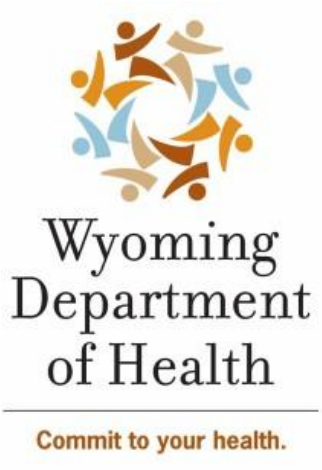

HealthStat 2016 Final Reports

December 15, 2016

HealthStat 2016: A Foreward

HealthStat is a performance management initiative that began in 2011. HealthStat is now entering its sixth year of implementation in the Wyoming Department of Health (WDH), and has progressed to a consistent and objective process by which department programs can be evaluated. Staff members have always known their programs, but now they have a method and a venue to regularly communicate with decision-makers that is clear and concise.

Through HealthStat, departmental leaders respond to program issues in an informed, timely, and coordinated fashion. It is hoped that the continued evolution of this culture of accountability will lead the WDH to greater heights in terms of effective and efficient program management. The work from the most recent year of this initiative is represented in the following pages.

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WDH | Division of Health Care Financing

Information contained in this section includes:

- Medicaid Overview
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- Medicaid Behavioral Health Program
- Medicaid Dental Program
- Medicaid Pharmacy Program
- Medicaid Third Party Liability
- Medication Donation Program
- Nursing Facilities
- Psychiatric Residential Treatment Facilities (PRTF)

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Wyoming Medicaid - Overall

Program Description

Medicaid is a federal-state partnership program established under Title XIX of the Social Security Act providing healthcare coverage for all low-income individuals and disabled individuals that meet eligibility criteria. Services consist of healthcare coverage as well as long-term care services and home and community based services for the elderly and individuals with disabilities. The primary populations served are children, pregnant women, extreme low-income caretakers of children, and the aged, blind, and disabled.

Program Expenditures and People Served

	SFY 2014	SFY 2015	SFY 2016
Total Claims Cost (millions)**	$514.5M	$519.5M	$554.6M
Average Monthly Enrollment (Member Months / 12)	70,355	74,472	66,696
Cost per Person (PMPM)	$609	$585	$669**

*Does not include Medicaid expenses not paid through the MMIS including administration, Medicare buy-in premiums, Medicaid Part D premiums, and provider taxes. Does not include non-Medicaid programs included in the DHCF budget and paid through MMIS including the Prescription Drug Assistance Program (PDAP) and other non-DHCF programs paid through the MMIS such as Children's Special Health.

**Value with a 3-month claim lag. PMPM increased from SFY 2015 to SFY 2016 due to more accurate eligibility determinations (reducing the number of member months), implementation of the Care Management Entity for mentally ill children ($5M), and an increasing home health and nursing home expenditures due to Wyoming's aging population.

Program Cost Notes

- Funded via federal match assistance percentage (FMAP) and state general funds. FMAP is as follows:
  - Claims: generally 50%, 90% for family planning
  - Administration: generally 50%, 75% for medical staff and direct eligibility determination staff
  - MMIS and WES operations and minor updates: 75%
  - Large technology replacements & system changes 90%
- Administration expenses have been 4% to 5.5% of total cost in recent years

Program Staffing

- 25 FT in Behavioral Health Division waivers
- 26 FT, 1 AWEC in Eligibility Unit
- 12 FT in Provider Services Unit
- 9 FT in Program Integrity Unit
- 6 FT, 3 AWEC in AIMS/WINGS Unit
- 6 FT in Medicaid Fiscal
- 7 FT in Medicaid Home Care Unit
- 3 FT, 2 AWEC in Health Management, THR, HIE
- 5 FT, 1 AWEC in Leadership & Administration
- Kid Care CHIP-3 FT
- Medication Donation- 2 FT (1.75 FTE), 1 temp.

Program Metrics

- Member Services- Eligibility, enrollment levels, benefit design.
- Ensuring client access to a robust provider network through adequate rate coverage and promoting provider participation in the Medicaid network.
- Cost of direct benefits such as total cost, Per Member Per Month cost and per recipient cost.
- Operational efficiency: administration cost, time to process claims, electronic vs. paper processes, error rates.
- Health care outcomes, emergency room usage, admission rates and readmission rates.

Events that have Shaped this Program

- Mandatory ACA changes including rules, processes, and the mandatory Medicaid expansion.
- Potential ACA changes such as the optional Medicaid expansion requiring significant research.
- Wyoming legislative studies and efforts including Medicaid Options Studies (2012), Medicaid Reform Bill (2013), and other legislative changes to the program.
- Major technology efforts including the Wyoming Eligibility System (WES), Eligibility Customer Service Center, Health Information Exchange (HIE), Total Health Record (THR), the Personal Health Record , MMIS ACA compliance, and the MMIS replacement project.

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Wyoming Medicaid – Members

PROGRAM CORE PURPOSE

Wyoming Medicaid provides uninsured eligible low-income, aged, or disabled individuals with comprehensive healthcare coverage.

