioners who provide management of the newborn infant
- Identify and address educational needs of community providers who care for opioid-exposed infants and their families
- Continue work from the VT 2017 CARA (CompPolicy Academy to support the implementation of Vermont's Plan of Safe Care (POSC)

The ICON project has accomplished:

- Development of *The Care Notebook*, a resource guide for opioid-dependent mothers
- Creation of resource booklets for providers working with pregnant women in treatment for opioid-dependence
- Provision of ongoing educational training sessions throughout Vermont
- Collaboration with ADAP on providing tools and resources for substance abuse screening
- Improved tracking of Hepatitis C-exposed infants
- Annual statewide training conference

Children and Recovering Mothers (CHARM)

ADAP continues to fund the Children and Recovering Mothers (CHARM) team: an empaneled, cross disciplinary group that supports pregnant and postpartum women and their babies through care coordination, wrap around supports, and monthly meetings that bring together social service, state, and medical care providers. ADAP funds the facilitation and data analysis for CHARM through the Kidsafe Collaborative.

Regional Partnership Program (RPP)

ADAP contributes funding to the Regional Partnership Program (RPP), a collaboration between the Department for Children and Families (DCF) Family services, and Lund. RPP is designed to improve the well-being of and permanency outcomes for children affected by parental substance use by increasing access and engagement of parents in treatment. RPP staff work in partnership with Family Services on the front end of the child welfare case, screening for problematic substance use, linking parents to indicated treatment services and addressing barriers to successful engagement.

There are Case Managers located in all 12 DCF offices throughout Vermont, providing the following services:

- Screening for substance use/misuse using the UNCOPE; make referrals to assessment as indicated.
- Addresses barriers to treatment engagement and/or services for each caregiver.
- Make necessary referrals and support linkage to treatment and other services to foster successful treatment engagement; and work in collaboration with the DCF investigator to establish, determine and communicate treatment recommendations.
- Provide consultation and information necessary to DCF in assessing child safety as it relates to parental substance use and provide general consultation and education as appropriate to social workers regarding addiction and treatment.
- Collaborate and assist child safety intervention staff involved in investigations and assessments; and documents services provided to families and tracks timeliness of treatment for eligible families.

ENHANCEMENTS SUPPORTED BY SABG FUNDS

In addition to providing funding for uninsured/underinsured people, and offering improved access to priority populations, several Preferred Providers have funded projects focusing on pregnant and parenting women with approval from ADAP for use of non-direct block grant funds.

The Welcoming Space

The Brattleboro Retreat Hub has opened a childcare program called The Welcoming Space for families to use while a parent or guardian attends treatment services. The Welcoming Space seeks to improve the ovearall health and well-being of the participating families by increasing family strengths, enhancing child development, and reducing the likelihood of child abuse and neglect.

Women's Healthy Living Program

Evergreen Treatment Services launched the Women's Healthy Living Program which provides child welfare involved and at-risk women access to transportation, childcare, individual counseling and case management, groups on relationships, parenting, and nutrition. The program's core curriculum, *Helping Women Recover: A Program for Treating Addiction,* is based on Stephanie Covington's addiction, trauma, and psychological development series. In offering women an array of services, the program strives to improve flexibility and meet the variable needs of women and families.

Messaging

ADAP is coordinating with the Divisions of Maternal Child Health and Health Promotion Disease Prevention on the development of messaging regarding substance use during pregnancy. A contracted evaluation team will provide qualitative data, providing insight and informing recommendations on future communications, as well as messaging and outreach strategies to the intended audience(s) of pregnant women and health care providers. The messaging is in the formative evaluation phase; estimated to be completed by August 2019.

DIVERSE POPULATIONS

State Health Improvement Plan (SHIP) in Development

As noted above, ADAP has participated with approximately 80 other partners in the development of the 2019-23 State Health Improvement Plan (SHIP) which focuses solely on reducing health disparities. Based on findings from the State Health Assessment (SHA) (http://www.healthvermont.gov/about/reports/state-health-assessment-2018) substance use is one of six health and social conditions identified as priorities in the plan: http://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan

The SHIP is built around four broad strategies (invest in policies and infrastructure that create healthy communities; invest in programs to promote resilience, connection and belonging; expand access to integrated person-centered care; and adopt organizational and institutional practices that advance equity) to improve outcomes in six priority health and social conditions (Childhood Development, Chronic Disease, Mental Health, Oral Health, Substance use and Social Determinants: House, Transportation, Food and Economic Security).

The SHIP also highlights four populations of focus (racial and ethnic minorities; people with disabilities; people of low economic status and the LBGTQ population. ADAP will play a lead role in guiding population-based prevention and recovery support strategies. Based on the needs assessment, ADAP's particular focus will be on the LGBTQ community and people of color.

Next steps will include the identification of specific priority outcomes and strategies by population. It is anticipated that this next planning phase will occur over the next year. Development of action plans and performance measures is in process.

Health Equity Advisory Team

The Health Equity Advisory Team (HEAT) is a cross-departmental workgroup that aims to support health equity work within the Vermont Department of Health. The goal of HEAT is to outline actions that can be taken to further and deepen health equity work by addressing internal systems and processes. The workgroup has four focus areas: transforming systems; building internal infrastructure; working across government; and fostering community partnerships. ADAP is a partial funder and participates as part of this team.

Cultural Brokers

ADAP supports Cultural Brokers who provide prevention, education and early intervention services to New Americans with and at risk for substance use disorders in the Chittenden region. Six brokers represent six immigrant and refugee communities (Somali, Somali-Bantu, Congolese, Bhutanese and Nepali) and act as effective liaisons with schools, clinics, community agencies, medical providers, mental health agencies, juvenile justice and law enforcement. The Cultural Brokers build trusting relationships with Vermont's New Americans in identifying and addressing issue of substance use. They also provide educational opportunities and information on available substance use disorder community resources. This program was developed as part

of Vermont's SAMHSA Screening, Brief Intervention and Referral to Treatment (SBIRT) grant. After the grant ended, the program was continued because of its high value in health equity work.

Health Disparities Impact Group

The Health Disparities Impact Group includes a range of racial and ethnic minorities including but not limited to New Americans, represented by the cultural brokers. Dr. M. Mercedes Avila, of the University of Vrmont's College of Nursing and Health Services and subject matter expert on health equity, facilitates this stakeholder group. The group identifies emerging needs and brainstorms strategies for linking racial and ethnic minorities with prevention, intervention and treatment resources in a more effective way. This group is supported by ADAP and is also a continuum of the SBIRT initiative. Dr. Avila also provides training for a range of providers in Vermont.

Regional Prevention Partnership

Regional Prevention Partnership grantees described above work to reduce alcohol and substance use among the LGBTQ, low socioeconomic status, and military family populations. This program encourages grantees to select evidence-based prevention strategies that specifically target these populations. Establishing Gay Straight Alliances (GSAs) in middle and high schools is an example of an evidence-based prevention strategy that is being implemented that, according to literature compiled by the regional Center for Application of Prevention Technologies, increases protective factors among LGBTQ youth in a school.

Workforce Development

The Regional Prevention Partnership has provided numerous statewide trainings for staff and grantees on working with populations such as youth, LBGTQ youth and people of low socioeconomic status. Training on Culturally Responsive Practice has been made available to treatment and prevention providers.

Translations

Patient information on opioids, and the Prescription for Controlled Substances Advisory Notice has been translated into the 6 to 7 languages most frequestly spoken in Vermont.

OPIOID STRATEGY

The Vermont Department of Health's Comprehensive Public Health Strategy to Reduce Opioid Use Disorder includes seven key actions:

- Public Information, Social Marketing and Messaging
- Improving Presecribing Practices and the Vermont Precription Monitoring System
- Prevention and Community Mobilization
- Safe Drug Disposal

- Early Intervention
- Overdose Prevention and Harm Reduction
- Improve Acces to Treatment and Recovery Services

Detail on the strategy, planned enhancements and Vermont's guiding legislation is available at: http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Opioid_Strategy_Brief_2019-21.pdf

WORKFORCE DEVELOPMENT

ADAP has focused on increasing development for existing providers of publicly funded prevention, intervention, treatment and recovery services through scholarships, trainings, a learning collaborative for Hub and Spoke providers, and partnerships. In 2018, ADAP partnered with Vermont State Colleges' Community College of Vermont to develop a three-credit course that met Office of Professional regulation education requirements for the Apprentice Addictions Professional credential recognized by ADAP.

ADAP has strengthened its relationship with state and regional workforce development providers, including but not limited to the Addiction Technology Transfer Center (ATTC), the Prevention Technology Transfer Center (PTTC) and the Vermont Blueprint for Health. Federal opioid response funds are partially funding:

- Training for clinicians working within Preferred Providers aimed at improved implementation of the standards for certified substance use disorder treatment programs, such as American Society of Addiction Medicine (ASAM) client placement criteria, assessment and treatment planning.
- Training of an additional 100 recovery coaches in FY19 and establishment of coach certification system (i.e., IC&RC) consistent with national standards.
- Health care provider training aimed at increasing the number of federally waivered buprenorphine prescribers.

ADAP is considering investment of additional block grant funds into addressing the following gaps: culturally competent services to diverse populations; EBPs in addressing stimulant and cannabis use; clinical and recovery coach supervision; and certification of prevention and recovery workers.

ADVISORY STRUCTURES

Vermont's Substance Abuse Prevention and Treatment Block Grant (SABG) Plan for 2020-2021 has been informed through stakeholders engaged in councils, commissions and other specific planning initiatives over the past two years. These have included:

Vermont Alcohol and Drug Abuse Council

The Vermont Alcohol and Drug Abuse Council (VADAC) serves in an advisory role to the Governor and the Agency of Human Services. The Council's charge is to advise the governor as to the nature and extent of alcohol and drug abuse problems; make recommendations to the governor for developing a comprehensive and coordinated system for delivering effective programs; provide for coordination and communication among the regional alcohol and drug abuse councils, state agencies and departments, providers, consumers, consumer advocates and interested citizens; develop educational and preventive programs and a plan for effectively providing preventive, education and treatment services to the Vermont public. Representation included both Departments of the Agency of Human Services and community members representing six sectors of the continuum of care. Reference §4803 and §4805 at http://legislature.vermont.gov/statutes/chapter/18/094

Opiate Coordination Council

As one of his first actions upon taking office, Vermont's Governor Phil Scott established, via executive order, a new Opioid Coordination Council (OCC). The 21-member council is charged with leading and strengthening Vermont's response to the opiate crisis by ensuring full inter- and intra-agency coordination between state and local governments in the areas of prevention, treatment, recovery and law enforcement activities.

The Director of Drug Prevention Policy, a position also established by the executive order, oversaw an extensive needs assessment which included listening sessions in communities, recovery centers, service organizations, coalitions, state agencies and departments. Council members developed a set of recommendations informed by prevention, intervention, treatment, recovery, workforce development and law enforcement stakeholders. These recommendations are reflected in the strategy for addressing the opioid crisis. The recommendations also inform the development of the system for addressing all psychoactive substances and are reflected in the enhancements outlined in Step 1. OCC recommendations and a full membership list is available at: http://www.healthvermont.gov/response/alcohol-drugs/governors-opioid-coordination-council

Marijuana Advisory Commission

Governor Scott established the Marijuana Advisory Commission, via Executive Order 15-17, to review research and key learnings from other states, and develop recommendations to inform cannabis policy development in three areas:

- Ensuring roadway safety
- Prevention, education, reducing youth access and how to best reduce overall impact on public health
- Taxation, regulation and responsible approaches to sale and taxation of cannabis for recreational use

The Commissioner of the Vermont Department of Health chaired the Prevention and Education Committee, which included input from stakeholders in mental health, education, substance use

prevention, youth and family services and agriculture. For final recommendations (January 2019) and a full list of commission membership:
https://marijuanacommission.vermont.gov/commissiondocuments

State Mental Health Block Grant Planning Council

Vermont's State Mental Health Block Grant Planning Council is comprised of a wide range of stakeholders including adult consumers of mental-health services, family members, parents of children and adolescents experiencing a serious emotional disturbance, providers of mental health services, advocates, and other interested members of the community. Membership on the Planning Council is by appointment by the Governor of Vermont, as delegated to the Secretary of the Agency of Human Services (AHS). The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) participates as a member of this Council.

State Health Improvement Plan (SHIP) Stakeholders

Approximately 80 organizations and partners participated in development of the 2019 State Health Improvement Plan (SHIP). Stakeholders represented included, but were not limited to, racial and ethnic minorities, the LBGTQ community, people with disabilities, people with lived experience in mental health and substance use disorder, people who inject drugs, new americans, health care providers, youth and elders. For more information reference: *Strategic Plans* section of this document.

Vermont Association of Addiction Treatment Providers (VAATP)

Vermont Association of Addiction Treatment Providers (VAATP) is the group that represents the publicly funded addiction treatment providers in Vermont. The VAATP meets regularly to discuss issues pertaining to substance use disorder treatment. The VAATP is chaired by one of the providers on a rotating basis. ADAP staff is invited to attend these meetings as needed to share federal, state and legislative updates, as well as to address program oversight and development issues as they relate to substance use dsiorder.

Stigma Theory of Change Stakeholders

ADAP has convened a group of people with lived experience to identify change factors, identify existing supports for reducing stigma associated with substance use disorder, and make recommendations on gaps in Vermont's strategy. This work will inform development of a stigma education campaign to be developed as part of Vermont's Opioid Strategy.

Proposed Change to Advisory Structures

Act 82, *an act related to substance misuse prevention*, passed the Vermont Legislature and was signed by the Governor. The Act, effective July 1, 2019:

- Replaces the Vermont Alcohol and Drug Abuse Council (VADAC) and the Vermont Tobacco Evaluation and Review Board (VTERB) with one Substance Misuse Prevention

Advisory Council. The Council has oversight of **all** substance misuse prevention programs across the Department of Health and make recommendations to the Commissioner of Health for improving prevention policies and programming.

- Renames Controlled Substances and Pain Management Advisory Council to the Vermont Prescription Monitoring System Advisory Council to advise the Commissioner of Health on matters related to the Vermont Prescription Monitoring System, and the appropriate use of controlled substances in treating acute and chronic pain, and in preventing prescription drug misuse and diversion.

SYSTEM STRENGTHS, CHALLENGES and STRATEGIC PRIORITIES

Vermont has developed a robust and comprehensive response for the prevention and treatment of opioid use disorder and opioid overdose along with all other substances. Public awareness about the dangers of prescription drug pain relievers and illicit opioids is at an all-time high. Federal SAMHSA, CDC and DOJ funds have provided an opportunity to enhance Vermont's system for addressing opioids and all substances; work is already underway in prevention, intervention, treatment and recovery. Strategic priorities for addressing capacity challenges are:

Equitable Geographic Access to Service

ADAP is seeking to assure equitable access to prevention, treatment and recovery services across regions by investing in capacity enhancements to support flow of Vermonters through the continuum, ensure fewer Vermonters are lost in transitions of care, and that Vermonters and Vermont communities receive needed support.

ADAP Clinical Services staff responsible for the oversight and monitoring of substance use disorder treatment (i.e., Preferred Providers) were reorganized to a regional approach, which more closely mirrors the current organization of the Regional Prevention Consultants. The number of Prevention Consultants has been increased so that each of the 12 health districts have access to one full-time equivalent (1 FTE). This increase allows for stronger regional needs assessment, collaboration and coordination across the continuum of care.

The Centralized Intake and Resource Center (under development) will provide Vermonters the ability to call one number to schedule an assessment with a substance use disorder treatment provider. Callers will also have access to information and referrals to other services (transportation, mental health, economic resources) irregardless of the caller's location or ability to pay for service.

Workforce Development

Workforce shortage continues to be one of the most significant barriers to equitable access to services. This shortage has been exacerbated by expansion of prevention, intervention, treatment and recovery programming to address Vermont's challenge with opioids, creating need for a higher number of FTEs. In addition, increased access to healthcare and greater integration of intervention and treatment services into primary health care settings has created more competition for the existing qualified workforce. A Licensed Alcohol and Drug Counselor

(LADC) can make a significantly higher salary working within a hospital or primary health care setting than they can working within a publicly funded Preferred Provider or designated mental health agency. This competition leads to a higher rate of turnover within the public agencies often serving the most complex clients. The shortage is further exacerbated by the high cost of education and professionals "aging out" of the workforce. In addition to the size of the workforce, a need for standardization and quality of care has increased the need for certification of the prevention and recovery workforce.

Vermont Governor Phil Scott has identified jobs and the behavioral health workforce as a top priority. This focus has initiated two changes:

- In response to Executive Order No. 02-17 and the Governor's call to review existing State mental health and drug and alcohol addiction laws and regulations, the Office of Professional Regulation adopted *emergency administrative rules* for certification/licensure of Apprentice Addiction Professionals (AAPs), Alcohol & Drug Counselors (ADCs), and Licensed Alcohol and Drug Counselors (LADCs). These rules, adopted 10/13/17, have maintained a high standard while removing overly complex and burdensome barriers to those individuals seeking credentials in Vermont. The rules are available at: https://www.sec.state.vt.us/professional-regulation/list-of-professions/alcohol-drug-abuse-counselors/statutes-rules.aspx.

- In 2018, the Vermont Legislature appropriated $5,000,000 over four years to expand the provider workforce. A working group led by the Secretary of Human Services, University of Vermont and Vermont State Colleges is developing a plan that would enhance degree programs and provide financial incentives to enter the behavioral health field. There is also a focus on creating more clearly defined career paths, linking programs of study in Vermont Institutions of Higher Educations (IHEs) to the Office of Professional Regulation's educational standards for licensees in the treatment field.

Evidence-Based Practices (EBPs) for Cannabis and Stimulant Prevention and Treatment

In 2018 Vermont Act 86 (H.511) removed civil and criminal penalties for possession of one ounce of marijuana, two mature and four immature marijuana plants by adults 21 years and older. At present the establishment of a regulated cannabis retail system is under debate in the Vermont Legislature. The unintended consequence of increased public awareness about opioids and the policy discourse related to the legalization of cannabis possession has contributed to reduced perception of risk in some areas. Preferred Providers have requested additional guidance and support in the implementation of evidence-based practices (EBP) specific to both cannabis and stimulant misuse.

Public Information and Social Marketing

ADAP has developed a robust public information strategy on opioid misuse and overdose prevention. Providers and other advisors have recommended enhancements to Vermont's public information and social marketing plan in the areas of stigma reduction, alcohol, cannabis and the

risks associated with stimulant misuse. High priority populations for social marketing are youth, young adults and pregnant women. Capacity development in this program area will address these substances. A social marketing strategy will be implemented to enhance and support all other recovery services being implemented.

Health Disparities and Diverse Populations

As noted above, ADAP has participated with approximately 80 other partners in the development of the 2019-23 State Health Improvement Plan (SHIP) which focuses on reducing health disparities. Substance use is one of six health and social conditions identified as priorities in the SHIP based on findings from the State Health Assessment (SHA).
SHA: http://www.healthvermont.gov/about/reports/state-health-assessment-2018
SHIP: http://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan

ADAP will play a leading role in guiding population-based prevention and recovery support strategies. Based on the Assessment particular populations of focus will be the LGBTQ community and people of color. Next steps will include the identification of specific priority outcomes and strategies by population. These will become strategic priorities for ADAP. Pregnant and parenting women of low socioeconomic status will continue to be a focus as well.

Populations by Age

Prevention, intervention, treatment and recovery services for youth and young adults continue to present as high need areas. Rapidly evolving impact of technology and other issues impacting changes in youth culture highlight the need for enhanced workforce development specific to working with youth and young adults. As opportunities become available, enhanced services for youth and young adults will be prioritized by ADAP and informed by the Youth Services Advisory Council (YSAC). Youth programming across the Agency of Human Services is coordinated through the representing community and school providers, as well as the Departments of Health, Mental Health, Children and Families, and the Agency of Education.

ADAP partners with the Department of Disabilities, Aging and Independent Living (DAIL) to focus on elder Vermonters, particularly as it relates to alcohol and prescription drug use. An Elder Substance Abuse Specialist is co-funded by and co-located in DAIL and ADAP, and guides service enhancements such as training and information for elder services professionals and volunteers.

Evaluation

ADAP includes evaluation as a strategy and funded service in every grant application proposal submitted to support a more robust evaluation effort. In addition ADAP supported a study of the Hub and Spoke System for the treatment of opioid use disorder. The brief, including outcomes, is available at:
http://www.healthvermont.gov/sites/default/files/documents/pdf/adap_HubSpokeEvaluationBrief.pdf

FEDERAL FUNDING SOURCES

The following is an overview of federal funding sources, beyond the SABG, which support Vermont's Opioid Strategy, as well as system enhancements intended to address needs related to multiple substances.

SAMHSA Regional Prevention Partnerships/Partnership for Success (10/1/15-- 9/30/20)

Goals of the grant are to reduce underage and binge drinking among 12-10 year-olds and reduce marijuana use and prescription drug misuse among 12–25 year-olds. Strategies include increasing prevention capacity through regional community prevention grants, training and evaluation

SAMHSA SPF Rx (9/1/16 – 8/31/21)

Goals of the grant are to decrease prescription drug misuse and abuse among Vermont's youth, and increase awareness of safe use, storage, and proper disposal of prescription pain medication. The SPF-Rx grant initiative employs a media and marketing campaign to heighten awareness of the dangers of prescription drug misuse among young adults. The grant will also increase the role and skills of pediatricians and community youth-serving agencies in reducing access to and misuse of prescription drugs among Vermont's youth.

SAMHSA State Opioid Response (SOR) (10/1/18 - 9/30/20)

The goal of the grant is to expand access to opioid use disorder prevention, treatment and recovery services. Support strategies include: Recovery coach training; Employment specialists; Recovery Coach Pregnant and Parenting Women's Specialists; Regional prevention centers; Family education and screening; Media and education campaigns to reduce stigma; Drug Disposal; ED Recovery Supports; Harm reduction packs: Service Delivery Enhancement (Rapid Access MAT); Treatment program enhancements; MAT in Corrections; VT Alliance of Recovery Residences certification support; staff.

CDC Rx Drug Overdose Prevention (10/1/15- 9/30/19)

The grant expands and enhances current prescription drug overdose prevention efforts. Supported strategies include: Vermont Prescription Drug Monitoring System (VPMS) enhancements; training, technical assistance and communication tools for prescribers and other medical professionals on evidenced- based prescribing practices and alternatives to narcotics for treating chronic pain; an ethnographic evaluation of high risk opioid users; training for first responders.

CDC Enhanced State Opioid Overdose Surveillance (9/1/2016-8/31/2019)

The goal of this grant is to improve speed and quality of data on opioid overdoses, and inform prevention and response efforts for opioid-involved overdoses. Strategies will increase timeliness and comprehensiveness of reporting of: nonfatal drug, heroin and opioid overdoses through ED

and EMS data; fatal opioid overdose through State Unintentional Drug Overdose Reporting System (SUDORS) which captures information on toxicology, death scene investigations, route of administration and other factors.

Department of Justice Bureau of Justice Administration Comprehensive Site-Based Program (10/1/18- 9/30/21)

The goal of this grant is to expand data collection and planning capacity. Strategies include: Identification of community level data related to opioid use and associated physical, mental, environmental and social health consequences; development of a platform for communities to access data to enhance the community's data-driven planning

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**

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

Footnotes:

VERMONT SABG 2020-2021
NARRATIVE PLAN – STEP 2
Step 2 Narrative

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

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.

DATA DRIVEN PRIORITY SETTING

The Vermont Department of Health (VDH) takes a *public health approach* to preventing substance use and other health problems, focusing on population-level change in which the goal is to reduce community-level and/or state-level indicators of substance use and related consequences. In 2018, Vermont completed a State Health Assessment (SHA) [i] which is a five-year update on the health status of Vermonters.

The SHA provides vital data for examining health inequities by race and ethnicity, gender, age, sexual orientation, disability, socioeconomic status and geography. This process drew upon an extensive array of public health data reports and data sources, the last state health assessment published in 2012 as Healthy Vermonters 2020, and the Midway to 2020 Report Card. Other sources of information include the state's hospital community health needs assessments[ii], Building Bright Futures reports[iii], and the Vermont Agency of Human Services' Community Profiles[iv], which included input from nine regional workshops across the state, provided a strong foundation.

The purpose of the SHA was to prioritize goals and objectives for health, and to help monitor trends, identify gaps and track progress. It is the basis for the State Health Improvement Plan (SHIP) for 2018-2023[v]. The SHA presents data about health outcomes and disparities, and are informed factors that contribute to health, as they relate to child and family health, chronic disease and injuries, environmental health, infectious disease, and access to care.

On June 18, 2014, the Public Health Accreditation Board awarded five-year accreditation status to the Vermont Department of Health (VDH). Vermont is currently undergoing the reaccreditation process.

The VDH received commendation from the Accreditation Board for its ability to use and present data and track performance using an online performance management system and the Public Health Stat process. Public Health Stat is an internal cross-divisional management process facilitated by the Performance Improvement Manager that promotes data-driven decision making, relentless follow through, and a focus on accountability. Every month, key department decision-makers and stakeholders come together for program planning and resource allocation

around department-wide goals. The meetings engage managers at all levels to develop data-driven solutions to achieve positive health outcomes.

APPROACH TO NEED AND GAP IDENTIFICATION

The Vermont State Epidemiological Outcome Workgroup (SEOW) is charged with bringing systematic, analytical thinking to the causes and consequences of the use of alcohol, tobacco and other drugs to guide decision-making about the allocation of resources. The SEOW consists of key state agency staff, epidemiologists, and representatives from higher education and the United Way. The SEOW generates an epidemiological profile, analyzes data to identify state and local trends, and responds to data collection and interpretation requests. These data are inclusive of, but not limited to, those listed below. A more complete listing of data sources available to the SEOW is included in the "Data Encyclopedia" [vi]maintained by VDH.

Commonly Used Data Sets

Name of Database	Measures	Frequency of Collection/ Distribution	Who Manages Data	Capacity to Analyze
ESSENCE	Emergency Department overdose rates	24 hours. Available weekly.	Infectious Disease Surveillance. Division of Health Surveillance.	Strong. Recent work with CDC.
Vermont Uniform Hospital Discharge Data Set	Emergency and Inpatient Discharges	Annually. Available one to two years after collection.	Health Statistics. Division of Health Surveillance.	Strong. Recent work with SAMHSA.
Office of the Chief Medical Examiner	Mortality	Monthly. Available three months after death.	Office of the Chief Medical Examiner.	Strong. Recent work with CDC.
Vital Records Death Certificate Data	Mortality	48 hours after death. Available upon request.	Health Statistics. Division of Health Surveillance.	Strong.
Behavioral Risk Factor Surveillance System	Prevalence of use and behaviors among adults 18+	Annually. 8-10 months after collection.	Health Statistics. Division of Health Surveillance.	Strong.

Name of Database	Measures	Frequency of Collection/ Distribution	Who Manages Data	Capacity to Analyze
Youth Risk Behavior Survey	Prevalence of use and behaviors among youth in grades 6-12	Every other year. Available 8-10 months after collection.	Health Statistics. Division of Health Surveillance.	Strong.
National Survey on Drug Use and Health	Prevalence of alcohol and illicit drug use and mental health issues Vermonters ages 12+	Annually. Available a year after collection	SAMHSA	Medium.
Pregnancy Risk Assessment Monitoring System	Prevalence of substance use during and prior to pregnancy among pregnant women	Annually. Available 2 years after year of birth.	Health Statistics. Division of Health Surveillance.	Strong, but with significant data lags.
Naloxone Data	Distribution of naloxone, number of reported overdose reversals by laypeople in the community	24 hours. Available monthly.	Health Statistics. Division of Health Surveillance.	Strong.
Substance Abuse Treatment Information System (SATIS-VT's TEDS Data)	Number of people treated for substance abuse in the state-funded system of care, by substance	Monthly. Available quarterly.	Alcohol and Drug Abuse Programs.	Strong.
Statewide Incident Reporting Network	Number of overdose EMS calls	Available quarterly.	Division of Emergency Medical Services.	Strong.
Vermont Prescription Monitoring System	Schedule II-IV drugs dispensed by VT-licensed pharmacies	Daily. Available quarterly.	Health Statistics. Division of Health Surveillance.	Strong.
Medicaid Claims	All claims for Medicaid recipients	Weekly. Available weekly.	Department of Vermont Health Access (DVHA)	Strong.

Estimating substance use and associated treatment need is challenging as each data source has gaps and many overlap with other data sources. For example, the Substance Abuse Treatment Information System (SATIS), which is the Vermont version of the SAMHSA Treatment Episode

Dataset (TEDS) to collect data from SABG-funded treatment providers, includes all substance use disorder treatment services provided for all payers, including Opioid Treatment Programs (OTP), but does not include fully identifying information to allow "de-duplication" when used in conjunction with other data sources.

SATIS doesn't include information for treatment providers who are not funded by the block grant, which includes office-based opioid treatment (OBOT) prescribers who are waivered to provide medication assisted treatment (MAT) with buprenorphine. More people in Vermont receive MAT in OBOTs than in OTPs so it significantly underrepresents the total treatment available in the state. In addition to the SABG-funded treatment services, substance use disorder treatment services are provided by mental health treatment providers, within hospitals, by private practitioners, and through physician offices. The Medicaid data set includes both funded and non-funded treatment providers but includes only those who are enrolled in Medicaid.

The SEOW assists communities in collecting and analyzing local quantitative and qualitative data and provides technical assistance on the local Results Based Accountability processes required by the state. The SEOW also assists with developing meaningful performance measures and indicators that can be tracked over time, including measures of organizational capacity and program implementation fidelity. The SEOW's work is the catalyst for quality assurance monitoring and program improvement.

The SEOW also helps ensure maximum utilization of existing resources, including making recommendations for shifting resources to regions with greater need, and identifying unmet needs, disparities, priority populations and system gaps. Effective substance use disorder program planning is grounded in a solid comprehension of alcohol and other drug *consumption and consequence patterns.* Understanding the nature and extent of consumption (e.g., underage drinking) and associated consequences (e.g., motor-vehicle crashes, substance-related hospital admissions, etc.) is critical for determining state priorities, aligning strategies to address them, and assessing progress in reducing them.

PERFORMANCE MANAGEMENT

In 2010, the Vermont Department of Health (VDH) was awarded a National Public Health Improvement Initiative cooperative agreement from the Centers for Disease Control and Prevention (CDC). This grant accelerated a movement already underway to increase performance accountability in Vermont. In 2015, the VDH became a leader within state government in the implementation of performance management framework which is now integrated with the State Health Assessment (SHA), State Health Improvement Plan (SHIP), outcomes-based legislation (Act 186), and core departmental operations and strategic plans. It functions at the program, organization, and system levels to ensure the VDH is using performance data to improve the public's health. This work is overseen by the VDH Director of Planning and Healthcare Quality and the cross-divisional Performance Management Committee.

SCORECARDS

As part of a larger performance management framework, the Healthy Vermonters 2020 performance management system brings together program performance data and population health data at state and local levels. This publicly available system holds the Vermont Department of Health (VDH) accountable for its strategies to improve health outcomes[vii]. The system utilizes two web-based software solutions to support transparent and accessible data-driven decision making -- thematic Scorecards to track performance with the Results Scorecard software, and geographically-focused "Maps & Trends" reports using InstantAtlas software.

Each component displays Healthy Vermonters 2020 indicators, which consist of the measures of population health status that constitute the State Health Assessment (SHA) priorities, including those around substance use. The Scorecard components also display program performance measures to help staff track how well their work contributes to those population indicators. To facilitate local-level decision making, the Maps & Trends pages disaggregate the indicators into relevant regional geographies.

The Healthy Vermonters 2020 performance management system is used to promote accessible data display, consistent and responsive systems, accreditation readiness, transparency, and responsiveness to Community Health Needs Assessment (CHNA) requirements. Staff and managers provide narrative context, or "stories behind the curve", for population indicators and program-performance measures that include interpretations of data, lists of partners, citations of effective evidence-based strategies, action plans, and links to additional resources.

ADAP's Strategic Plan[viii] and associated program implementation and service contracting is influenced by multiple planning processes that cascade down from Vermont legislation, Governor's Office, Agency of Human Services, and Vermont Department of Health (VDH), as well as incorporating Federal priorities. Having a common, well aligned performance management system ensures mutually reinforcing and harmonized effort statewide. The measures are reviewed regularly and are adjusted as priorities shift, systems change, and/or goals are achieved.

VERMONT PREVALENCE

The following table "Summary of Statewide Prevalence Estimates from National Survey on Drug Use and Health (NSDUH)[1]" released in November 2018, shows the Vermont ranking of prevalence rates relative to other U.S. states and the District of Columbia. Vermont's prevalence rates are in the highest quintile in the nation for alcohol, marijuana, and cocaine use as well as alcohol and illicit drug use dependence among all ages. Heroin use is in the highest quintile for all ages except 26+. Past year cocaine use among 18-25-year-old Vermonters is now the highest prevalence in the nation, 30% higher than the next highest state (Massachusetts). This group also has the lowest perception of risk from using cocaine once a month. Research has clearly demonstrated that low perception of risk is directly related to increase in use. More positively, Vermont has made significant progress in addressing pain reliever misuse and remains low in methamphetamine use.

NSDUH 2016-2017 Vermont Data Summary by Age Group

Prevalence and Quintile Rankings*

Substance and Age Group	Past Month	VT Quintile	Past Year	VT Quintile
Alcohol (12+)	62.1%	1		
12-17 Consumption	13.6%	1		
18-25 Consumption	70.9%	1		
26+ Consumption	65.3%	1		
Marijuana (12+)	**18.6%**	1	**23.8%**	1
12-17	10.7%	1	17.9%	1
18-25	38.8%	1	50.1%	1
26+	**15.9%**	1	**19.9%**	1
Cocaine (12+)			3.5%	1
12-17			0.9%	1
18-25			12.2%	1
26+			2.2%	1
Heroin (12+)			0.5%	1
12-17			0.1%	1
18-25			1.0%	1
26+			0.4%	2
Pain Reliever Misuse (12+)			**4.2%**	3
12-17			2.8%	5
18-25			**8.0%**	2
26+			3.7%	4
Methamphetamine (12+)			0.5%	4
12-17			0.1%	4
18-25			1.3%	2
26+			0.4%	4
Alcohol Use Disorder (12+)			7.3%	1
12-17			2.5%	1
18-25			16.0%	1
26+			6.2%	1
Illicit Drug Use Disorder (12+)			3.8%	1
12-17			4.0%	1
18-25			11.2%	1
26+			2.4%	1

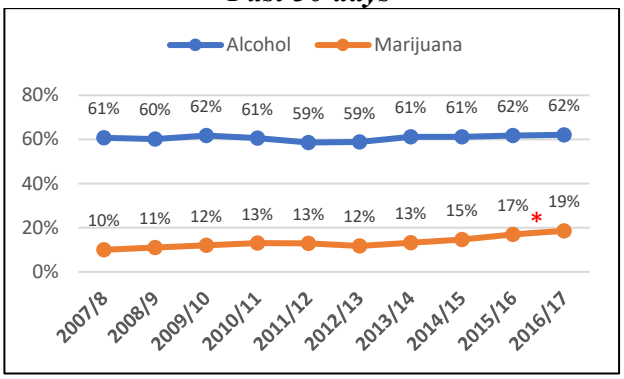
* Rank among 50 States and DC (1 = highest 10, 5 = lowest 10) - Quintiles more accurately reflect rankings due to instability in year-to-year individual ranks. **Red in Rankings** indicates VT in first quintile. **Red in prevalence estimates** indicates a significant increase from 2015-2016; **green in prevalence estimates** indicates a significant decrease from 2015-2016.
Use of all substances is highest among those 18-25 years of age.