OUTCOMES

Performance Metric	CY 2016 Target	CY2017 Target	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Estimated % / # of Uninsured Wyoming Children under Age 19, Under 138% of Federal Poverty Level (FPL) (2013 regional average** – 11.9%)	<5%	<5%	13.2% 4,242	10.4% 3,221	10.6% 3,332	N/A	N/A
Estimated % / # of Uninsured Wyoming Adults Age 18 to 64, Under 138% of FPL* (2013 regional average** – 37.3%)	N/A	N/A	39.2% 24,043	37.9% 22,437	33.1% 19,340	N/A	N/A
Estimated % / # of Uninsured Wyoming Children under Age 19, All Incomes* (2013 regional average** – 8.5%)	N/A	N/A	9.2% 12,846	7.1% 10,049	6.7% 9,503	N/A	N/A
Estimated % / # of Uninsured Wyoming Adults Age 18 to 64, All Incomes* (2013 regional average** – 19.3%)	<16% by 2018 (WDH Strategic Plan)	<16% by 2018 (WDH Strategic Plan)	20.4% 72,616	19.3% 68,779	17.1% 60,856	N/A	N/A
Average Months of Member Enrollment per year (overall)	10	10	9.35	9.30	9.53	9.85	9.17

* US Census Small Area Health Insurance Estimates (SAHIE). http://www.census.gov/did/www/sahie/data/interactive
** Region is defined as bordering states of Montana, Colorado, Idaho, South Dakota, Utah, and Nebraska. Wyoming is excluded from the regional calculation.
(-) Indicates data not yet available
N/A indicates data not yet available. CY 2015 SAHIE data is scheduled for release in early 2017.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Enrolled Members (unique count, complete SFY)*	89,328	89,684	88,642	91,062	88,775	N/A*	N/A*	N/A*	N/A*
% of State Population Enrolled in Medicaid[1]	15.5% (577,080)	15.4% (583,131)	15.2% (584,304)	15.5% (586,107)	-	N/A*	N/A*	N/A*	N/A*
Member Months	835,267	833,648	844,694	896,103	609,974	N/A*	N/A*	N/A*	N/A*
Average Monthly Enrollment	69,610	69,479	70,389	74,628	66,696	N/A*	N/A*	N/A*	N/A*
Recipients (unique count of members who used at least one service)	73,835	73,776	72,658	74,041	66,598	N/A*	N/A*	N/A*	N/A*

* Beginning with the SFY2016 report, enrollment is now calculated using data from the DSS (via the COGNOS system), rather than from the MMIS (via the COLD system). All years have been updated using the new system to ensure comparability.
[1] For individuals enrolled at any time during the SFY compared to population as of the start of the SFY (July 1). Population source: US Census. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2015 (NST-EST2015-01).
(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Wyoming Medicaid provides a comprehensive benefit package to eligible and enrolled members. These include benefits similar to the 10 essential health benefits of the ACA, as well as vision and dental. *Vision and Dental coverage for adults was eliminated beginning in SFY 2017 due to budget reductions.* This primary benefit package is available to all full-benefit enrollees (children, pregnant women, disabled, aged, and family care adults) and is similar but more extensive than the type of benefits traditionally associated with private health insurance. For some members, such as the Medicare Buy-in group, Wyoming Medicaid only pays the premiums for those individuals to enroll in Medicare but does not directly pay claims. Limited or emergency services are provided to some smaller groups such as non-citizens. For most individuals enrolled in Medicaid, the actuarial value of the primary medical benefit package coverage is 95% to 100%.

- In addition, for members meeting certain additional standards of need, Wyoming Medicaid also covers institutional levels of care such as hospice, nursing homes, and intermediate care facilities. As an alternative to individuals meeting institutional level of care need, Wyoming Medicaid also provides home and community based support services through waivers to support individuals staying in their homes and communities. These types of services have not traditionally been covered by other forms of insurance.

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Wyoming Medicaid – Financial Stewardship

PROGRAM CORE PURPOSE

Wyoming Medicaid provides health insurance coverage for qualified low-income individuals at a stable cost that is lower or comparable to appropriate benchmarks.

OUTCOMES

Performance Metric		SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016*
Per Member Per Month (PMPM)		$600	$540	$610*	$616	$609	$585	$662
Children PMPM	Children**	$190	$171	$172	$184	$190	$190	$207
	Foster Care Children	$600	$540	$543	$600	$648	$605	$551
	Newborns	$625	$563	$664	$650	$624	$655	$610
Non-Disabled Adults PMPM	Family-Care Adults**	$450	$405	$486	$466	$459	$436	$436
	Pregnant Women***	$800	$720	$1,057	$1,069	$929	$761	$969
Aged Individuals PMPM	Assisted Living Facility	$1,800	$1,620	$1,722	$1,698	$1,744	$1,809	$1,851
	Long-Term Care Waiver	$1,600	$1,440	$1,809	$1,676	$1,647	$1,641	$1,674
	Nursing Home	$4,000	$3,600	$3,869	$3,842	$3,782	$3,790	$4,313
	PACE	$2,500	$2,250	N/A	$2,516	$2,504	$2,483	$2,428
Disabled Individuals PMPM	Acquired Brain Injury	$4,000	$3,600	$3,915	$4,121	$4,133	$4,173	$3,808
	Adults with ID/DD	$5,300	$4,770	$5,724	$5,641	$5,485	$5,243	$5,399
	Children with ID/DD	$2,450	$2,205	$2,368	$2,466	$2,402	$2,491	$2,539
	Suppl. Security Income SSI	$725	$653	$705	$685	$737	$733	$755