TRENDS AND POPULATIONS

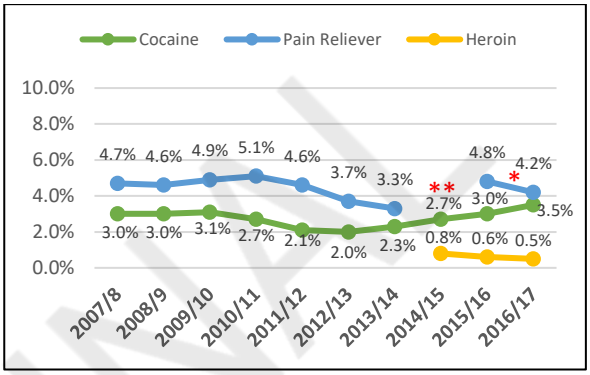
Over the past 10 years, past 30-day alcohol use has remained relatively steady while past 30-day marijuana use nearly doubled from 10% to 19% of Vermonters aged 12+. Use of other substances is much lower and is measured by past year use rather than past 30-day use.

Substances Used by Vermonters ages 12+ by Substance Type (NSDUH)

Percent of Vermonters Age 12+ Using in the ***Past 30 days***



Percent of Vermonters Age 12+ Using in the ***Past Year***



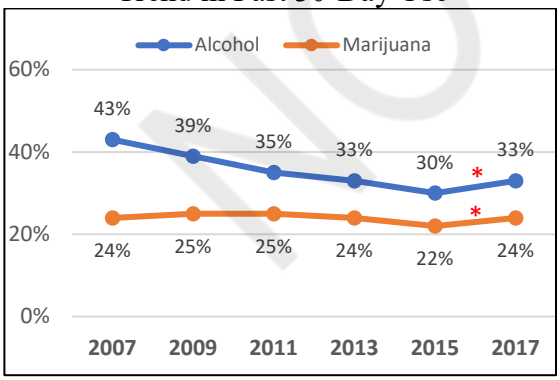
*Statistically significant change between 2015/2016 and 2016/2017

** Methodology changed for non-medical use of pain relievers and data prior to 2015/16 are not comparable to 2013/14 and earlier.

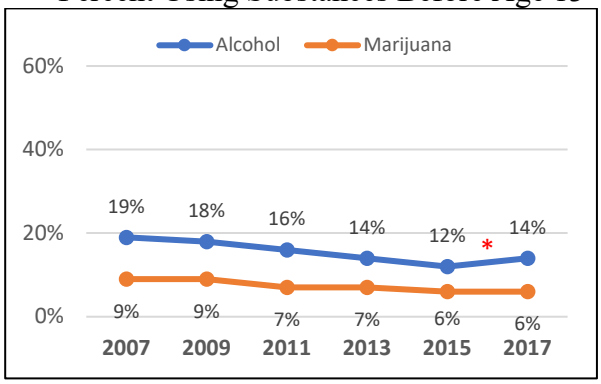
Vermont also uses the Youth Risk Behavior Survey (YRBS) to monitor prevalence among students. In 2017, 83% of Vermont middle school students and 76% of high school students completed the survey. The YRBS asks about behaviors and attitudes, including toward substance use. Reversing the trend of the previous decade, current use of alcohol and marijuana significantly increased between 2015 and 2017.

Substances Use by Vermont 9-12th Grade Students (YRBS)

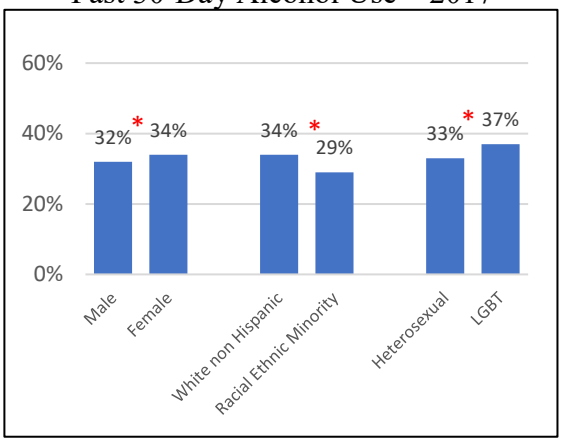
Trend in Past 30-Day Use



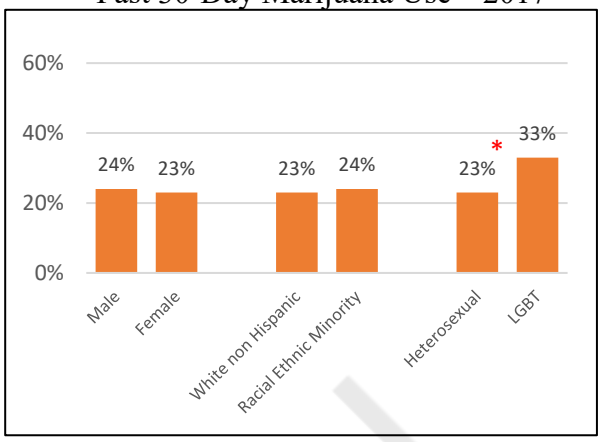
Percent Using Substances Before Age 13



Past 30-Day Alcohol Use – 2017



Past 30-Day Marijuana Use – 2017



*Statistically significant difference

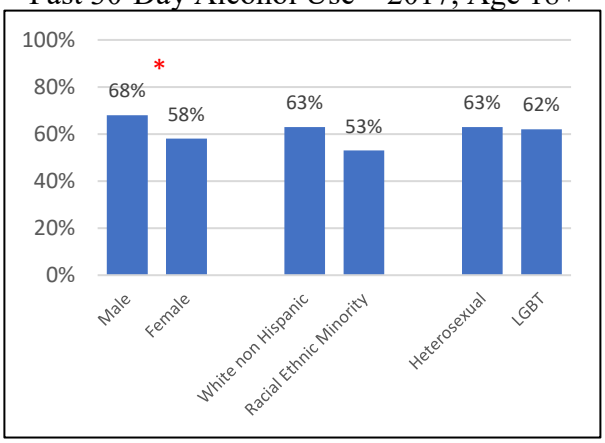
There are significant differences in grade 9-12 current use of alcohol and marijuana for different demographic groups. Vermont females are more likely to use alcohol than males, white non-Hispanic students are more likely to use alcohol than racial and ethnic minorities. LGBT students are significantly more likely to use both alcohol and marijuana than heterosexual students.

The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey conducted annually among adults 18 and older. The Vermont BRFSS is completed by the Vermont Department of Health (VDH) in collaboration with the Centers for Disease Control and Prevention (CDC). All U.S. states, Washington D.C., and most U.S. territories participate in the BRFSS.

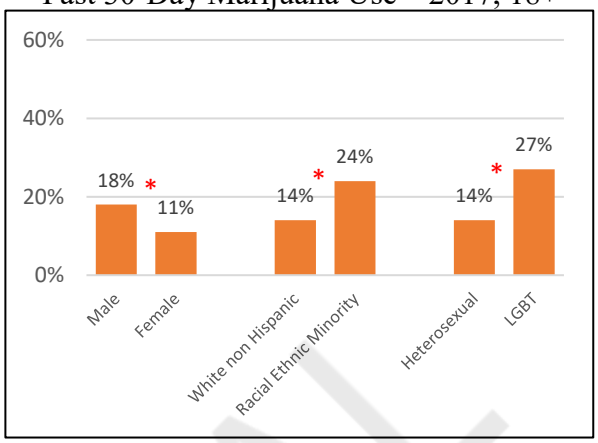
In 2017, Vermont BRFSS surveys were completed among 6,516 adults from across the state. These results were then weighted to be representative of the entire adult population. This allows calculations of prevalence estimates for populations not typically reported in NSDUH. These numbers show adult subpopulations have different patterns of use than those of high school students. Alcohol and marijuana use among males is consistently higher than for women but alcohol use for the groups shown below is not significantly different. Marijuana is significantly more likely to be used by people who are racial or ethnic minorities or those who are LGBT.

Substances Use by Vermont Adults (BRFSS)

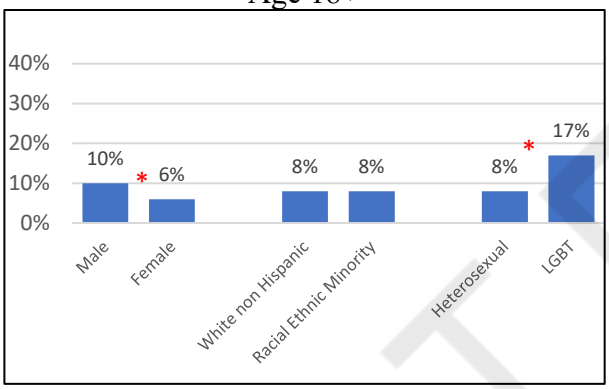
Past 30-Day Alcohol Use – 2017, Age 18+



Past 30-Day Marijuana Use – 2017, 18+

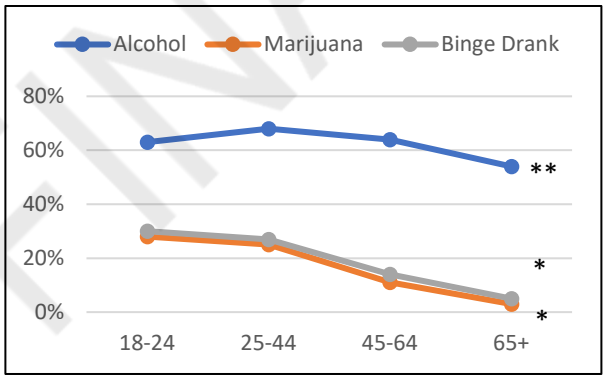


Ever Misuse a Prescription Drug 2017 Age 18+



*Statistically significant difference

30 Day Substance Use by Age Group 2017



* All differences by age are statistically significant, except that between adults 18- 24 and 25-44

** Rates are statistically higher among those 25-64 than those 65 and older

BRFSS data also show that past 30-day alcohol use increases with income and education achieved. There are no statistical differences in binge drinking by annual household income but those with some college education are statistically more likely than those with less education to binge drink. There are no statistical differences in current marijuana use by education level but adults in homes making less than $25,000 annually are statistically more likely to use marijuana than those in homes with incomes of at least $75,000 per year.

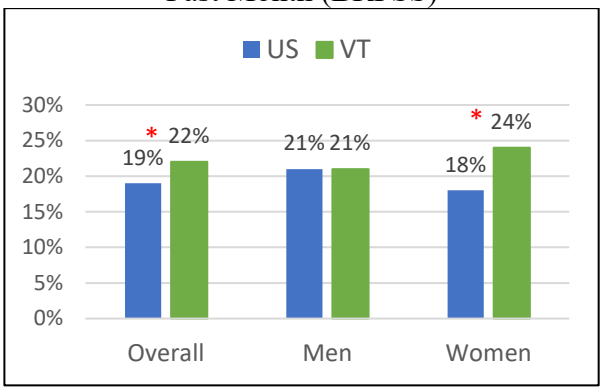
Adult past 30-day alcohol use and binge drinking are statistically unchanged between 2011 and 2017; marijuana use has increased in each year since use was decriminalized (July 2013). In 2017, use is statistically similar to that in 2016, but statistically higher than that in every other year since 2011. The rate of ever misusing prescription drugs remains statistically similar since 2011. Misuse of prescription drugs in the last 30 days is unchanged at one percent in each year since 2011.

Alcohol use among older adults is of concern in Vermont. In 2017, among those age 65 and older, 22% drank at a risky level, which is defined as three or more drinks on one occasion for

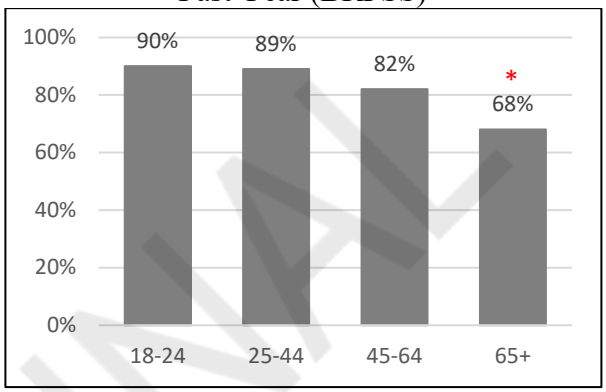
men and two or more drinks for women. This is significantly higher than the US rate of 19%. Women typically have higher rates. This population may be particularly vulnerable to the adverse effects of alcohol as it may impact the course of chronic disease or increase risks of injury at lower doses than younger adults. Individuals age 65+ are also less likely to be asked about their alcohol use during a routine checkup.

Older Adults – Alcohol Screening & Use

Risky Drinking Among those Age 65+, 2017 Past Month (BRFSS)



Alcohol Screening at Check Up by Age, 2016 Past Year (BRFSS)



*Statistically significant difference

SUBSTANCE USE DURING PREGNANCY

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey of women, who recently gave birth, that asks about their experiences and behaviors before, during and shortly after their pregnancy. The numbers below reflect the experiences of women who gave birth in 2017.

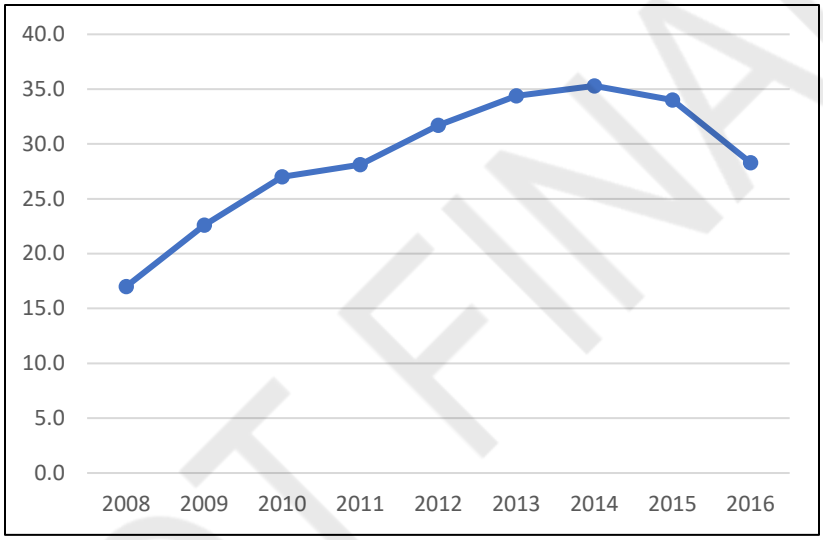
- Alcohol use is common before pregnancy with 68% of women reporting alcohol use and 18% reporting binge drinking (4+ drinks in 2 hours) in the three months prior to pregnancy. During pregnancy, 15% drank alcohol.
- Substance use other than alcohol and tobacco is reported by 19% of women in the month prior to pregnancy and 11% during pregnancy. Marijuana was the most commonly used substance but 4% of women report using pain relievers in the month before pregnancy and 3% used them during pregnancy.
- Pregnant women in Vermont are very likely to be asked about their substance use during prenatal visits– 97% were asked about alcohol use and 85% were asked if they were using drugs such as marijuana, cocaine, crack, or methamphetamine.

Vermont has wide accessibility to medication assisted treatment (MAT) for people with opioid use disorder (OUD), and this includes programs that are specifically tailored to pregnant women. The American College of Obstetricians and Gynecologists recommends that all pregnant women with opioid dependence be in active treatment, including the use of MAT, which is consistent with the state's strategy for perinatal quality improvement at birthing hospitals in the diagnosis and treatment of neonatal abstinence syndrome (NAS) and in improving MAT services for pregnant women.

In Vermont, four out of five opioid exposed infants are delivered to women who are receiving MAT (Vermont Medicaid Claims, 2010). The NAS code may be assigned to newborns following exposure to opioids in utero; it reflects the need to monitor for physical withdrawal symptoms and, in some cases, treatment for those symptoms.

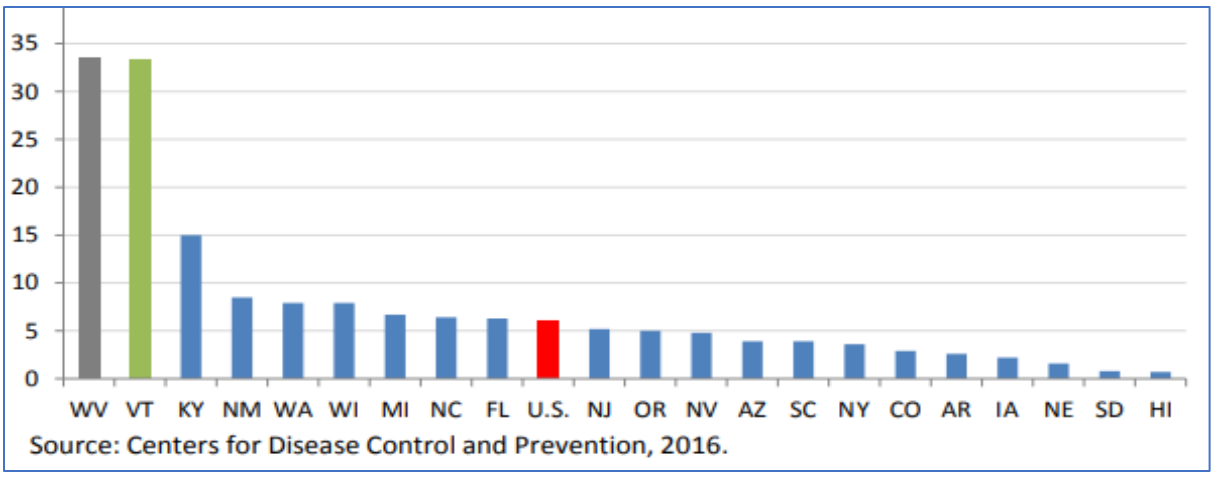
From 2013 to 2016, Vermont's rate of newborns assigned the NAS code leveled and dropped (see below figure) although rates should be reviewed with caution as they are impacted by policy and coding decisions which vary significantly from state to state, hospital to hospital, and year to year. Reporting NAS is complex and Vermont has participated in a CDC effort to build a NAS surveillance system[ix] as well as the Council of State and Territorial Epidemiologists to identify a standard case definition for NAS.