* Includes manual adjustments for ICF-ID WY Life Resource Center expenditures
** Kid Care Chip premium for SFY 2016 is $237 (Plan A) and 2016 Marketplace premium is $525 (lowest price gold plan with $1000 deductible and $6350 max out of pocket)
*** Excludes Presumptive Eligibility

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Recipients (unique count of members who received services)	73,833	73,771	72,646	73,741	72,546	N/A*	N/A*	N/A*	N/A*
Enrollment	88,134	87,946	86,188	89,252	88,775	N/A*	N/A*	N/A*	N/A*
Member Months	837,403	834,792	844,262	893,666	813,625	N/A*	N/A*	N/A*	N/A*
Claims Expenditures(M)*	$511.7**	$513.9	$514.5	$519.5	$538.6	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per Recipient	$6,804	$6,965	$7,083	$7,045	$7,424	N/A*	N/A*	N/A*	N/A*
Cost per Enrolled Member	$5,700	$5,843	$5,970	$5,820	$6,067	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
* All expenditures in outputs are in millions.
** Includes manual adjustments for ICF-ID WY Life Resource Center expenditures
*** Excludes Presumptive Eligibility

STORY BEHIND THE PERFORMANCE

- The Per Member Per Month (PMPM) calculates the average cost of a member per month. PMPM = (Claims Expenditures / Member Months). The PMPM is based on claims only, and does not include administration costs, Disproportionate Share Hospital, Qualified Rate Adjustment, provider tax, or Electronic Health Record provider incentive payments. Member months are the number of months a person is eligible and enrolled in Medicaid. Both measures are intended to allow better comparison of costs with other Medicaid programs, private insurance, and other premium based Programs.

- During SFY 2014 two new waivers were created, the Comprehensive Waiver and the Supports Waiver, to replace the Adult Developmentally Disabled (DD), Child DD, and Acquired Brain Injury (ABI) waivers. Members of the Adult DD waiver completed transitioning to the two new waivers by September 30, 2014, with transitions of Child DD occurring by June 30, 2015. ABI transition is planned for SFY 2017. To ensure accurate performance management of these populations over time, the data for ABI, Adults with ID/DD, and Children with ID/DD in this report includes both the original eligibility programs and the associated Comprehensive and Supports eligibility programs.

- Per capita spending on healthcare in Wyoming was $7,040 in 2009. This equates to $586.66 per month. More recent data was not available. Online: http://kff.org/other/state-indicator/health-spending-per-capita/

- Potential valid benchmark for the children population would be:

    - The Wyoming Kid Care Chip program. Kid Care Plan A does not have copays and had a premium cost of $236.90 in SFY 2016.

    - The least expensive 80% actuarial value Marketplace plan (BlueSelect Gold Basic) for a Wyoming child (ages 0-18) was $261 per month in 2016 in Laramie County with a $1,000 deductible and $6,350 maximum out of pocket. Online: https://www.healthcare.gov/see-plans/#/plan/results

- A potential benchmark for the family care adult population could be a 2016 Marketplace plan for Wyoming. In Laramie County, the least expensive 80% actuarial value plan (BlueSelect Gold Basic) had a $525 monthly premium for a 40-year old with a $1,000 deductible and $6,350 maximum out of pocket. Online: https://www.healthcare.gov/see-plans/#/plan/results

- The target for all SFY 2017 PMPMs is a reduction of 10%, to reflect statewide budget reductions.

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Wyoming Medicaid – Provider Network

PROGRAM CORE PURPOSE

Wyoming Medicaid ensures client access to a quality, cost-effective healthcare provider network through the management of provider enrollment and reimbursement. 42 U.S.C § 1396a(a)(30)(A) requires states to *"assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."*

OUTCOMES – PROVIDER ENROLLMENT

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of licensed & practicing physicians enrolled # of physicians enrolled (in-state / out-of-state)	99%+	99%+	99-100% (est.) 1,655 in 5,717 out	99-100% (est.) 1,658 in 6,016 out	99-100% (est.) 1,671 in 6,552 out	99-100% (est.) 1,800 in 7,664 out	99% + (est.) 1,891 in 7,472 out
% of in-state nursing facilities enrolled # nursing facilities enrolled (in-state / out-of-state)*	100%	100%	100% 37 in 12 out	100% 37 in 13 out	100% 39 in 15 out	100% 55 in 21 out	100% 55 in 19 out
% of in-state hospitals enrolled** # hospitals enrolled (in-state / out-of-state)	100%	100%	100% 28 in 330 out	100% 28 in 333 out	100% 29 in 331 out	100% 30 in 279 out	100% 31 in 270 out
% of in-state pharmacies enrolled # pharmacies enrolled (in-state / out-of-state)	>95%	>95%	N/A 122 in 103 out	N/A 124 in 82 out	86% (est.) 127 in 90 out	95%*** (est.) 131 in 97 out	98.5% 131 in 93 out
% of in-state licensed & practicing dentists enrolled # of dental providers enrolled (in-state / out-of-state)	>85%	>85%	N/A 280 in 134 out	N/A 287 in 131 out	76% 300 in 137 out	78% 324 in 131 out	79% 327 in 143 out

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
* includes swing beds
**31 licensed by OHLS in 2016
***Metric updated to reflect % enrollment of pharmacies licensed and able to enroll with Medicaid