Vermont NAS rate per 1,000 live births (Diagnosis Code 779.5/P96.1)



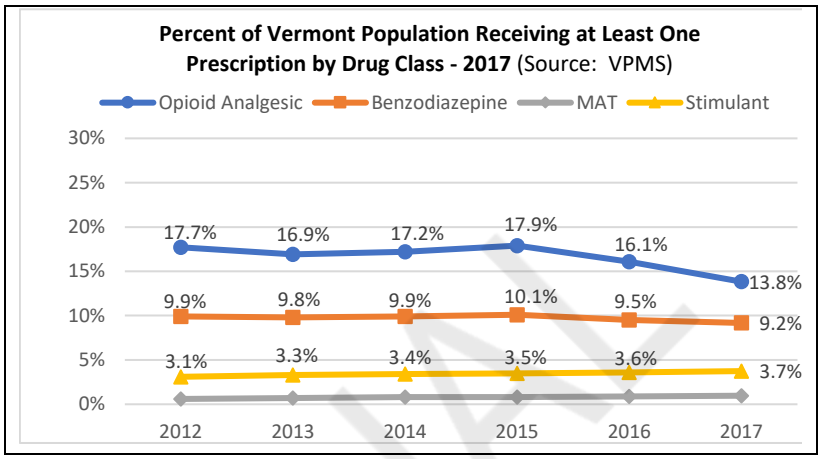
In 2013, the most recent year for which comparable data are available across states, the rate of babies born to Vermont residents in Vermont hospitals and having the medical code for Neonatal Abstinence Syndrome (NAS) was 33.3 per 1,000 hospital births.[x] Vermont's rate was more than five times the U.S. rate of 6.0 per 1,000 hospital births in 2013 (see below figure). Among the 21 states with comparable data for 2013, only the rate in West Virginia was slightly higher at 33.4 per 1,000 hospital births.

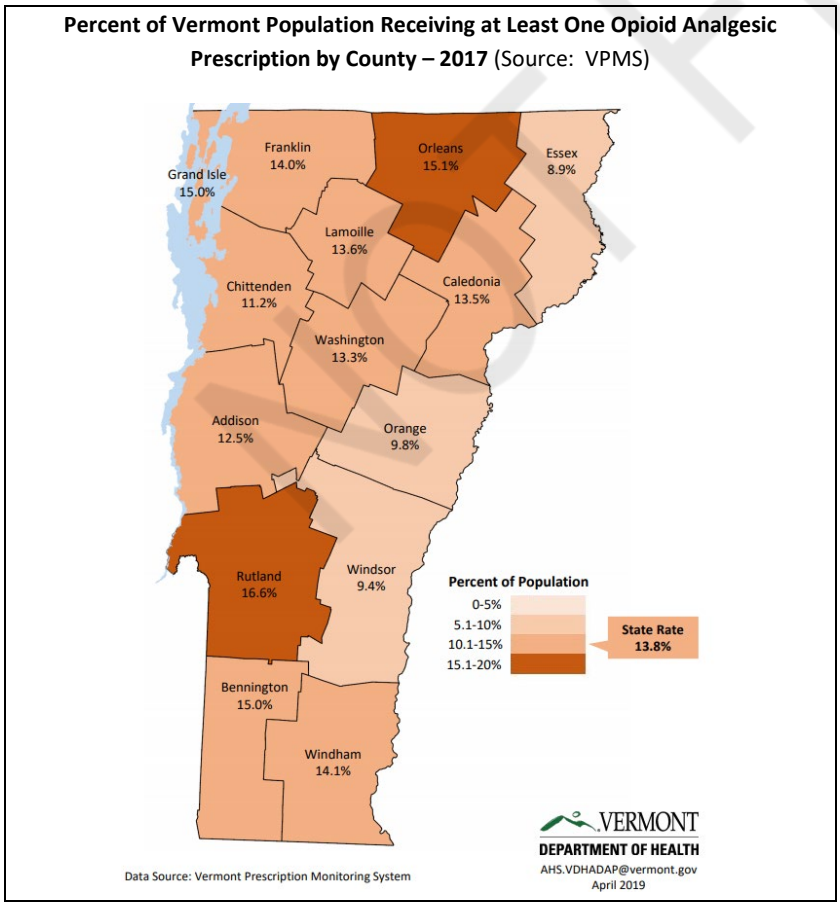
Rate of Newborns Who Were Assigned the NAS Code per 1,000 Hospital Births
21 States, 2013



PRESCRIPTION DRUG USE

Vermont has a prescription drug monitoring program (PDMP) called the Vermont Prescription Monitoring System (VPMS). The VPMS gets daily uploads of all DEA schedule II-IV drugs dispensed by Vermont licensed pharmacies. Opioid analgesics, used for treating pain, are the most commonly dispensed scheduled drugs, with 13.8% of Vermonters receiving at least one prescription in 2017. There are some changes in stimulant and benzodiazepine dispensing trends, but both are less common than opioids. More opioids are dispensed to women than men, and the percent of the population receiving opioids increases as people get older with over 22% of people age 65+ receiving at least one prescription.



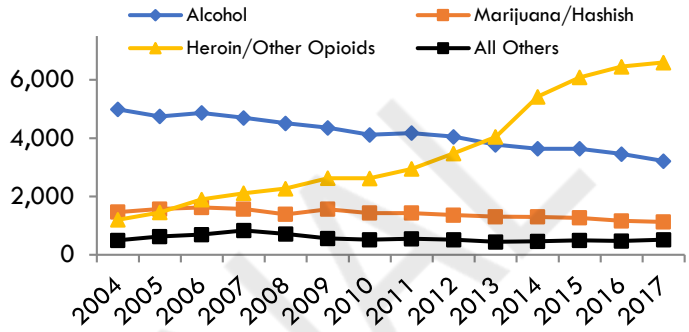


Vermont has focused on decreasing the use of prescription opioids through legislation, and prescriber and consumer education because most people using opioids begin with prescription opioids. These efforts have been effective -- between Q1 2016 and Q1 2019 there was a 39% reduction in the amount of opioid analgesics dispensed based on morphine milligram equivalent, a measure that represents the pain-killing capacity for many different individual drugs using a single measure. There are regional differences in the prescribing that are being addressed through technical assistance and education to prescribers.

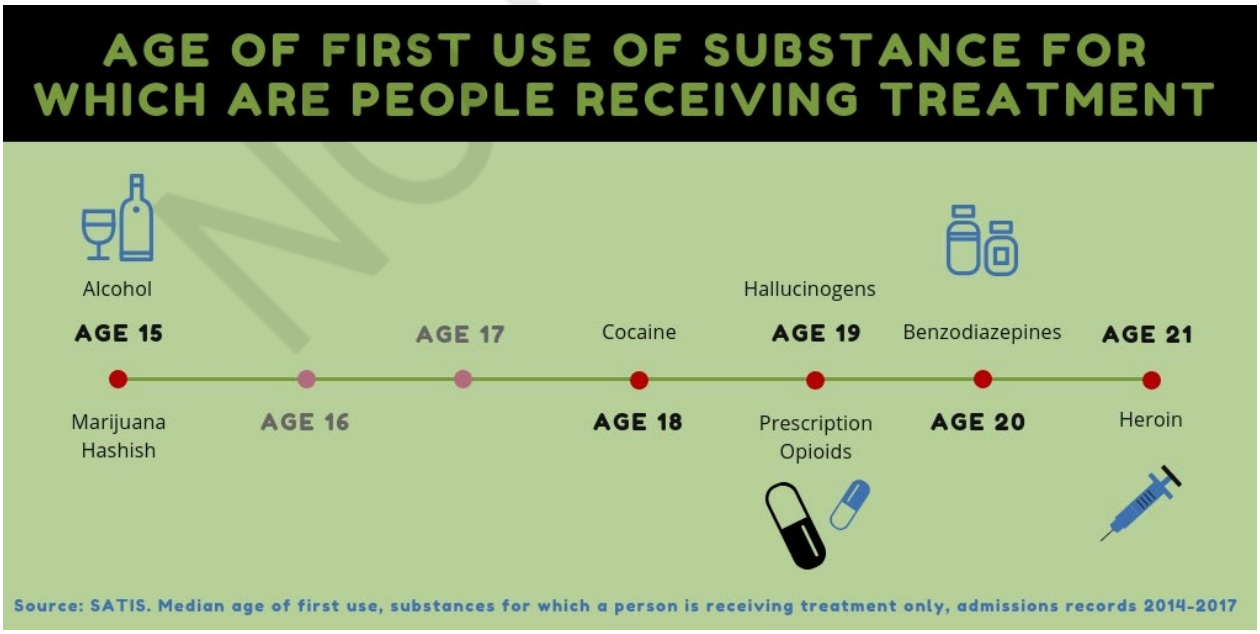
TREATMENT TRENDS

The Vermont Substance Abuse Treatment Information System (SATIS) includes information from specialty treatment facilities funded by the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs. SATIS does not include data about people who were treated for substance use disorders by doctors, in hospitals, or by counselors that are in private practice. SATIS data show significant increases in treatment for opioid use disorders and decreases in treatment for alcohol.

Number of People Receiving Treatment by ADAP-funded Treatment Providers by Primary Substance Used at Admission by State Fiscal Year (Data Source: SATIS)

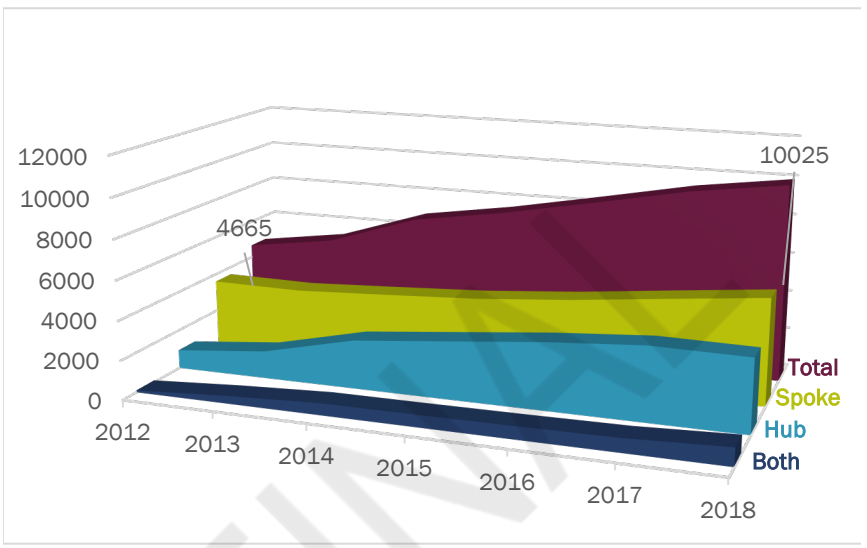


Many people entering treatment use more than one substance. The primary substance of misuse is typically the substance that is preferred and used most frequently but people also use substances simultaneously and will substitute substances when his or her preferred substance is not available. SATIS collects information about the age each substance for which a person is receiving treatment was used for the first time but does not collect the age of first use of all substances the person has used. The age of first use of substances reported in SATIS is shown below based on over 20,000 treatment admissions between 2004 and 2017. The median age of first alcohol and marijuana use among people receiving treatment for those substances in Vermont is 15.



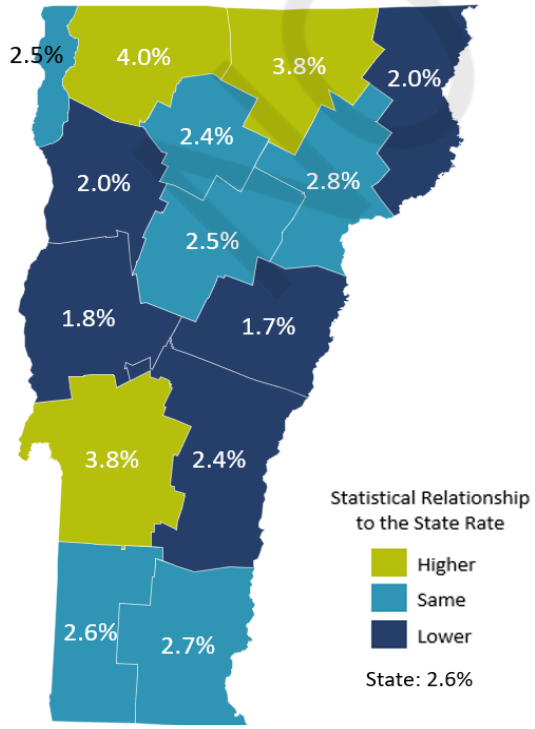
Vermont has seen significant increases in the number of people seeking treatment for opioid use disorder (OUD) and Vermont developed a statewide system of care, the Hub and Spoke system[xi,xii], specifically to treat OUD using medication assisted treatment (MAT). This system was developed using both state and federal resources. The hubs are specialty opioid treatment programs (OTP) that use both methadone and buprenorphine to treat OUD. Spokes provide office based opioid treatment (OBOT) with prescribed buprenorphine. OBOT providers are typically primary care physicians. More people receive care through the spokes than the hubs.

Number of Vermonters Age 18-64 receiving MAT in hubs and spokes
(Data sources: SATIS for hubs, VPMS for Spokes)



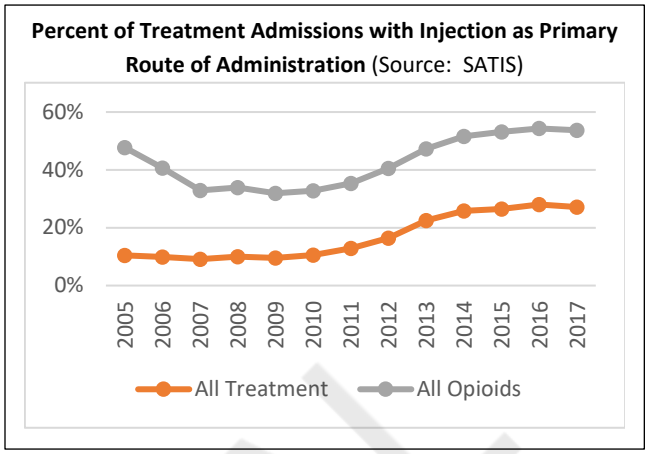
There are currently no waiting lists for OUD treatment in the hubs, down from a high of over 600 people in 2015. [Note: spoke data are not funded through the SABG but are integral to the system of care. The source of the data for the spokes is the Vermont Prescription Monitoring System (VPMS) which includes all payers, as does the SATIS data for the hubs, providing a more complete snapshot of people receiving MAT in Vermont.]

Percent of Vermonters Age 18-64 Receiving MAT for OUD by County Compared to State Rate – CY2018
(Sources: VPMS, SATIS)



There is significant county-level variability in percentage of people receiving MAT in hubs and spokes with some counties having as many as 4.0% of people age 18-64 receiving services. Given the lack of wait for service and the stabilization in demand, the current focus has been harm reduction and identifying people with OUD who are not seeking care and moving them toward treatment. This is especially important because those in treatment are increasingly likely to inject drugs, leading to increases in infectious diseases such as HIV, hepatitis B, hepatitis C (HCV), and endocarditis. Vermont's rate of acute HCV was more than

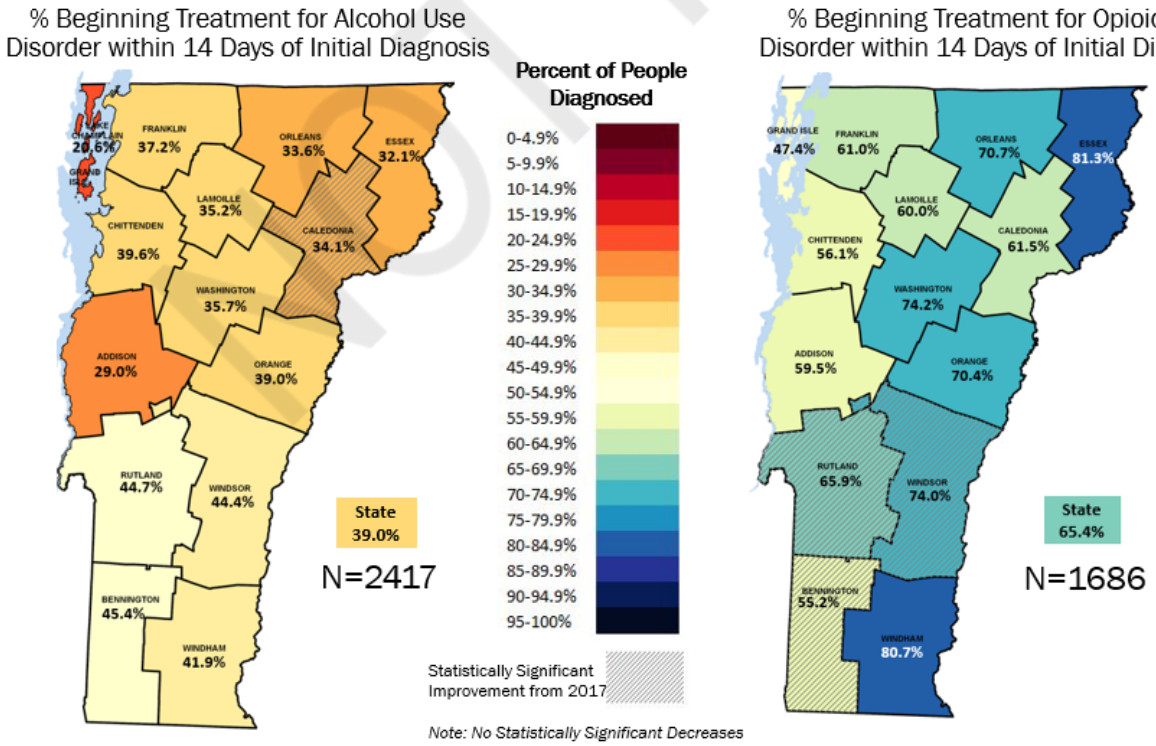
twice the CDC's Healthy People 2020 goal in 2016.[xiii] Increases in injection as a route of administration is driven by the increases in the number of people admitted with primary opioid use.