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
Physician rates as a % of the regional average and a % of the Medicare rate	133% 138%	134% 122%	121% 92% & 104%*	111% 98%	-	N/A	N/A	N/A	N/A
Nursing facilities % cost coverage with the upper payment limit (UPL)**	92%	89%	87%	83%	91%	N/A	N/A	N/A	N/A
Hospital % cost coverage with the qualified rate adjustment (QRA)*** (inpatient & outpatient)****	90% 66%	85% 71%	83% 67%	85% 68%	-	N/A	N/A	N/A	N/A
Dental rates as a % of the regional average and a % of the estimated provider cost*****	124% 107%	132% 107%	117% 96%	94% 88%	-	N/A	N/A	N/A	N/A
% of hospital inpatient days paid by Medicaid	15.42%	15.28%	15.89%	13.41%	-	N/A	N/A	N/A	N/A
EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
Payment of claims (days): Provider billing process + State payment process = Service date to Payment date	28.9 + 4.4 = 33.3	27.9 + 4.2 = 32.1	26.9 + 4.4 = 31.3	27.38 + 4.63 = 32	29.15 + 4.15 = 33.3	27.3 + 4.9 = 32.2	27.45 + 4.35 = 31.8	28.1 + 4.3 = 32.4	30.2 + 4.0 = 34.25
% of all claims denied	11.38%	10.45%	9.65%	10.63%	12.9 %	11.3%	9.95%	12.4%	13.4%

(-) Indicates data not yet available
N/A indicates data not available on a quarterly basis
* 92% non-facility, 104% facility
** UPL implemented mid-year 2011; data is collected by FFY
*** QRA participating hospitals only; data is collected by FFY
**** in-state hospitals only
***** Based on the 2013 ADA Survey of Dental Fees and Expenses

STORY BEHIND THE PERFORMANCE

- On an annual basis, Medicaid's actuarial contractor produces a benchmark report, detailing Medicaid's expenditure and reimbursement trends throughout the previous fiscal year. The Department calculates Wyoming Medicaid rates in each service area as a percentage of other states' Medicaid rates, Medicare rates, and cost estimates, as possible. The SFY2015 Benchmark report outlines data supporting the following:
  - Wyoming Medicaid generally pays higher than Medicaid programs in surrounding states, with rate benchmarks ranging from 92% of regional state payments for laboratory services to 214% of regional state payments for optician and optometry services.
  - In SFY 2015, Wyoming Medicaid rates continued to meet or exceed the Medicaid rates in most neighboring states
  - In SFY 2015, Wyoming Medicaid rates as a percentage of Medicare's ranged from 66% for home health services to 99% for hospice services.
- While Medicaid strives to meet the direction set forth in 42 U.S.C. § 1396a(a)(30)(A), there are federal regulations regarding the upper payment limitations of Medicaid payments for hospital, physician, prescription drugs, and laboratory services. For inpatient hospital services, Medicaid cannot exceed the provider's customary charges (42 CFR 447.271). For hospitals that do not receive disproportionate share hospital (DSH) supplemental payments, Medicaid payment cannot exceed a reasonable estimate of what Medicare would have paid (42 CFR 447.272). For outpatient hospital and clinic services, again Medicaid payment cannot exceed a reasonable estimate of what Medicare would have paid.
- SF89 – Legislation passed in March of 2014 allowing specified licensed mental health professionals to enroll with Medicaid as pay-to-provider exclusive of supervisory oversight. MMIS system changes were completed and deployed effective July, 2014 allowing enrollment and direct billing to Medicaid. During the 2015 General Session, SEA 21 also added provisionally licensed mental health professionals as a qualified provider type for Medicaid.
- 2015 General Legislative Session approved an increase in nursing facility reimbursement with an appropriation of $8,414,886. This resulted in the implementation of a new rate model and increased rates effective July 1, 2015. Hospice and swing bed rates, being tied to the state average nursing facility rate, were adjusted accordingly. Methodology caps placed on the Wyoming Retirement Center and the Wyoming Life Resource Center were removed and both state-owned facilities' rates adjusted to 100% of reported cost.
- Legislation in the 2015 General Session added chiropractic services to the Medicaid State Plan. Legislation in the 2016 Budget Session added independently practicing licensed dietitians to the Medicaid State Plan.
- Subpart E requirements of the ACA mandate Medicaid enrollment for all ordering (including prescribing) and rendering providers. This will require additional lower level practitioners who had not previously been Medicaid-enrolled to enroll before March 24, 2015.
- Other provider participation initiatives that impacted enrollment, eligibility, and claims denial rates in SFY 2016 include: 1) Mandatory re-enrollment, 2) ICD-10 implementation on October 1, 2015, 3) Electronic claims mandate implemented July 1, 2015, and 4) Mandatory inclusion of the ordering, referring, prescribing, and attending provider on all claim types in preparation for changes effective July 1, 2016 when all ordering, referring, prescribing, and attending providers must be enrolled with Medicaid.

Medicaid - Electronic Health Record Incentive

Program Description

The Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to Eligible Healthcare Professionals (EPs) and Eligible Hospitals (EHs) to Adopt, Implement, and Upgrade to EHR. This includes using the EHR technology in a meaningful way (Meaningful Use (MU)), with the ultimate goal of improving patient care and outcomes.

Program Expenditures and People Served

	CY2014	CY2015	CY2016*
Total Program Cost	$3,815,811	$5,054,090	$6,024,000
Total Amount Paid in Incentives	$3,285,714	$3,311,780	$972,185
Non 600 Series**	13.9%	34.5%	-

* As of July 31, 2015
**600 series are defined as direct service contracts
(-) Indicates data not yet available

Program Cost Notes

- Incentive payments are 100% Federal Funded.
- Professionals are paid over 6 years
  - Yr. 1 - $21,250 Yr. 2 – 6 - $8,500
- Hospital incentive payments are calculated using the most recent 12 month cost report. The total incentive amount is divided into 3 payments based on the amount calculated in the first year in the program
  - Yr. 1 – 50% Yr. 2 – 40% Yr. 3 – 10%
- Program Administration is a 90/10 Federal match

Program Staffing

- 1 FTE
- 1.5 AWEC
- Other – Contractors – Health Tech Solutions (EHR System) and Myers and Stauffer (MU audits)

Program Metrics

- Estimated 250 Wyoming professionals and 27 hospitals could be eligible to participate in the program.
- Currently 159 Wyoming professionals and 23 hospitals are registered for the EHR Incentive Program
- Total amount of incentive payments since program inception: $20,779,966.15.
  - Total paid for Adopt/Implement/Upgrade: $3,237,083
  - Total paid for MU: $17,542,882
- Myers and Stauffer contracted to complete post payment audits for Adopt/Implement/Upgrade and MU
- Wyoming has chosen to accept CMS hospital audits for MU.
- 3 payment recoupments from professionals have been made due to inability to provide adequate attestation documentation to the auditors.

Events that have Shaped this Program

- The program launched in Dec. 2011 with Adopt/Implement/Upgrade incentives. Eligibility requirements include that the provider must be using a certified EHR and must meet the Medicaid volume of 30% (20% for pediatricians) in a consecutive 90 day reporting period from the previous year.
- Aug. 2012: Launch of Stage 1 Meaningful Use. Eligibility requires the use of EHRs in a meaningful way by capturing patient data electronically.
- Jan 2014: Launch Stage 2 Meaningful Use. Eligibility requires electronic reporting to the State.
- December 2016: Last year for providers to register for the incentive program and attest for AIU.
- Stage 3: Pending final approval for Stage 3. Eligibility will require the ability to track improvement electronically.
- Dec. 2021: Program ends.

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Medicaid - Electronic Health Record Incentive

PROGRAM CORE PURPOSE

The Electronic Health Record (EHR) Incentive Program's purpose is to guide Wyoming's Eligible Professionals (EPs) and Eligible Hospitals (EHs) through the progressive stages of implementing the electronic exchange of medical information in a meaningful way (MU), with the goal of improving patient care and overall healthcare outcomes.

OUTCOMES

Performance Metric	CY 2016 Target	CY 2017 Target	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
% of EPs Returning to Attest for Meaningful Use (cumulative)	45%	40%	44%	42%	73%	28%	42%
% EHs Returning to Attest for Meaningful Use (cumulative)	100%	100%	70%	64%	113%**	92%	50%
Public Health Connections EPs/EHs	10	30	0	2	7	10	50

** EPs/EHs have the option to skip a year of reporting

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016*
OUTPUTS					
Adopt/Implement/Upgrade (AIU) - Total Number of Eligible Professionals (EP) paid	40 EP	45 EP	18 EP	8 EP	6 EP
Stage 1 – Year 1 Total Number of EPs / EHs paid per CY	13 EP 7 EH	16 EP 6 EH	34 EP 0 EH	1 EP 0 EH	4 EP 0 EH
Stage 1 – Year 2 Total Number of EPs / EHs paid per CY	0 EP 7 EH	6 EP 4 EH	13 EP 12 EH	14 EP 0 EH	7 EP 0 EH
Stage 2 – Year 1 Total Number of EPs / EHs paid per CY	0 EP 0 EH	0 EP 5 EH	2 EP 5 EH	4 EP 11 EH	4 EP 1 EH
Total Number of EPs / EHs completed Medicaid EHR Incentive Program reporting requirements and received 100% of Medicaid Incentive dollars	N/A	0 EP 5 EH	0 EP 5 EH	0 EP 11 EH	0 EP 1 EH
Public Health Connections EPs/EHs	0	2	7	10	50
EFFICIENCIES					
% of Program Cost for Incentive Payments	84%	75%	65%	64%	19%
Recoupment of payments based on post-payment audits	2	1	0	0	0

* As of July 31, 2016
N/A indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- To date, 23 eligible hospitals have been paid $16,599,382.81 for an average of $721,712.29 per EH; 155 eligible professionals have been paid $4,200,583.34 for an average of $27,100.53 per EP.
- Total incentive payments paid to date: $20,779,966.15.
- This program is funded by the American Recovery and Reinvestment Act (ARRA), 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act.
- Eligible Professionals in this program includes physicians, dentists, mid-levels, and eligible physician assistants. Eligibility is determined by Medicaid patient volume and use of certified electronic health records.
- Outreach for this program includes face to face onsite visits to provider offices, email blasts on upcoming webinars and new information from CMS, surveys for amount of knowledge on the program, and follow up phone calls to answer any additional questions. The Program also assists providers on the registration process, reporting, and attestation.