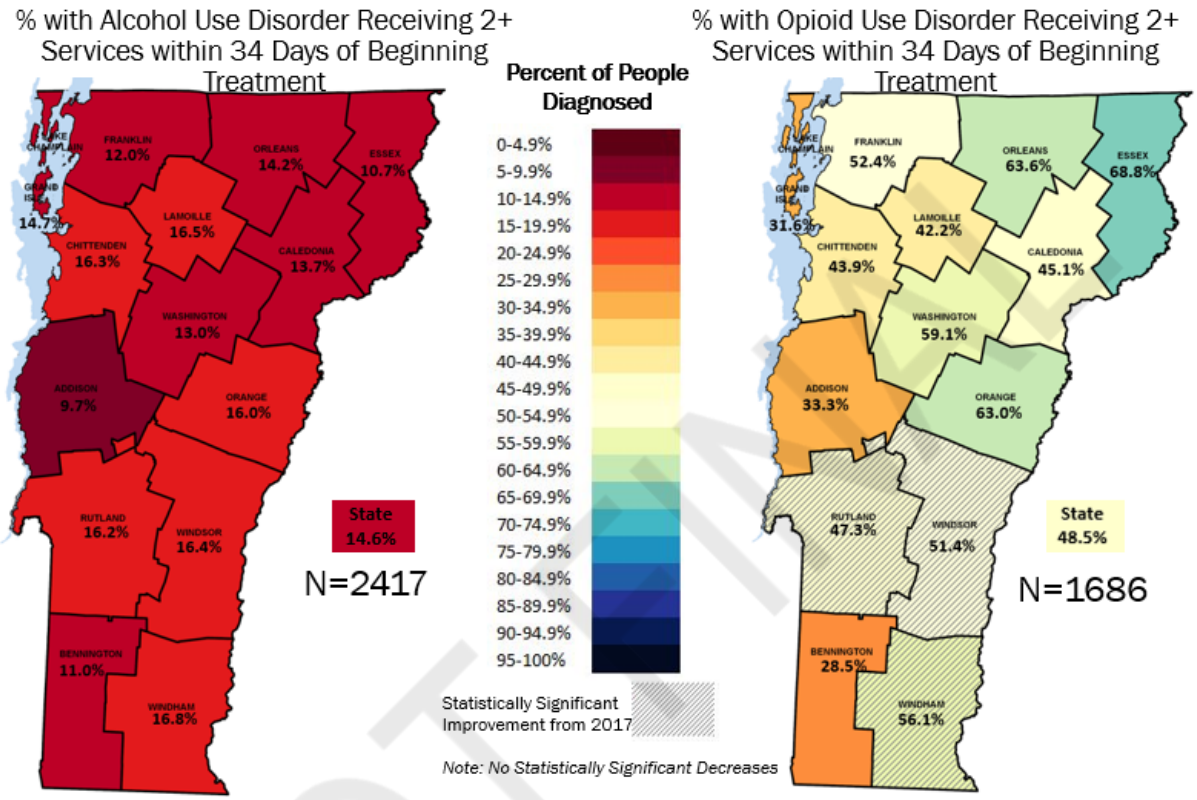
Medicaid claims, which include services provided by physicians, counselors in private practice, hospitals, and other provider types, indicate that Vermont is doing well getting those with opioid use disorder into treatment (treatment initiation) and keeping them in treatment (treatment engagement) but not as well as helping those with alcohol use disorder, even though many more people are diagnosed with alcohol use disorder as with opioid use disorder.

Initiation and engagement rates for substances other than opioids or alcohol most closely follow the rates for alcohol. The methadone or buprenorphine that alleviates symptoms of withdrawal and decreases cravings for opioids provides incentive to enter and stay in treatment. Treatment for other substances, such as alcohol, marijuana, and cocaine rely on therapy to change behavior which is much more challenging for the person undergoing treatment.

Treatment Initiation Among Medicaid Enrollees – Percent Receiving a Treatment Service within 14 Days of Initial Diagnosis (2018)



Treatment Engagement Among Medicaid Enrollees– Percent Receiving 2 or more Treatment Services within 34 Days of Treatment Initiation (2018)



Source: Medicaid Claims – Definitions are based on 2019 Healthcare Effectiveness Data and Information Set (HEDIS) modified to accommodate VT billing mechanisms

There are increases in the number of people seeking treatment for stimulants, a new area of focus for Vermont. Simulants are typically used as a secondary or tertiary substance of misuse, often with opioids. In 2009, 21% of admissions involved a stimulant, increasing to 29% in 2018 (SATIS). Cocaine/Crack is the most frequently used stimulant.

SUMMARY OF UNMET SERVICE NEEDS/CRITICAL GAPS

Below is a summary of unmet service needs and critical gaps within the current system:

- It is important to continue messaging and prevention activities to address Vermont's high substance use – it is higher than national levels for nearly all substances except methamphetamines.
- There is substance-level variation among subpopulations: the LGBT population typically has statistically higher substance use than the heterosexual population.
- Substance use is highest among people age 18-24.

- It is important to continue focusing on substance use among pregnant women; prenatal care is an essential component of reducing use of all substances during pregnancy.
- Injection drug use has increased as opioid use disorder increased.
- Adult alcohol use has remained stable but fewer adults are receiving treatment for alcohol use disorder and those who do initiate treatment often don't engage in treatment.
- Marijuana use is increasing in both adolescents and adults as Vermont has pursued marijuana legalization.
- It is important to continue monitoring stimulant use, especially cocaine use, in the event there is a need to take specific action if there are increases.

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[i] Vermont State Health Assessment 2018 http://www.healthvermont.gov/sites/default/files/documents/pdf/VT%20State%20Health%20Assessment%202018%20Full%20Report.pdf

[ii] Hospital Needs Assessments https://gmcboard.vermont.gov/hospital-budget/health-needs

[iii] Building Bright Futures Report http://buildingbrightfutures.org/wp-content/uploads/2019/01/BBF-2018-HAVYCF-FINAL-SINGLES.pdf

[iv] Vermont Agency of Human Services Community Profiles http://humanservices.vermont.gov/ahs_community-profiles

[v] State Health Improvement Plan http://www.healthvermont.gov/sites/default/files/documents/pdf/ADM_State_Health_Improvement_Plan_2019-2023.pdf

[vi] Vermont Data Encyclopedia http://www.healthvermont.gov/sites/default/files/documents/pdf/Data_Encyclopedia.pdf

[vii] Health Department Performance Tools http://www.healthvermont.gov/about/performance

[viii] ADAP Strategic Plan http://www.healthvermont.gov/sites/default/files/documents/2017/02/ADAP_Strategic_Plan.pdf

[ix] Lind JN, Ailes EC, Alter CC, et al. Leveraging Existing Birth Defects Surveillance Infrastructure to Build Neonatal Abstinence Syndrome Surveillance Systems — Illinois, New Mexico, and Vermont, 2015–2016. MMWR Morb Mortal Wkly Rep 2019;68:177–180. DOI: http://dx.doi.org/10.15585/mmwr.mm6807a3

[x] Centers for Disease Control and Prevention, "Incidence of Neonatal Abstinence Syndrome – 28 States, 1999-2013," Morbidity and Mortality Weekly Report, August 12, 2016. It is difficult to know if consistent standards are used when assigning the code for Neonatal Abstinence Syndrome to newborns. Nevertheless, both the CDC and Vermont Department of Health view the CDC data as being the most reliable rates available when comparing rates across states

[xi] http://www.healthvermont.gov/response/alcohol-drugs/treating-opioid-use-disorder

[xii] J Addict Med. 2017 Jul-Aug; 11(4): 286–292. doi: 10.1097/ADM.0000000000000310

[xiii] https://www.cdc.gov/hepatitis/statistics/2016surveillance/pdfs/2016HepSurveillanceRpt.pdf

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

   Background: In Vermont, there are some providers that serve both mental health (MH) and substance abuse (SA) clients, some serve only mental health, and some serve only substance abuse.

   The providers serving both MH and SA clients generally have one data system/EHR (electronic health record) from which they extract the separate data sets needed by the Division of Alcohol and Drug Abuse Programs (ADAP) or the Department of Mental Health (DMH). Providers serving ADAP only exclusively collect Treatment Episode Data Set (TEDS) information; those serving DMH collect MH information.

   The TEDS information reported to ADAP includes admission, and discharge records at both the provider and client levels as well as service level data for state use. There is a unique client identifier to allow identification of a specific person across providers (and dependent on the accuracy of data collected by providers) in the system but it does not include full identifying information.

   The MH data system collects full identifying information for those served.

   Prevention data is collected through a variety of paper and online tools, such as Survey Gizmo. This includes process data including demographics and strategy progress for Block Grant funded individual, evidence-based strategies while demographics for funded environmental evidence-based strategies are calculated using census data. Some limited pre/post outcome data is collected on family–based programs. Vermont currently has no common data system for collecting, storing, and analyzing prevention data. The only “client level” prevention data currently collected is demographic data, even with individual based strategies. Prevention is heavily focused on environmental strategies, which is not conducive to collection of “client-level” data.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

   Many of the providers of substance abuse and mental health services also provide services to other populations served through the Vermont Agency of Human Services. Vermont funds many of these services through Medicaid so provider data systems/EHRs generally also include the ability to extract necessary billing information of Medicaid and other insurers. In most cases, the populations being served drive the data that is collected – if there are combined systems, it is largely at the provider level rather than at the State level.

   At the State level, ADAP and DMH maintain separate data systems. ADAP’s full data system doesn’t link to any other data system. Mental Health’s system does not link to any other data source.

Prevention data is not part of a larger data system as explained above.

Vermont's Substance Abuse Treatment Information System (SATIS) contains required TEDS admission and discharge data elements and also contains service-level data for all clients receiving substance use disorder treatment for all payers. Detailed information is available here: https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_SATIS_Provider_Data_Elements_ICD_10_0.pdf

The Mental Health system is the Monthly Service Report (MSR) is described here: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/MSR-DataSubmissionDefinition_v51.5_061917.pdf

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)?

   The referenced document (https://www.samhsa.gov/data/quality-metrics/block-grant-measures) went to a "404 not found" page. Without seeing the proposed measure, we are reiterating our response to the 2016/17 application:

   Vermont cannot report on measures other than those that can be calculated using current mandatory TEDS reporting. While VT has access to Medicaid claims data we can't use this because this data often doesn't indicate that screenings have occurred since they're done within a general wellness visit and there is no specific coding for this. Even when codes have been opened we see minimal billing for the services.

   Demographic data and strategy progress is collected for all individual strategies and the demographic reach of environmental strategies are calculated using census data. No client specific data for prevention programs is collected.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

   Again, the referenced document (https://www.samhsa.gov/data/quality-metrics/block-grant-measures) went to a "404 not found" page. Our response to the 2016/17 application is shown below.

   More specific definitions are needed for nearly all proposed measures, particularly the prevention measures. It is unclear, for instance, how to measure employment for prevention programming. Many of the measures would need to continue to come from prevalence and population level data sets. It would also be helpful to have clarification of how the measures would be used.

   Treatment measures: Some of the measures requested are best suited to data available on health information exchanges – information such as tobacco use and other medical conditions is not included in the current systems. The Vermont exchange, VITL, currently connects over 90% of physicians and hospitals. However, substance abuse and mental

health specialty providers are not included in VITL for a couple of reasons. One is that EHR/meaningful use incentive funding is not available to these providers which mean that many providers do not have systems capable of connecting with the exchange. Another issue is regulatory -- 42 CFR Part 2 prevents substance abuse treatment providers from exchanging data freely in the health exchanges and Vermont has not yet found a way to connect these providers to VITL[i], because of the legal complexities associated with consent and because individual providers interpret 42 CFR 2 differently.

Vermont needs to invest in data collection systems as we currently use legacy systems to collect data from SA and MH providers. These systems are critical to funding and monitoring of the systems and to comply with SAMHSA's block grant funding requirements. Vermont has not had the funding and staff support necessary to pursue a common data system.

Most providers lack the funding and information technology expertise to make changes to existing systems and implement new systems.

Prevention measures: As a department of public health, prevention evidence-based strategies are heavily weighted toward environmental population-based outcomes. Reach and demographic information is calculated using census data.

Footnotes:

[i] Vermont Information Technology Leaders, Inc. (VITL) is a nonprofit organization that assists Vermont health care providers with adopting and using health information technology, to improve the quality of care delivery, to enhance patient safety, and to reduce the cost of care. VITL is legislatively designated to operate the health information exchange (HIE) for Vermont, and is governed by a collaborative group of stakeholders including health plans, hospitals, physicians, other health care providers, state government, employers, and consumers.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Parent Engagement in Prevention Messaging

Priority Type: SAP

Population(s): PP, Other

Goal of the priority area:

Educate parents on the importance of their role in preventing underage drinking and illicit drug use.

Objective:

Total hours of prevention content consumed on the ParentUp website as measured by the number of visitors multiplied by the average amount of time spent viewing content.

Strategies to attain the objective:

Media and social marketing strategies enhance and augment Vermont's comprehensive prevention strategy, including school, community and family-based programs. Youth report that parents have the most influence on their substance use decisions. ParentUpVT.org provides strategies and actionable items for parents and caregivers to help prevent drug and alcohol use among youth. The website focuses on helping parents talk about expectations around alcohol and drug use with kids, tips on monitoring their teen, making connections with other parents, and knowing the warning signs of a problem. The State proposes to increase traffic to the website through promotion across multiple media channels, as well as through community coalitions and partner engagement. Usefulness of web content to parents will be improved to increase average time spent on the website.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators

Baseline Measurement: 159.1 hours (SFY17)

First-year target/outcome measurement: 5% over baseline (167.1 hours)

Second-year target/outcome measurement: 10% over baseline (175.0 hours)

Data Source:

Campaign reporting materials

Description of Data:

Number of visitors to the ParentUp site multiplied by the average time spent viewing content. Over the last decade, the Division of Alcohol and Drug Abuse Programs (ADAP) has supported a comprehensive, evidenced-based substance misuse prevention approach. This means prevention efforts are delivered across a wide range of categories including individual, family, school, community, and through effective policy implementation. These efforts have been generally successful in reducing Vermont youth involvement with alcohol and drugs. For example, according to the Vermont Youth Risk Behavior Survey (YRBS), the number of high school students reporting alcohol use prior to age 13 has decreased from 21% in 2005 to 12% in 2015 before increasing to 14% in 2017. The percent of students who have ever drank alcohol significantly decreased over the last decade, from 66% in 2007 to 58% in 2017. However, from 2015 to 2017 the percent ever drinking alcohol significantly increased (56% vs. 58%). Schools are indispensable partners in Vermont's substance misuse prevention strategy.
Vermont youth report that parents have the most influence on their substance use decisions. ParentUpVT.org provides strategies and actionable items for parents and caregivers to help prevent drug and alcohol use among youth. This social media campaign and newly updated website include resources and interactive tools that account for differing parenting styles. The website focuses on helping parents talk about expectations around alcohol and drug use with kids, tips on monitoring their teen, making connections with other parents, and knowing the warning signs of a problem.

Data issues/caveats that affect outcome measures::

This measure is highly dependent on availability of funding to develop website content and the media mix to drive traffic to the

website.

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

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	$9,688,646		$61,205,886	$10,431,562	$2,365,114	$0	$0
a. Pregnant Women and Women with Dependent Children**	$581,319		$5,508,530	$0	$0	$0	$0
b. All Other	$9,107,327		$55,697,356	$10,431,562	$2,365,114	$0	$0
2. Primary Prevention	$2,583,639		$0	$11,546,995	$0	$0	$0
a. Substance Abuse Primary Prevention	$0		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
4. Tuberculosis Services	$0		$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)	$645,909		$0	$0	$2,161,180	$0	$0
10. Total	**$12,918,194**	**$0**	**$61,205,886**	**$21,978,557**	**$4,526,294**	**$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.

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

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	222	140
2. Women with Dependent Children	3861	1976
3. Individuals with a co-occurring M/SUD	17232	5262
4. Persons who inject drugs	14093	4012
5. Persons experiencing homelessness	2707	529

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

Note: The numbers above represent the estimated number per year. Aggregate treatment numbers are based on SFY2018 data. Methodology Pregnant Women Estimate: The VT Birthrate in 2017 is 9.1 per 1000 people (CDC: https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf) 2017 VT population estimates http://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vermont-population-estimates). Expected pregnancies = birthrate * population. NSDUH for 2016/2017 (https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables) estimates that 9.39% of Vermonters age 12+ have abuse or dependence for alcohol or illicit drug use. SAMHSA (https://www.samhsa.gov/specific-populations/age-gender-based) estimates that nationally, rate of substance dependence or abuse for males ages 12 and up was greater than the rate for females (10.7% vs. 5.7%). Applying that ratio (5.7/10.7) to the 9.39% and multiplying it by the number of births results in the expected number of pregnant women with SUD per year. In Treatment: The number of women pregnant at the time admission (SFY18) from SATIS – the Substance Abuse Treatment Information System, Vermont's version of TEDS. Women with Dependent Children Estimate: The Census Factfinder (https://www.census.gov/quickfacts/fact/table/vt,US/PST045217) household information provides information on households with minor children. Queried the system for Vermont, 2017 data. Took total households and calculated the portion of households with minor children (http://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vermont-population-estimates) led by married couples, or by women alone. NSDUH for 2016/2017 (https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables) estimates that 9.39% of Vermonters

age 12+ have abuse or dependence for alcohol or illicit drug use. SAMHSA (https://www.samhsa.gov/specific-populations/age-gender-based) estimates that nationally, rate of substance dependence or abuse for males ages 12 and up was greater than the rate for females (10.7% vs. 5.7%). Applying that ratio (5.7/10.7) to the 9.39% and multiplying it by the number women of childbearing age results in the expected number of women with dependent children with SUD per year. In Treatment: The number of women with dependents at the time admission from SATIS – the Substance Abuse Treatment Information System, Vermont's version of TEDS. There were several providers improperly reporting this data element so the numbers have been adjusted to apply the rates of women with dependent children from those that are correctly reporting to those providers that not. Individuals with co-occurring MH/SUD Estimate: NSDUH https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.htm#taba31b) reports that 3.4% of the adult population had both any mental health and SUD in the past year. This was multiplied by the Vermont population 18+ (http://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vermont-population-estimates). In Treatment: Vermont's SATIS system does not collect information about co-occurring disorders. Estimates were made based on the total people served in the Preferred Provider system in 2018 and multiplied by NSDUH estimates (https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.htm#cooccur2) that reports that 45.6% of the adult population in treatment for SUD also had serious mental illness. Persons who inject drugs Estimate: Lifetime PWID comprised 2.6% (95% confidence interval: 1.8%–3.3%) of the U.S. population aged 13 years or older, representing approximately 6,612,488 PWID (range: 4,583,188–8,641,788) in 2011. The population estimate of past-year PWID was 0.30% (95% confidence interval: 0.19 %–0.41%) or 774,434 PWID (range: 494,605–1,054,263). (http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0097596). Multiplied the 2.6% to the Vermont population 13+ (http://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vermont-population-estimates). In Treatment: The number of people who report IVDU for primary, secondary, or tertiary substance of abuse who received treatment during SFY18 from SATIS – the Substance Abuse Treatment Information System, Vermont's version of TEDS. This is not limited to admissions because many of these individuals are receiving long term treatment with methadone or buprenorphine within the Preferred Provider network. There are an estimate additional 4700 people (2018) receiving Medication Assisted Treatment with buprenorphine for opioid use disorder outside the block grant funded preferred provider system so this number significantly underestimates the portion of IVDU who are receiving treatment. Persons experiences homelessness Estimate: It is difficult to estimate the number of people who are homeless. Vermont reports sheltering over 3872 people (https://dcf.vermont.gov/sites/dcf/files/OEO/Docs/HOP-AR-2018.pdf) in 2018 and the Vermont Statewide Point in Time Survey (http://helpingtohousevt.org/wp-content/uploads/2018/05/2018-PIT-Report-FINAL-5-30-18.pdf) indicate that of those who were surveyed, 6% were unsheltered. Multiplied those to get an estimate that 246 were unsheltered for a total of 3872 were homeless at some point during the year. Of those sheltered, 7% reported having SUD, of those not sheltered, SAMHSA reports (https://www.samhsa.gov/homelessness-housing) that ONDCP estimates that 2/3 have SUD. In addition to those numbers, we know based on surveys with people who use hard drugs that approximately 50% of people who have opioid use disorder and who are not in treatment (estimated at 4500 people in Vermont in 2018) are homeless these were also included in the estimate. In Treatment: The number of people homeless at the time admission from SATIS – the Substance Abuse Treatment Information System, Vermont's version of TEDS.