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Eligibility Customer Service & Call Center

Program Description

The Wyoming Department of Health Customer Service Center determines eligibility for Modified Adjusted Gross Income (MAGI) programs, including Medicaid children, low-income adults, pregnant women, and 77Kid Care CHIP, as well as Medicare Saving Programs, Employed Individuals with Disabilities (EID), Breast and Cervical Cancer (BCC), and Tuberculosis. Applications and renewals are taken via telephone, online, fax, email, walk-ins, and mailed in hard copies.

Telephone Processing

	Jan 2015*	July 2015*	June 2016*
Number of Calls (in month)	11,929	11,948	9,612
Average Speed to Answer (minutes)	29.1	23.2	5.5
Average Application Processing Time (days)	11	15.5	6.5

* Point in time shown due to rapid change over short time period.

Cost Notes

- 75% Federal match on the cost of staffing the Customer Service Center
- Monthly Customer Service Center operations cost is $384,000

Staffing

- 36 FTE (contractor)
- 0 AWEC
- 4 Other (temporary employees with contractor)

Program Metrics

- Average total monthly call volume: 11,731 for July 1, 2015, through June 30, 2016, with August 2015 being the highest at 14,914 calls that month.
- Average speed to answer in July 2015 was 23.2 minutes, but for the month of June 2016, that decreased to 5.5 minutes.
- Average application processing time has been as low as 1 day; for the month of June 2016, the average was 5.5 days.

Events that have Shaped this Program

- Original staffing level under the Northrop Grumman contract was 26 FTE on October 1, 2013 (soft launch date).
- Surge staff was added to reduce a backlog of applications and renewals in August of 2014.
- Permanent staff positions were added through a contract amendment in June of 2015, and the staffing budget is now based on a contractual Level of Effort.
- With increased staffing, application processing time improved and call volume related to application processing decreased.
- As of October 1, 2016 Northrop Grumman was replaced by Deloitte Consulting LLP for the System contract and Maximus Health Services, Inc. for the Customer Service Center.

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Eligibility Customer Service & Call Center

PROGRAM CORE PURPOSE

The Wyoming Department of Health Customer Service Center answers eligibility requests quickly, processes Medicaid and Kid Care CHIP applications efficiently, and provides excellent customer service.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Average Speed to Answer (minutes)	<10	<10	N/A	N/A	N/A	22.54	10.90
Client Satisfaction Survey Results (1 to 5, with 5 Being Most satisfactory).	>4.3	>4.6	N/A	N/A	N/A	4.26*	4.52*
Average Processing Time for New Application (days)	**<10**	**<10**	N/A	N/A	N/A	10.24 (July 2015)	6.5 (June 2016)

* 489 Customer Satisfaction Surveys completed in SFY 2015; 609 Customer Satisfaction Surveys completed in SFY 2016
N/A indicates data not available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# Processed of: New Applications (A) Renewals (R) Total (T)	N/A	N/A	N/A	8,883 A 10,740 R 19,623 T*	22,591 A 22,413 R 45,004 T	4.540 A 5,296 R 9.836 T	4,343 A 5,444 R 9,787 T	11,117 A 10,998 R 22,115T	11,474 A 11,415 R 22,889 T
Total Call Volume	N/A	N/A	N/A	108,965	140,769	55,193	53,772	71,189	69,580
EFFICIENCIES									
Average Handle Time (minutes)	N/A	N/A	N/A	11.1	12.65	10.5	11.4	12.7	12.6
# of Abandoned Calls and Abandonment Rate**	N/A	N/A	N/A	40,447 37%	25,533 24%	18,143 33%	22,304 42%	16,261 30%	9,272 18%

* Partial numbers reported in SFY 2015
**Abandonment rate does not include outbound calls
N/A indicates data not available

STORY BEHIND THE PERFORMANCE

- The Customer Service Center (CSC) opened on October 1, 2013.
- The CSC was co-located with State Staff in the Century Link Building, Cheyenne until 9/30/2016.
- Normal business hours of the CSC are 7:00AM to 6:00PM (MST) Monday through Friday (excluding State holidays).
- As of February 2014, all of the Medicaid and Kid Care CHIP eligibility determinations are being processed through the WDH Customer Service Center (CSC) and the Medicaid Long Term Care Eligibility Unit. These functions transitioned from 29 DFS field offices to centralized Medicaid eligibility processing to promote consistent policy decisions.
- Eligibility rules for Medicaid and Kid Care CHIP programs are built into the rules engine of the Wyoming Eligibility System (WES) which is utilized by the Customer Service Center.
- The WES is 98% functional as of October 1, 2016, but much of the missing functionality is what is needed to determine eligibility in a truly no-touch manner, e.g. electronically.
- On July 1, 2016, Deloitte Consulting LLP and Maximus Health Services Inc. began a three month transitionary period in preparation for replacing the existing vendor, Northrop Grumman. The Northrop Grumman contract for the system and the Customer Service Center expired on September 30, 2016. As of October 1, 2016, Deloitte became the system vendor and Maximus the Customer Service Center vendor.
- The WES/CSC Contract Manager is currently closely monitoring both vendors to verify that deliverables are of high quality and all service level agreements (SLAs) are met or exceeded in performance.

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Medicaid Long Term Care Eligibility Unit

Program Description

The Medicaid Long Term Care Eligibility Unit determines financial eligibility for Community Choice Waivers, Comprehensive Waiver, Support Waiver, Acquired Brain Injury Waiver, Children's Mental Health Waiver, Program of All-Inclusive Care for the Elderly (PACE), Nursing Home, Inpatient Hospital, and Hospice. Applications and renewals are taken via telephone, online, fax, email, walk-ins, and mailed hard copies.

Program Expenditures and People Served

	SFY 2014	SFY 2015	SFY 2016
Cost of Operations	N/A	$1,108,931	$1,662,309
Average Monthly Enrollment	N/A	5,966	6,376
Cost per Person	N/A	$185.88	$260.71
Non-600 Series*	N/A	100%	100%

N/A indicates data not available due to the creation of a new program

* 600 series is defined as direct service contracts.

Program Cost Notes

- 75% Federal match on the cost of employees completing eligibility work.

Program Staffing

- 16 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Average monthly case enrollment and average cases per worker monthly have increased from SFY 2015 to SFY 2016.
- Average application processing time for approvals is 20.35 days and for denials is 23.34 days.
- Average processing time for renewal approvals is 4.01 days and for denials is 15.68 days.

Events that have Shaped this Program

- From August 2012 through April 2013 the Department of Family Services (DFS) transferred 12 positions to WDH for the creation of the Long Term Care Unit and WDH supplied the other positions for the unit.
- In August of 2012, the Long Term Care Unit began transitioning cases from DFS starting with Albany, Laramie, and Platte counties.
- From August 2012 through May of 2013, the Long Term Care Unit transitioned cases from different areas of the state until all Long Term Cases were housed in the Long Term Care Unit.
- Centralizing the Long Term Care Unit has helped streamline processes and provided consistency statewide.
- Centralizing the Long Term Care Unit has improved coordination with the WDH entities that provide medical necessity screening and case management services.

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Medicaid Long Term Care Eligibility Unit

PROGRAM CORE PURPOSE

The Medicaid Long Term Care Eligibility Unit conducts eligibility functions for the Medicaid Long Term Care programs efficiently, timely, and accurately while providing excellent customer service.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015*	SFY 2016
Average processing time for new application approvals (days)	<45	<45	N/A	N/A	N/A	20.98	20.35
Average processing time for new application denials (days)	<45	<45	N/A	N/A	N/A	22.87	23.34
Average processing time for renewal approvals (days)	<30	<30	N/A	N/A	N/A	8.41	4.01
Average processing time for renewal denials. (days)	<30	<30	N/A	N/A	N/A	18.24	15.68

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric or change in metric
* Data is from March 2015 through June 2015

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Average # of new Applications processed monthly	N/A	N/A	N/A	132	152	130	134	139	165
% of new Applications denied monthly	N/A	N/A	N/A	38%*	33%	N/A*	38%*	35%	31%
Average # of Renewals processed monthly	N/A	N/A	N/A	305	325	303	308	302	348
% of renewals closed monthly	N/A	N/A	N/A	3%*	2%	N/A*	3%*	2%	2%
EFFICIENCIES									
Average number of active cases per month	N/A	N/A	5,519	5,966	6,376	5,907	6,026	6,285	6,466
Average number of active cases per worker	N/A	N/A	587	597	633	591	603	629	637

(-) Indicates data not yet available
N/A indicates data not available
N/A* indicates data not available on a quarterly basis
* Data for applications and renewals are from March 2015 through June 2015

STORY BEHIND THE PERFORMANCE

- The Long Term Care Unit started operations August 1, 2012.
- All Long Term Care cases in Wyoming are processed by the unit as of May 2013. This has allowed for centralized Long Term Care eligibility processing to promote consistent eligibility determinations.
- As of February 2014, cases were converted from the Eligibility Payment Information Computer System (EPICS) at the Department of Family Services to the Wyoming Eligibility System (WES) at the Department of Health.
- As of April 2014, caseload management tools became available in WES. These tools allow workers to run their active caseload, cases not authorized, cases not finalized, cases that are pending and renewal reports. Workers are required to run these reports weekly to ensure cases are worked timely and accurately. The supervisors and manager also run these reports as a quality assurance (QA) function.
- The supervisors and manager track the number of cases in the unit as well as average caseload per worker to ensure that cases are evenly distributed across the unit.
- New staff are provided with extensive training before they are given a caseload. They are provided one on one training on policy and procedures, how to interview clients, how to document cases, customer service, WES, EMWS, HIPAA, and Administrative Hearings, and go through a series of training modules on WY Train. They also attend the department new employee training.
- Ongoing training for all staff occurs during weekly meetings. Training is conducted for new policy and procedures, ongoing policy and procedure questions or clarifications, and areas identified through QA processes that need to be addressed.
- The number of average monthly cases has increased from SFY 2015 to SFY 2016. Some of the increase is due to changes in waiver programs and an appropriation to reduce the wait list and an increase in individuals in PACE. Increases are also due to the number of people applying who are found eligible.
- The Long Term Care Unit has a toll free number for clients, providers, and others to call. Individuals will get a staff member to speak with on the phone without a wait time. The only time individuals would need to leave a message is if all staff are in a meeting or it is outside of office hours. Calls are returned within 24 business hours if a message is left.

Kid Care CHIP

Program Description

The Wyoming Children's Health Insurance Program (CHIP) is a public/private partnership between the Wyoming Department of Health and a private insurance company to provide medical, vision, and dental insurance to all CHIP enrolled children. CHIP is intended for low-income, uninsured children between birth and eighteen years of age living in families with income up to 200% of the Federal Poverty Level. CHIP is jointly financed by the Federal and State government with 88% Federal match and 12% coming from the State General Fund.