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

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*	$4,844,323
2 . Primary Substance Abuse Prevention	$1,291,819
3 . Early Intervention Services for HIV**	$0
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$322,955
6. Total	**$6,459,097**

* 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 are 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.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

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	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$0**
Total SABG Award*		**$6,459,097**
Planned Primary Prevention Percentage		**0.00 %**

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

Total SABG Award is populated from Table 4 - SABG Planned Expenditures $1,291,819

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	$314,824
Universal Indirect	$465,055
Selective	$490,891
Indicated	$0
Column Total	**$1,270,770**
Total SABG Award*	**$6,459,097**
Planned Primary Prevention Percentage	**19.67 %**

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

$21,049 reduction in Selective to account for activities reported in Table 6

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

Footnotes:

Planning Tables

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

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

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	$0	$6,863	$6,863
2. Infrastructure Support	$0	$0	$0
3. Partnerships, community outreach, and needs assessment	$0	$13,391	$13,391
4. Planning Council Activities (MHBG required, SABG optional)	$0	$0	$0
5. Quality Assurance and Improvement	$120,192	$0	$120,192
6. Research and Evaluation	$0	$0	$0
7. Training and Education	$0	$795	$795
8. Total	**$120,192**	**$21,049**	**$141,241**

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

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 homes[31] and ACOs[32] 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/cciio/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 Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP), the Vermont Department of Mental Health (DMH), and the Department of Vermont Health Access (DVHA) which oversees Vermont Medicaid, partner to develop, promote, and support policy and evidence-based practices that directly contribute to the integration of mental health and primary health care including services for individuals with co-occurring mental and substance use disorders, and provides for the inclusion of primary, specialty care and community-based settings. The partnership is predicated on an established inclusionary governance, leadership and decision-making structure with shared goals, priorities and values. The outputs from this partnership are grounded in the Vermont Model of Care as the foundation for care delivery transformation.

The Vermont Model of Care includes key elements that directly contribute to integration: person-centered services and supports which addresses the whole person; actively involved primary care provider to advance access, holistic care and evidence-based practice; single point of contact such as a care or case coordinator; assessments and screenings to determine the type(s) and level of service; comprehensive care plan that is indicative of person-center/holistic care; interdisciplinary care team; support during care transitions; and use of technology for information sharing such as adoption of electronic health records.

In addition, as noted in Vermont's System of Care Overview (Step 1), initiatives that advance integration include but are not limited to:

Some Vermont communities had previously implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) and this is now being expanded through Screening, Brief Intervention, and Navigation to Services (SBINS). It is an approach that helps health care providers identify risks to their patients' health and wellbeing, from a wide range of sources including drug and alcohol use, housing and food insecurity, inter-partner violence, and more. When risks are present, trained counselors offer patients support and help them access the services they need to address risk factors and maintain or improve their health. SBIRT screenings focused on risky substance use; SBINS screenings identify a broader range of risk factors including depression, substance use, and social determinants of health. SBIRT refers patients to treatment; SBINS navigates with patients and stays engaged until patients have the help they need.

The Hub and Spoke System is a statewide partnership of specialty treatment centers and a network of medical practices that provide comprehensive Medication Assisted Treatment (MAT) services to Vermonters diagnosed with opioid use disorder. Regional treatment centers that are federally accredited Opioid Treatment Programs (OTPs also called "Hubs") are located around the state

and treat patients by providing medication assisted outpatient treatment using principally methadone or buprenorphine to help a person not use illicit opioids. OTPs provide counseling and other services along with the medication. The "spoke" is a three-person primary care team with a care coordinator/clinician, nurse and physician for every 100 patients providing buprenorphine or methadone treatment. A primary aspect of the program is the wrap-around services provided to the client based on a unique treatment plan overseen by a doctor and buttressed by the nurses and counselors who connect the client with community-based support services, whether referral to mental health treatment, job placement, and/or family and recovery support.

Workforce Development: The Blueprint for Health is implementing learning collaborative to expand and strengthen the Hub and Spoke system. These learning collaborative reach prescribers, nurses and care coordinators. Strategies include Office-based Opiate Treatment 101, a statewide collaborative for Spoke embedded staff and monthly clinical case reviews with care coordinators and prescribers. In addition, Vermont has worked to create and foster a practice improvement entity, Vermont Collaborative for Practice Improvement and Innovation (VCPI), which is administered by Northern Vermont University. VCPI is currently implementing a co-occurring disorder learning community serving mental health and substance use disorder treatment providers system wide.

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.

The State of Vermont and federal government have been meaningful and effective partners in health care reform for many years. The Centers for Medicare and Medicaid Services (CMS) has provided Vermont with flexibility and tools to improve the delivery of health care in Vermont and improve the health and lives of Vermonters. Specifically, Vermont's Global Commitment to Health 1115 demonstration waiver (GC waiver) and the Vermont All-Payer Model Agreement (APM) are examples of how the federal government and a state can design a program that furthers federal goals while being customized for the strengths and needs of an individual state. The APM Agreement and Global Commitment Demonstration are complementary frameworks that support Vermont's health care reform efforts. Each agreement provides federal support to further Vermont's strategic goal of creating an integrated health care system, including increased alignment across payers and providers.

Medicaid has historically been the primary funder of substance use disorder treatment services in Vermont and that work continues. In 2018, Vermont applied for, and received of approval from CMS, of an amendment to the GC waiver which resulted in the ability to allow for payment of otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an Institution for Mental Disease. The amendment was effective July 1, 2018.

In 2013, Vermont used CMS enhanced federal matching funds to build the "Hub and Spoke" system. This framework integrates programs providing higher levels of care with programs offering MAT in general medical settings. 2016 data shows, when comparing Vermonters with opioid use disorder (OUD) receiving MAT (MAT group) against a group receiving one or more inpatient visits, one or more outpatient emergency department visits, or two or more nonhospital outpatient visits with a diagnosis for opioid use disorder but who did not receive MAT (non-MAT group), the MAT group had lower expenditures excluding treatment, lower inpatient hospitalizations, lower inpatient days, lower outpatient emergency department use, and higher primary care visits than the non-MAT group. This system has become a national model that is being implemented in other states. In a 2017 evaluation of the system, Hub and spoke participants reported a 96% decrease in opioid use and statistically significant reductions in the use of alcohol and illicit drugs except cannabis/marijuana, which stayed relatively unchanged. They also report significant reductions in illegal activities, overdoses, emergency department use and feelings of depression and anger.

DVHA and VDH/ADAP initiated a payment reform effort for residential treatment. Medicaid payments to residential treatment providers were changed from a per diem payment to an "episodic payment" effective January 1, 2019. The episodic payment delivers a single price for all services needed by a patient for the entire episode of care – substance use disorder, mental health, and medical care. It includes both residential detoxification and residential treatment, with pharmaceutical benefits continuing to be billed separately. The payment is determined by two factors: the primary diagnosis and, if present at intake, co-morbidities. This was designed to incentivize providers to admit only those patients that need the full resources of residential care, thereby promoting the good stewardship of public resources and ensuring people receive appropriate types and levels of care. Patients with OUD and resultant infective endocarditis who are receiving intravenous antibiotics can be treated in the residential setting rather than in a hospital, allowing patients to receive treatment for both simultaneously.

Through this payment change, DVHA and VDH/ADAP developed a method of reimbursement that provides a framework to pay for outcomes rather than discrete services; incentivizes innovation and cost-containment through increased provider flexibility; and ensures financial stability to providers through the delivery of more predictable payments.

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 Department of Vermont Health Access (DVHA) and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) jointly monitor access to care. The DVHA monitors the provider network through mapping with, at a minimum, an annual review by the Managed Care Medical Committee. Access to the Hub & Spoke/MAT system is monitored

monthly. VDH/ADAP monitors TEDS/SATIS admissions data for total admissions and payment mix. VDH/ADAP conducts quality assurance/compliance site visits on the Preferred Provider network with the support of TEDS/SATIS data.

The Green Mountain Care Board is responsible for monitoring access for the QHPs.

Identifying and monitoring QHPs is the responsibility of the Vermont Department of Financial Regulation (DFR). DFR produces annual Health Plan Report Cards for Vermont managed health care plans.
http://www.dfr.vermont.gov/sites/default/files/2014_MCODataFilingEvalRpt_UpdateDec2014.pdf

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?

Vermont has been at the forefront parity of mental health and substance use disorder treatment with robust Medicaid coverage for services and the additional flexibility of the Global Commitment to Health 1115(a) Waiver.

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

In 2018, Vermont applied for, and received approval from CMS, for an amendment to the Global Commitment to Health 1115(a) Waiver which resulted in the ability to allow for payment of otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an Institution for Mental Disease. The amendment was effective July 1, 2018.

Please indicate areas of technical assistance needed related to this section

Vermont is not seeking technical assistance at this time.

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

Footnotes:

1 https://blueprintforhealth.vermont.gov/sites/bfh/files/SBINS-Planning-Guidance-Letterhead-v6.pdf

2 http://dvha.vermont.gov/global-commitment-to-health/vermont-global-commitment-to-health-approval-documents?portal_status_message=Changes%20saved

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 status[47]. 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 populations[48]. 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**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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?

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) supports Cultural Brokers who provide prevention, education and early intervention services to new Americans, with and at risk, for substance use disorder (SUD) in the Chittenden region. Six brokers represent immigrant and refugee communities such as (Somali, Somali-Bantu, Congolese, Bhutanese and Nepali) and act as effective liaisons with schools, clinics, community agencies, medical providers, mental health agencies, juvenile justice and law enforcement. Cultural Brokers build trusting relationships with new Americans for identifying and addressing substance use and provide educational opportunities and information on available community resources. This program was developed as part of Vermont's SAMHSA Screening, Brief Intervention and Referral to Treatment (SBIRT) grant. After the grant ended, the program was continued because of its high value in health equity work.

Please indicate areas of technical assistance needed related to this section

Vermont is not seeking technical assistance at this time.

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

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 ÷ 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?

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) supports primary prevention strategies that are evidence-based or promising practices and that are overseen by the VDH/ADAP Evidence-based Workgroup. There are non-financial incentives for community-based groups implementing prevention programming to establish and maintain collaborations with relevant community and regional partners, such as, but not limited to, health care providers, law enforcement, education, town government, juvenile justice and diversion, and businesses. Those entities implementing primary prevention strategies receive points when competing for funding when they demonstrate active and substantial partnerships.

VDH/ADAP executed grants with substance use disorder (SUD) treatment providers as a result of a Request for Application (RFA) issued to improve the strategic use of block grant funds. The purpose of the RFA was to solicit applications from SUD treatment providers that contributed to a comprehensive service delivery system while addressing the unique needs and barriers to treatment and recovery throughout the continuum of care, in particular for IV drug users and pregnant and parenting women including their children. The selected providers demonstrated high-quality, research-based best practice treatment, and allowed for increased access and availability of residential and non-residential substance use treatment. The RFA process has been adopted by VDH/ADAP.

VDH/ADAP implemented a payment reform project with the Department of Vermont Health Access (i.e., Medicaid) in conjunction with in-state residential treatment providers. Instead of a per-diem rate, in-state residential providers will be paid an episodic payment to include detoxification and treatment. The episodic payment amount is determined by the primary SUD diagnosis present at admission and, if present, a co-morbidity.

The payment change unites utilization management to the broader provider oversight thereby reducing administrative burden and costs to both the State and providers, delivers more predictable and timely payments, offers flexibility that supports comprehensive, coordinated care while encouraging innovation, incentivizes the appropriate level of care, improves data quality

to move towards more standardized approach for tracking population health.

The goals of the payment change are to ensure appropriate levels of care for individuals, improve transitions of care and outcomes for individuals, provide for financial stability and viability, allow for a more holistic approach to provider management and oversight, provides for a framework that pays for outcomes rather than discrete services. The model will evolve further with a value-based component.

The following figure depicts the episodic payment model based on primary substance diagnosis in conjunction with the type of co-occurring disorder:

ADDED IN ATTACHMENTS

The Hub and Spoke system is a nationally recognized treatment system of Hubs (OTPs) and Spokes (DATA 2000 waivered physicians) who provide Medication Assisted Treatment (MAT) to individuals with opioid use disorder. The Hub and Spoke system ensures that care is effective, coordinated and supported. Hub and Spoke programs operate as Health Homes under Vermont's Medicaid State Plan. The specific Health Home services are: comprehensive care management, care coordination, health promotion, transitional care, individual and family support services, and referral to community and social support services.

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

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

Footnotes:

ENV FACTOR 3 – INNOVATION IN PURCHASING DECISIONS (graphic within narrative):

		No Co-occurring Disorder	Co-occurring Disorder Weighted Score		
		A	B	C	D
SUD Primary Diagnosis	*Alcohol or Benzodiazepines*	$4,033	$4,273	$4,530	$4,803
	Other	$3,532	$3,745	$3,969	$4,206

No Co-occurring	A
Bipolar Disorder	B
Liver disease/Cirrhosis,	
Diabetes	
Post Traumatic Stress Disorder	
Homeless	C
Family substance use	
Intellectual Disability	
Pregnancy	
Personality disorders	
Endocarditis	D
Deafness-bilateral	
Psychotic disorders	

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?

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) grant/contract agreements issued with SABG funds include general assurance provisions such as grantee/contractor compliance with:

-45 CFR and 42 CFR
-Medication Assisted Treatment rule available at: http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-medication-assisted-therapy-for-dependence.pdf
-Substance Abuse Treatment Certification rule available at: http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_substance-abuse-treatment-certification.pdf

The Agency of Human Services Standard Provisions (Attachment F) Medicaid contract services language includes: Inspection of Records: Any contracts accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid program must fulfill state and federal legal requirements to enable the Agency of Human Services (AHS), the United States Department of Health and Human Services (DHHS) and the Government Accounting Office (GAO) to: Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and Inspect and audit any financial records of such Contractor or subcontractor.

The grant/contract agreements include mandatory compliance with federal and state regulations and procedures, including:

Public Inebriate Program: The process of screening and determining appropriate placement for individuals meeting criteria for Incapacitation, due to either the intoxication or withdrawal from alcohol or other drugs, as defined in 18 V.S.A. Chapter 94. Results of the screening process may include individuals being referred for further medical assessment, alternative placements to incarceration, or placement within restrictive facilities.

Uncompensated Care: Grantee will provide clinical services as described in the Substance Abuse Treatment Certification rule and approved through their organization's certification process.

45 CFR: The Vermont Department of Health is required to comply with 45 CFR, Part 96, Subpart L – Substance Abuse Prevention and Treatment Block Grant.

The VDH/ADAP conducts a series of activities and strategies that are used to identify issues to monitor program compliance. Initially and at regular intervals, the VDH/ADAP certifies that programs achieve compliance with program regulations, applicable laws and rules, the Substance User Disorder Treatment Standards, and grant provisions.

The VDH/ADAP implemented a new version of its Treatment Standards document August 1, 2018 and renamed it the "Preferred Provider Substance Use Disorder Treatment Standards". These Treatment Standards continue to include SABG requirements. The Treatment Standards are available at:
http://www.healthvermont.gov/alcohol-drugs/professionals/treatment-provider-certification

The site visits identify areas in which the Preferred Provider is not in compliance and results in a required corrective action plan that brings the Provider into compliance with the Treatment Standards. VDH/ADAP collaborates with the Provider to prioritize planning needs to implement the corrective action plan. Technical assistance is provided when appropriate.

The VDH/ADAP has implemented a Compliance Assessment Tool (CAT) in alignment with the Treatment Standards. The CAT was developed in response to Preferred Provider input and to allow for a uniform, systemic approach to review and scoring Provider compliance with the standards. The CAT is a weighted scoring tool used as part of VDH/ADAP oversight/ monitoring and certification activities to determine a Preferred Provider's level of compliance with the Treatment Standards and the period of certification.

The application of the CAT results in a score that is based on the number of points the Preferred Provider received and the total possible points. The period of certification is based on the percent that the provider achieved. For example, Preferred Providers who achieve 90% or higher receive a three-year certification.

The initial version of the CAT was piloted on March 9, 2018 with consent from a Preferred Provider. The final version of the CAT was distributed on November 7, 2018. A presentation with the scoring rubric was discussed at a meeting of providers on December 20, 2018. The tool is consistently being used on all site visits.

The CAT assists ADAP staff in generating a report that includes findings that are categorized as recommended or required. Providers are given an opportunity to address a finding of non-compliance with oversight through the corrective action process. The VDH/ADAP may order suspension or revocation of certification at any time for non-compliance.

Please indicate areas of technical assistance needed related to this section

Vermont is not seeking technical assistance at this time.

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

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**[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?

Vermont does not have any federally recognized tribes.

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

Vermont does not have any federally recognized tribes.

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

Vermont does not have any federally recognized tribes.

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

Vermont is not seeking technical assistance at this time.

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

Footnotes:

Vermont does not have any federally recognized tribes.

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)

  - alcohol and / or other drug car crashes
  - fatalities and injuries
  - alcohol and drug related crime
  - alcohol and other drug emergency room visits

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities

- [ ] Others (please list)

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

- [ ] Archival indicators (Please list)
- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

The SEOW assesses all statewide substance abuse consumption and consequence data available to identify priorities which are underage and high-risk alcohol use, marijuana use and prescription drug misuse and abuse. SABG primary prevention funds support either staff or programs to address these priority issues.

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

Narratve 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.

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

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

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) funds a statewide contractor to provide training to the prevention workforce, and regional Prevention Consultants who serve the entire state providing training and technical assistance to communities.

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

If yes, please describe mechanism used

Narratve 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:

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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

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

The criteria used by the Evidence-Based Workgroup (EBW) is the guidance provided by SAMHSA in its publication titled, "Identifying and Selecting Evidence-based Strategies." The Vermont EBW continues to utilize the definition of evidence-based and the three (3) Guidelines for evidence that are outlined in this document.

Narratve 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:

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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.

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:

The Vermont Alcohol and Drug Information Clearinghouse provides print and electronic information to grantees and contractors and to the general public. The Vermont Department of Health website has been revised and updated. All Vermonters have access to educational materials available on the website including drug fact sheets, drug disposal and safe storage information, national awareness days/months and screening information. In addition, the website hosts current media campaigns including ParentUP, Do Your Part and Check Yourself.

b) Education:

The school-based grant program funds evidence-based curriculum and parenting programs (Life Skills, Project Northland, Guiding Good Choices, Creating Lasting Connections, Strengthening Families and Nurturing Parenting Programs) as well as education and training provided to school staff, educational support groups, and peer leadership educational programs. The annual college symposium provides educational opportunities for attending colleges to further understand the connection between substance misuse and academic achievement and quality of student life. In addition to school-based services, the Rocking Horse Educational Group for pregnant and parenting women provides education on family management and substance misuse. One of the Prevention Expansion grants provides educational groups on substance misuse and basic prevention education for Africans Living in Vermont.

c) Alternatives:

Through community and school-based funding, ADAP is funding youth leadership programs that provide training and opportunities for students to analyze data and conduct presentations to the community, parents and school administrators to increase education and awareness of the issues. This type of programming can lead to changes in school alcohol and drug policy, and community norm change such as elimination of alcohol sponsored events, the creation of substance free events and the designation of substance free parks.

d) Problem Identification and Referral:

The school-based grants require screening and referral to services if warranted, as well as colleges utilizing the computer-based eCHECKUP for online screening and brief intervention for alcohol and marijuana use. In addition, regional Prevention Consultants direct those in need to where they can access screening and referral services.

e) Community-Based Processes:

Using the Strategic Prevention Framework (SPF), regional Prevention Consultants together with community partners, gather and analyze data, assess capacity and readiness, develop logic models and strategic plans, ensure implementation with fidelity, and utilize process and outcome evaluation results to improve strategy outcomes. The Prevention Consultants provide technical assistance to all communities utilizing the SPF and provide training and networking activities with traditional and non-traditional partners. Specific community capacity building includes media advocacy, promotion of statewide media campaigns, promotion and cultural competency. The Prevention Expansion and Infrastructure grants provide for enhancements of local policy, responsible beverage seller and fake ID training, building local capacity for effective engagement of the health care reform movement and the role primary substance misuse prevention can play, and integration of substance misuse prevention and trauma informed initiatives.

f) Environmental:

The Prevention Infrastructure and Expansion grants provide implementation of education on policy approaches/changes, community mobilization, media advocacy restricting outlet density, social marketing and enhanced local enforcement strategies.

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

The accounting system uses discrete account codes to differentiate between services and levels of care.

Narratve 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:

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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.

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:)
- **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):

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm
- **c)** ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Strategic Plan 2017-2020

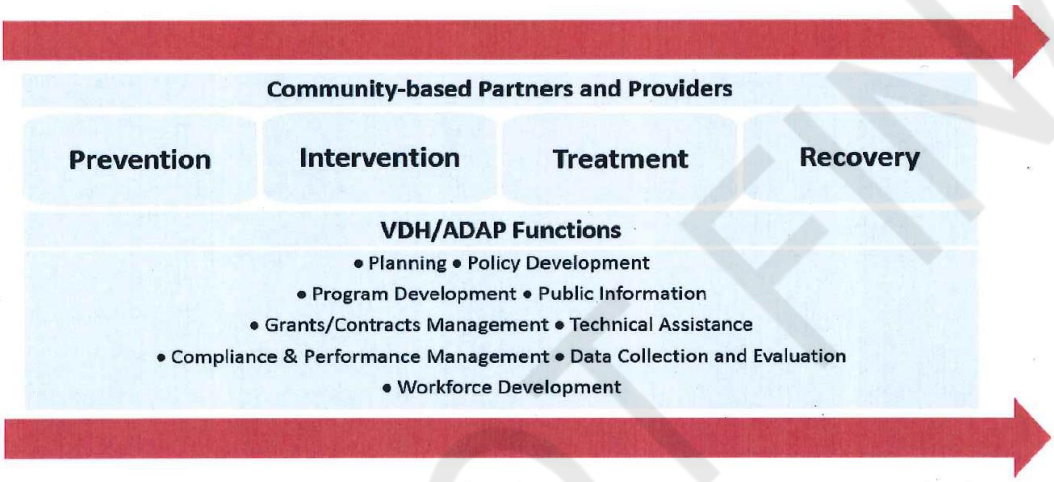
Motto

Prevention Works | Treatment is Effective | People Recover

Mission

ADAP's mission is to help Vermonters prevent and eliminate the problems caused by alcohol and other drug use. Working in partnership with other public and private organizations, ADAP plans, supports, and evaluates a comprehensive system of services.

Vermont's Continuum of Care



Performance Management and Public Accountability

ADAP's long-term substance misuse indicators are informed by the framework for Healthy People 2020, as well as Vermont data trends to reveal needs and gaps. Programs and initiatives aim to bend the curve on the following long-term indicators:

- % of persons age 12 and older who need and do not receive alcohol treatment.
- % of persons age 12 and older who need and do not receive illicit drug use treatment.
- % of adolescents in grades 9-12 who used marijuana in the past 30 days.
- % of adolescents in grades 9-12 binge drinking in the past 30 days.
- % of adults age 18-24 binge drinking in the past 30 days.
- % of adults age 65 and older who drink at a level of risk.

The above indicators can be found on the Vermont Department of Health's Performance Dashboard, together with performance measures for specific programs. For more information on the Performance Dashboard, please see the following link: healthvermont.gov/scorecard-alcohol-drugs.

Message from Division Director

Dear Staff and Partners

I am pleased to share the updated Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) strategic plan for 2017 – 2020. The plan outlines priorities for our work to ensure that Vermonters impacted by substance misuse get the information and help they need.

ADAP works collaboratively to support Vermont's Agency of Human Services' mission: strive to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves.

For more information, please visit the following link: healthvermont.gov/alcohol-drugs ■

Cynthia Thomas
Director, Vermont Department of Health, Division of Alcohol and Drug Abuse Programs

Strategic Plan 2017-2020

ADAP's Strategic Plan 2017-2020 sets out program and operational priorities for the next three years. In support of these priorities, ADAP has identified strategies that are informed by Vermont's Agency of Human Services (AHS) Strategic Plan and reflect ADAP's primary investments across the Department of Health's six goals. The strategies incorporate evidence-based practices, collaborative efforts and strong partnerships with local provider and community-based organizations to implement the most effective initiatives possible. For each strategy, quantifiable targets and measures are identified to help monitor progress, with the hope and determination of contributing to the ultimate outcome: to prevent and eliminate the problems caused by alcohol and drug misuse.

Goal 1: Effective and Integrated Public Health

Strategies:

- **AHS Substance Abuse Treatment Coordination (SATC):** Support AHS SATC to establish an integrated approach to serving Vermonters with substance abuse problems. This includes training of direct service staff to provide screening and implementation of regional pilots for service coordination across departments. (AHS)

  Targets: - Increase the # of regional pilots being implemented by 1 per year
  - Increase the # of AHS staff trained to provide screening

  Measures: - # of AHS regional pilots being implemented
  - # of AHS staff trained to provide screening

- **Linkages between Treatment and Recovery:** AHS will increase the percentage of individuals leaving treatment with more supports than when they started through adding additional recovery support and improving the linkages between treatment providers and recovery centers. (AHS)

  Targets: - Increase the # of individuals who have more social supports on discharge than on admission by 25%
  - 100% of treatment grants include requirement for referral to recovery by FY18

  Measures: - # of individuals who have more social supports on discharge than on admission
  - % treatment grants include requirements for referral to recovery centers

Goal 2: Communities with the Capacity to Respond to Public Health Need

Strategies:

- **Regional Prevention Capacity:** Increase and strengthen regional capacity by funding communities and schools through the Regional Prevention Partnerships (RPP) grant, School-based Substance Abuse Services (SBSAS) grant and the Prevention Consultant (PC) system.

  Targets: - Increase the # of VDH health district offices funded under the RPP from 6 to 12
  - At least 20 supervisory unions with functioning SBSAS grant program

  Measures: - # of VDH health districts funded under the RPP
  - # of supervisory unions with functioning SBSAS grant program

- **Trained and Qualified Prevention Workforce:** Increase the number of prevention practitioners in Vermont working toward ICRC (International Certification and Reciprocity Consortium) certification by providing training in ICRC competency areas and educating practitioners about certification resources.

  Targets: - 12 trainings in ICRC competency areas will be offered by the end of FY18

  Measures: - # of trainings in ICRC competency areas offered

- **ASAM Criteria:** Assure that individuals receive services at appropriate levels of care as defined by American Society of Addiction Medicine (ASAM) placement criteria.

  Targets: - 100% of treatment providers are utilizing ASAM placement criteria by FY18

  Measures: - # of treatment providers utilizing ASAM placement criteria as measured by site review documentation

- **Medication-Assisted Treatment (MAT):** AHS will increase access to Medication-Assisted Treatment (MAT) for opioid addiction by adding additional hub services and increasing the number of spoke providers. (AHS)

  Targets: - Increase the # of individuals receiving MAT per 10,000 Vermonters age 18-64

  Measures: - # of individuals receiving MAT per 10,000 Vermonters age 18-64

Goal 3: Internal Systems that Provide for Consistent and Responsive Support

Strategies:

- **Data Systems:** Improve data systems used to support ADAP reporting and service delivery.

  Targets: - Information Technology (IT) plan completed by 7/1/17
  - 12 Preferred Provider locations will use the updated Substance Abuse Treatment Information System (SATIS) by 7/1/17
  - 100% of new demonstration grant applications will include an analysis of the IT needs associated with the funding

  Measures: - IT Plan completed
  - # of preferred provider locations using updated SATIS

- **Policies and Procedures:** Improve coordination and consistency by developing internal and external policies and procedures for programs and operations.

  Targets: - Policy/procedure need areas and ADAP leads identified by 7/1/17
  - Guidance documents for at least 5 priority areas will be developed by 7/1/18

  Measures: - Policy/procedure need areas and ADAP leads identified
  - # of guidance documents developed

- **Monitoring:** Continuously improve and enhance quality of care through ongoing, objective, and systematic monitoring of providers and implementing an independent peer review process.

  Targets: - Increase the # of independent peer review site visits to preferred providers by 2 in CY17

  Measures: - % of treatment provider site visits in CY17 that were performed through an independent peer review process

- **Quality Improvement:** Develop a culture among providers to engage in continuous quality improvement by providing the services of a practice facilitator.

  Targets: - Minimum of 2 Preferred Providers will have implemented at least 1 quality improvement project in CY17
  - ADAP will implement at least 1 AIM project per calendar year

  Measures: - # of Preferred Providers implementing a quality improvement project
  - # of AIM projects implemented by ADAP

- **Evaluation:** Assess effectiveness of programs and initiatives by maintaining and increasing evaluation and data collection capacity.

  Targets: - A minimum of 10% of the federal demonstration grant budget, where allowable, will be allocated to evaluation

  Measures: - % of federal demonstration grant budget allocated to evaluation

Goal 4: A Competent and Valued Workforce that is Supported in Promoting and Protecting the Public's Health

Strategies:

- **Core Competency Trainings:** Increase provider access to training in core competencies. Priorities for this period are: Substance Abuse Prevention Skills (SAPST), American Society of Addiction Medicine (ASAM) placement criteria, co-occurring disorders, motivational interviewing, trauma-informed care at the individual and community level, Standards and Linguistically Appropriate Services (CLAS) and recovery coaching.

  Targets: - Increase or maintain the # of provider trainings in these areas

  Measures: - # of provider trainings offered

- **Evidence-based Practices:** Promote the adoption of evidence-based practices through learning collaboratives, including but not limited to environmental strategies, screening and brief intervention, adolescent and family treatment, co-occurring disorders, contingency management and medication-assisted treatment in primary care and community settings.

  Targets: - Implement at least 4 learning collaboratives annually

  Measures: - # of learning collaboratives fully implemented by FY19

- **Staff Orientation:** Increase understanding of comprehensive system of care among ADAP staff by establishing an orientation process which is consistent across program areas and expose staff to best practices in operational management, prevention, treatment, recovery and performance management.

  Targets:
  - Orientation protocol developed in FY17
  - 100% of new staff complete orientation protocol within 6 months of hire in FY18
  - 100% of all staff complete orientation protocol in FY19

  Measures:
  - Orientation protocol completed
  - # of new staff who complete orientation protocol
  - # of all staff who complete orientation protocol

Goal 5: A Public Health System that is Understood and Valued by Vermonters

Strategies:

- **Public Information:** Increase the public's understanding of the substance abuse services system through development of resources that describe how to access substance abuse services, and promote substance abuse service outcomes.

  Targets:
  - Increase # of Health Department resources (e.g. publications, web-based tools) available to the public that describe how to access substance abuse services, or promote substance abuse service outcomes by 1/1/19

  Measures:
  - # of Health Department resources (e.g. publications, web-based tools) available to the public that describe how to access substance abuse services, or promote substance abuse service outcomes

- **Social Marketing:** Promote behavior change by conducting social marketing campaigns with high need populations including but not limited to young adults.

  Targets:
  - Increase the reach of social marketing initiatives (including % of target population reached, # of impressions, and # of active engagements)

  Measures:
  - % of target population reached, # of impressions, and # of active engagements

Goal 6: Health Equity for All Vermonters

Strategies:

- **Health Equity:** Improve substance abuse services for racial, ethnic, and underserved populations through provider training, and implementation of National Standards for Culturally and Linguistically Appropriate Services (CLAS) and expand the use of cultural brokers throughout the state.

  Targets:
  - Increase the # of providers trained in cultural competency
  - Increase the # of translations of key materials

  Measures:
  - At least 3 trainings completed by 7/1/19
  - At least 2 translations of priority materials completed by 7/1/19

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	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

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 VDH/ADAP conducts a series of activities and strategies that are used to identify issues to monitor program compliance. Initially and at regular intervals, the VDH/ADAP certifies that programs achieve compliance with program regulations, applicable laws and rules, the Substance User Disorder Treatment Standards, and grant provisions.

The site visits identify areas in which the Preferred Provider is not in compliance and results in a required corrective action plan that brings the Provider into compliance with the Treatment Standards. VDH/ADAP collaborates with the Provider to prioritize planning needs to implement the corrective action plan. Technical assistance is provided when appropriate.

A report is generated as a result of the site visit and includes findings that are categorized as recommended or required. Providers are given an opportunity to address a finding of non-compliance with oversight through the corrective action process. The VDH/ADAP may order suspension or revocation of certification at any time for non-compliance.

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 activites 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 VDH/ADAP conducts a series of activities and strategies that are used to identify issues to monitor program compliance. Initially and at regular intervals, the VDH/ADAP certifies that programs achieve compliance with program regulations, applicable laws and rules, the Substance User Disorder Treatment Standards, and grant provisions.

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The VDH/ADAP requires performance reporting including reporting regarding 90 percent capacity and the 14-120 day treatment requirements.

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.

The VDH/ADAP conducts a series of activities and strategies that are used to identify issues to monitor program compliance. Initially and at regular intervals, the VDH/ADAP certifies that programs achieve compliance with program regulations, applicable laws and rules, the Substance User Disorder Treatment Standards, and grant provisions.

The site visits identify areas in which the Preferred Provider is not in compliance and results in a required corrective action plan that brings the Provider into compliance with the Treatment Standards. VDH/ADAP collaborates with the Provider to prioritize

planning needs to implement the corrective action plan. Technical assistance is provided when appropriate.

A report is generated as a result of the site visit and includes findings that are categorized as recommended or required. Providers are given an opportunity to address a finding of non-compliance with oversight through the corrective action process. The VDH/ADAP may order suspension or revocation of certification at any time for non-compliance.

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.CÂ§ 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, plese provide a brief description of the elements and the arrangement

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 memebers, 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.

Two sub-recipients (5% of the total block grant sub-recipients) will participate in an independent peer review process.

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 opertunity 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) Preformance-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

c) Coordination of Various Activities and Services ○ Yes ◉ No

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

The SUD administrative regulations are available at:
http://www.healthvermont.gov/about-us/laws-regulations/rules-and-regulations

The Mental Health administrative regulations are available at:
https://mentalhealth.vermont.gov/policy-and-legislative-resources/rules

Footnotes:

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.