Program Expenditures and People Served

	2013	2014	2015	2016*
Total Program Cost	$16,106,809	$14,439,334	$10,525,605	$10,423,309
People Served**	5,538	5,209	2,898	3,540
Cost per Person	$2,762	$2,772	$2,890	$2,944****
Non-600 Series***	5.2%	4.2%	7.7%	6.3%

*2016 is year-to-date. Providers have 12 months to submit claims.
**Average monthly enrollment.
***600 series is defined as direct service contracts.
****Average total cost per member per month is $245.37 (premiums, administration, supplemental payments) and the amount paid per member per month in medical and dental services (BCBS, Delta Dental) is $184.89.

Program Cost Notes

- Per Member Per Month (PMPM) premium price increased 3.98% from 2015/2016 to 2016/2017.
- Prescription drug charges increased by 9% from 2015 to 2016.
- Institutional charges increased by less than 2% from 2015 to 2016.
- Utilization rate decreased by 5.4% from 2014/2015 to 2016/2017; mostly in mental health provider (office), outpatient surgery and hospital emergency rooms.

Program Staffing

- 3 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Kid Care CHIP families do not pay a premium but do pay a minimal co-pay for services, except for well child checks, immunizations, and preventive and diagnostic dental for which there is no co-pay. A single families' out of pocket expenses has never exceeded 5% of the family gross annual income.
- The bulk of Kid Care CHIP enrollment, 46%, is between the ages of 7 and 13, while children 16 – 23 months of age consume the highest percentage of CHIP benefit services.

Events that have Shaped this Program

- Since its inception in 1997, CHIP has been reauthorized three times, most recently in April 2015. Currently, CHIP is funded through September 30, 2017 and authorized to September 30, 2019.
- In 2001 the WY Legislature and the WY Department of Health made the decision for Kid Care CHIP to be a public/private partnership with a private insurer to oversee the benefit and claims administration of CHIP. Every three years since 1999 a Request for Proposal has been issued for the benefit and claims administration duties.
- In 2007 and 2009 Kid Care CHIP received CMS Outreach grants that allowed significant dollars to be spent to raise statewide awareness, leverage enrollment opportunities, and sustain interest and support for the program.
- The Affordable Care Act of 2010 brought the introduction of the streamlined application, the centralized Customer Service Center, and mandated new income guidelines for Medicaid children resulting in 1,251 CHIP children being transitioned to Medicaid.

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Kid Care CHIP

PROGRAM CORE PURPOSE

Kid Care CHIP (Children's Health Insurance Program) makes available to eligible Wyoming children affordable health insurance and a comprehensive network of providers while overseeing the eligibility and enrollment process. CHIP is intended for low-income children whose families do not qualify for Medicaid but cannot afford private health insurance.

OUTCOMES

Performance Metric		SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
# of children enrolled (monthly average)		3,200	3,575	5,538	5,831	4,464	2,989	3,540
# and % of Wyoming medical providers in network		94%	94%	1,254 93%	1,276 93%	1,222 94%	1,128 94%	1,014 93%
# and % of Wyoming dental providers in network		80%	80%	204 80%	200 80%	203 71.5%	210 76.4%	215 78.5%
# and % of children with at least 1 primary care provider appointment		54%	54%	4,301 49%	4,450 50.5%	3,476 44.9%	2,153 41.9%	2,311 39.9%
# and % of children receiving services	medical	74%	74%	6,273 72%	6,534 74.2%	5,327 68.6%	3,490 66.9%	3,892 66.6%
	dental	52%	52%	4,282 58%	4,316 52%	3,634 53%	3,984 52%	2,833 49%

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Total unique enrollment	8,724	8,841	5,864	7,418	7,638	3,683	3,735	3,774	3,864
# of Core Set of Children's Health Care Quality Measures Reported*	5 N/A 12 yes 4 no	5 N/A 7 yes 8 no	5 N/A 11 yes 4 no	6 N/A 15 yes 3 no	-	N/A*	N/A*	N/A*	N/A*
CAHPS positive responses regarding providers & healthcare** (1) Customer service (2) Getting care needed (3) Getting care quickly (4) Dr. communicating well	N/A	N/A	N/A	87.85% 93.32% 95.41% 94.87%	92.05% 90.75% 94.22% 98.50%	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Unit cost per outreach/ impression ($)	N/A	N/A	N/A	0.01	0.07	N/A	0.01	N/A	0.07

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis
* Count of N/A indicates the number of measures not applicable for Wyoming
** 181 of 678 surveys completed 27.63% response rate

STORY BEHIND THE PERFORMANCE

Reducing the Number of Uninsured Children*

- An estimated 1,781 children remain uninsured in the CHIP age and income category: under 19 years of age with family income of 138% to 200% FPL (2014). Previously, approximately 1,943 children in this age/income category were uninsured (2013).
- An estimated 5,113 children under 19 years of age with family income below 200% FPL remain uninsured. (2014). Previously, approximately 5,164 children in this age/income category were uninsured (2013).

Enrollment and CHIP Family Demographics**

- Fifty-eight percent (58%) of CHIP enrollees are between 7 and 15 years of age.
- Approximately four percent (4%) of CHIP enrollees are between birth and twenty-three months of age.
- Nearly eighty percent (80%) of CHIP families are enrolled in CHIP Plan C, for families with income between 151% and 200% FPL.

Services utilized by CHIP children***