Vermont is not seeking technical assistance at this time.

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

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 Trauma[58] 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.

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

Vermont is not seeking technical assistance at this time.

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

Footnotes:

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?	

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

Vermont is not seeking technical assistance at this time.

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

Footnotes:

Environmental Factors and Plan

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)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] 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?

Vermont's Hub and Spoke system is a statewide partnership of specialty treatment centers and a network of medical practices that provide comprehensive Medication Assisted Treatment (MAT) services to Vermonters diagnosed with opioid use disorder. Regional treatment centers that are federally accredited Opioid Treatment Programs (OTPs also called "Hubs") are located around the state and treat patients by providing medication assisted outpatient treatment using principally methadone or buprenorphine. OTPs provide counseling and other services along with the medication. The "spoke" is a three-person primary care team with a care coordinator/clinician, nurse and physician for every 100 patients providing buprenorphine or methadone treatment. A primary aspect of the approach is the wrap-around services provided to the client based on a unique treatment plan overseen by a doctor and buttressed by the nurses and counselors who connect the client with community-based support services, whether referral to mental health treatment, job placement, and/or family and recovery support.

Rapid Access to Medication Assisted Treatment (RAM) is a pilot that was launched in Central Vermont in July 2018 as a community collaboration with support from the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP). The goal of the RAM is specifically targeted to initiate Medication Assisted Treatment (MAT) within 72 hours from first contact with a person diagnosed with opioid use disorder, when medically appropriate.

This is accomplished through collaboration, creating gateways to access with defined clinical pathways, peer-based recovery supports, refining processes using a critical eye within a specific provider and across the system, and tracking time to treatment.

Ongoing community meetings are utilized to identify barriers, seek creative solutions and refine collaboration both systemically and on a case by case basis.

RAM includes multiple service providers, including the local hospital emergency department who initiates inductions, and provides rapid access to care while enhancing quality of care, including recovery supports and continued guidance throughout the care hand-offs. This has been accomplished using existing resources organized in a thoughtful and effective manner. It bridges the various access points for care to allow for better transitions of care, which is where individuals are often lost, and offers seven day a week system entry. There are plans to expand RAM to more communities.

**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.*

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

Footnotes:

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**[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**

[62] Practice 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?

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) offers Public Inebriate Programs located throughout the state as an alternative to either incarceration or costly emergency room stays for individuals incapacitated from the acute effects of drugs or alcohol intoxication or withdrawal. Individuals are screened for levels of incapacitation and case dispositions are developed, including supervision by a family member or voluntary placement in a monitored "public inebriate" bed, until such time as the individual no longer meets the criteria for incapacitation and are safe to leave. Individuals may be offered referrals for treatment upon leaving or may receive some level of discharge planning support.

VDH provides mass distribution of the medication Naloxone which can reverse overdoses of opioids. Naloxone is available to interested individuals at community distribution sites such as treatment providers, recovery centers and needle exchange programs. Additionally, Vermont has a "standing order" for Naloxone, signed by the Commissioner of Health, where it can be purchased through a pharmacy by anyone interested in carrying Naloxone. Vermont's first responders are widely equipped with Naloxone, including many police departments and emergency medical personnel. Vermont has a "good Samaritan law" in effect for those individuals who report an overdose situation.

VDH/ADAP is using Opioid State Targeted Response (STR) grant funding to create a statewide, toll-free, centralized intake/call center for Vermonters. This call center will be staffed to handle emergencies and connect individuals to services and resources. This new system will work in collaboration with the existing mental health emergency services system and 211, the statewide resource line.

VDH/ADAP is continuing to utilize STR grant funds as well as new State Opioid Response (SOR) grant funding to expand a program that places recovery support services in Emergency Departments. The primary purpose of the program is to dispatch peer recovery coaches from recovery centers to the Emergency Department in response to an individual presenting with an opioid overdose or diagnosis of substance use disorder, and to engage and support the individual in seeking treatment (and other services) upon discharge.

Rapid Access to Medication Assisted Treatment (RAM) is a pilot that was launched in Central Vermont in July 2018 as a community collaboration with support from the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP). The goal of the RAM is specifically targeted to initiate Medication Assisted Treatment (MAT) within 72 hours from first contact with a person diagnosed with opioid use disorder, when medically appropriate.

This is accomplished through collaboration, creating gateways to access with defined clinical pathways, peer-based recovery supports, refining processes using a critical eye within a specific provider and across the system, and tracking time to treatment. Ongoing community meetings are utilized to identify barriers, seek creative solutions and refine collaboration both systemically and on a case by case basis.

RAM includes multiple service providers, including the local hospital emergency department who initiates inductions, and provides rapid access to care while enhancing quality of care, including recovery supports and continued guidance throughout the care hand-offs. This has been accomplished using existing resources organized in a thoughtful and effective manner. It bridges the various access points for care to allow for better transitions of care, which is where individuals are often lost, and offers seven day a week system entry. There are plans to expand RAM to more communities.

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

Vermont is not seeking technical assistance at this time.

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

Footnotes:

Environmental Factors and Plan

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.

The Department of Mental Health has invested heavily in improving, expanding, and refining Vermont's array of peer services, many of which were developed or enhanced following the passage of Act 79 in 2012. This expanded array of services includes community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre- crisis telephone-based support, referral and emotional support. Peer programming supported by the Department of Mental Health includes:

Alyssum: Two-bed program providing crisis respite and hospital diversion and step-down. Located in Rochester, Vermont.

Another Way: Community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving individuals who are not eligible for or choose not to be enrolled in Designated Agency Community Rehabilitation and Treatment services. Located in Montpelier, Vermont.

NAMI-Vermont: Statewide family and peer organization providing support groups and educational and advocacy groups for individuals with mental health conditions and their families. Headquarters in Williston, Vermont.

Northeast Kingdom Human Services Peer Cadre: Respite and peer support for individuals waiting in hospital emergency departments for inpatient psychiatric care. Focused on North Country Hospital in Newport, Vermont.

Northeast Kingdom Youth Services: Community Outreach, support groups and crisis intervention for young adults at risk of hospitalization. Focused on St. Johnsbury, Vermont.

Pathways Vermont – Peer Support Line: Statewide telephone peer support to prevent crisis and provide wellness coaching. Headquarters in Burlington, Vermont.

Vermont Psychiatric Survivors: Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings. Headquarters in Rutland, Vermont.

Pathways Vermont Community Center: Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services. Located in Burlington, Vermont.

Wellness Workforce Coalition: Provides infrastructure and workforce development for organizations that provide peer support. Statewide activities include: 1) Coordinating core training (e.g., Intentional Peer Support), 2) Workforce development (e.g. recruitment, retention, career development), 3) Mentoring, 4) Quality improvement, 5) Coordination of peer services, 6) Communication and networking, 7) Systems advocacy. Headquarters in Montpelier, Vermont.

Each of these programs works closely with the Wellness Workforce Coalition (WWC) to participate in core training and mentoring for staff using the Intentional Peer Support Curriculum, a national training resource for peer support providers. These peer organizations work with the WWC to improve their infrastructure (e.g. financial management and board development) and to expand their capacity for collecting and reporting Results-Based Accountability measures, including recovery-oriented measures to determine if individuals receiving support and services are "better off."

Vermont contracts with the Copeland Center to provide statewide training, coaching and mentoring on the use of Wellness Recovery Action Planning (WRAP) in both professional and peer organizations.

Vermont has adopted SAMHSA's definition of recovery and expects all service providers within the mental health system of care to provide services that are recovery-oriented. This expectation is supported through quality management and oversight of DMH-funded programs and support of regular training and educational events (e.g. conferences, WRAP training) promoting the concept of recovery.

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

Recovery support services for substance use disorders focus on the following: helping people find, maintain, and enhance their recovery experience through peer support, sober recreation, and educational opportunities. Vermont's recovery system includes 12 Recovery Centers located throughout Vermont, as well as a centralized Vermont Recovery Network (VRN).

A recovery center is a local, consumer driven, non-residential facility providing peer supports, sober recreation activities, volunteer opportunities, community education and/or recovery support services. Recovery centers provide non-clinical services that assist with establishing community connections that lead to employment, housing and other social supports in a safe, drug and alcohol -free environment. Recovery centers are committed to supporting a person's efforts in preventing relapse and should relapse occur, in quickly returning to recovery.

Recovery support services assist individuals in maintaining alcohol and drug free lifestyles with opportunities to improve their quality of life through age, gender, and culturally appropriate supports. Individual services revolve around the support from the Peer Recovery Coach, an individual in active recovery from substance use disorder who has gone through the Peer Recovery Coach training.

Recovery Centers offer several groups to support recovery such as:
-Evidence Based Practice (EBP) groups: Making Recovery Easier, Seeking Safety, Wellness Recovery Action Planning (WRAP)
-Community Groups: Yoga, Meditation, Acupuncture; age specific recovery groups; ongoing 12 Step meetings

Recovery centers support people in:
-seeking employment and education
-finding sustainable housing
-having healthier relationships
-developing their own physical, mental, and spiritual health
-other areas of recovery capital essential to the long road of recovery

The Vermont Recovery Network (VRN) is a non-profit organization that supports statewide recovery services through advocacy with the state government, seeking funding from local, state, and federal sources, supporting coordination of services amongst the centers, and maintaining the Vermont Recovery by-laws, which guide the practice of all the member centers.

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

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) received technical assistance through the SABG to assess the recovery system and determine strengths, innovations and best practices; challenges and growth opportunities; and recommendations. The assessment was conducted by two consultants, one from Georgia and one from Rhode Island, who conducted interviews with applicable stakeholders, performed a document review and produced a report. The VDH/ADAP hosted a meeting with recovery center and Vermont Recovery Network (VRN) representatives to review the report, solicit input and reach agreement on next steps. A program manager has been hired to oversee all Recovery Services, including but not limited to, systems change as recommended by the report, oversight of center grants, payment and evaluation of services.

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP), in collaboration with the Vermont Recovery Network (VRN), has implemented a program that places recovery support services in Emergency Departments. The primary purpose of the program is to dispatch peer recovery coaches from recovery centers to the Emergency Department in response to an individual presenting with an opioid overdose or diagnosis of substance use disorder, and to engage and support the individual in seeking treatment (and other services) upon discharge.

Another program that is underway in Chittenden County is the "New Mom's in Recovery" program. An infant and child friendly space in the recovery center for pregnant and parenting Moms has opened and has served over 30 women in the last six months. Services include peer recovery support groups and individual services, identification and referral to needed community services, telephone recovery services and referrals to prenatal services. Vermont will expand this program to three (3) additional recovery centers that have demonstrated the capacity and readiness for this program.

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

Vermont is not seeking technical assistance at this time.

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

Footnotes:

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?

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

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

Footnotes:

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 Congress[68] 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).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, 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.

[65]Centers 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.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department 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**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) understands that importance of integrating services across the system of care and carries this understanding to all aspects of working with service providers, communities and other state agencies/departments/offices. There are several state level groups charged with ensuring that the youth system of care is integrated, comprehensive and effective. VDH/ADAP
is an active member of these five groups:

Youth Services Advisory Council: has broad state agency and community partner representation and works to integrate and improve the full spectrum of youth services to achieve better outcomes for youth and young adults in Vermont.

State Interagency Team (SIT): composed of representatives from state agencies/departments/ offices and family representatives. The SIT recommends solutions for individual situations and develops solutions to challenges that occur across the system of care. The SIT also may make recommendations regarding fiscal policy or programmatic changes at the local, regional or state level necessary to enhance the state system of care for children, adolescents and families.

Vermont Reclaiming Futures Initiative: aims to enhance the ability of the juvenile justice system to identify and address substance use and mental health needs as early as possible; establish greater opportunities for youth, family, and community engagement;

and build on youth and family assets and strengths.

Children and Family Council: advises the Governor and legislature about issues related to the youth justice system, at-risk youth and prevention. The Council monitors Vermont's compliance with the Juvenile Justice Delinquency Prevention Act (JJDP) Act, including assuring the protection of youth involved with the justice system and addressing issues of racial and ethnic disparities. It promotes the use of evidence-informed and developmentally appropriate strategies when working with youth and families. The Council works to prevent young people from getting involved with the justice system.

Justice for Children Task Force: identifies barriers in the child welfare system that may keep foster children in foster care for longer than necessary. The Task Force works to remove these barriers and to increase the likelihood of children finding safe, permanent homes as quickly as possible.

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

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) supports the University of Vermont (UVM) Catamount Recovery Program Director, and UVM BASICS Program Coordinator in hosting bi-monthly community building, idea-sharing, and solution-oriented coalition meetings for Vermont college personnel who are responsible for addressing issues related to substance misuse on campus. Nine colleges participate in these half day meetings.
The VDH/ADAP continues to support training, implementation and piloting of Restorative Practice approaches in middle and high schools in Vermont to address substance use prevention and intervention.

The VDH/ADAP has expanded the School Based Substance Abuse Services grant to include the option to receive additional resources to implement universal screening in one or more grades in middle and high schools in Vermont.

The VDH/ADAP contributes funding to support substance use disorder screeners who accompany the Department for Children and Families social workers on visits to families with open cases where substance misuse is suspected. When a family member screens positive for substance misuse, the screener provides case management support to connect the family member with assessment and recommended treatment services with significant success.

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

Vermont is not seeking technical assistance at this time.

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

Footnotes:

In the last session, the Vermont legislature passed Act No. 82 (S.146). Human services; substance misuse prevention
https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT082/ACT082%20As%20Enacted.pdf
Hiring for the Chief Prevention Office and Manager of Substance Misuse Prevention are currently in process and committee membership is currently being determined.

An act relating to substance misuse prevention
This act consolidates the work of several substance-specific committees and boards into the newly established Substance Misuse Oversight and Advisory Committee, which is tasked with improving the health outcomes of all Vermonters through a holistic approach to substance misuse prevention that addresses all categories of substances. The Council shall be staffed by the Manager of Substance Misuse Prevention, who shall also be responsible for completing an inventory of substance misuse prevention programs in the State.
The act establishes the permanent position of Chief Prevention Officer within the Office of the Secretary of Administration. The Chief Prevention Officer shall coordinate across State government and in collaboration with community partners, policies, programs, and budgets to support and improve the well-being of all Vermonters through prevention efforts.
The act repeals the Tobacco Evaluation and Review Board and divides the responsibility of the Board between the Department of Health and the Substance Misuse Prevention Oversight and Advisory Council.
The act renames the Controlled Substances and Pain Management Advisory Council to be the Vermont Prescription Drug Advisory Council.
Effective Date: July 1, 2019

Membership. The agenda of the Council shall be determined by an executive committee composed of the following members:
(A) the Commissioner of Health or designee, who shall serve as chair;
(B) a community leader in the field of substance misuse prevention, appointed by the Governor, who shall serve as vice chair;
(C) the Secretary of Education or designee;
(D) the Commissioner of Public Safety or designee; and
(E) the Chief Prevention Officer

The members of the executive committee jointly shall appoint members to the Council with demographic and regional diversity. Members of the Council shall collectively offer expertise and experience in the categories listed below with the understanding that a single member may offer expertise and experience in multiple categories:
(A) at least two people with lived substance use disorder experience, including a person in recovery and a family member of a person in recovery;
(B) one or more youth less than 18 years of age;
(C) one or more young adults between 18 and 25 years of age;

(D) the Director of Trauma Prevention and Resilience Development
(E) persons with expertise in the following disciplines:
(i) substance misuse prevention in a professional setting;
(ii) pediatric care specific to substance misuse prevention or substance use disorder;
(iii) academic research pertaining to substance misuse prevention or behavioral addiction treatment;
(iv) education in a public school setting specific to substance misuse prevention;
(v) law enforcement with expertise in drug enforcement, addressing impaired driving, and community policing;
(vi) community outreach or collaboration in the field of substance misuse prevention;
(vii) the criminal justice system;
(viii) treatment of substance use disorder;
(ix) recovery from substance use disorder in a community setting;
(x) municipalities;
(xi) community-based, nonprofit youth services;
(xii) substance use disorder or substance misuse prevention within the older Vermonter population; and (xiii) comprehensive communications and media campaigns.

Environmental Factors and Plan

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)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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(A) at least two people with lived substance use disorder experience, including a person in recovery and a family member of a person in recovery;
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(v) law enforcement with expertise in drug enforcement, addressing impaired driving, and community policing;
(vi) community outreach or collaboration in the field of substance misuse prevention;
(vii) the criminal justice system;
(viii) treatment of substance use disorder;
(ix) recovery from substance use disorder in a community setting;
(x) municipalities;
(xi) community-based, nonprofit youth services;
(xii) substance use disorder or substance misuse prevention within the older Vermonter population; and (xiii) comprehensive communications and media campaigns.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* 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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(C) the Secretary of Education or designee;
(D) the Commissioner of Public Safety or designee; and
(E) the Chief Prevention Officer

The members of the executive committee jointly shall appoint members to the Council with demographic and regional diversity. Members of the Council shall collectively offer expertise and experience in the categories listed below with the understanding that a single member may offer expertise and experience in multiple categories:
(A) at least two people with lived substance use disorder experience, including a person in recovery and a family member of a person in recovery;
(B) one or more youth less than 18 years of age;
(C) one or more young adults between 18 and 25 years of age;
(D) the Director of Trauma Prevention and Resilience Development
(E) persons with expertise in the following disciplines:
(i) substance misuse prevention in a professional setting;
(ii) pediatric care specific to substance misuse prevention or substance use disorder;
(iii) academic research pertaining to substance misuse prevention or behavioral addiction treatment;
(iv) education in a public school setting specific to substance misuse prevention;
(v) law enforcement with expertise in drug enforcement, addressing impaired driving, and community policing;
(vi) community outreach or collaboration in the field of substance misuse prevention;
(vii) the criminal justice system;
(viii) treatment of substance use disorder;
(ix) recovery from substance use disorder in a community setting;
(x) municipalities;
(xi) community-based, nonprofit youth services;
(xii) substance use disorder or substance misuse prevention within the older Vermonter population; and (xiii) comprehensive communications and media campaigns.

Environmental Factors and Plan

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:	
c)	Other (e.g. public service announcements, print media)	○ Yes ◉ No

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

Footnotes: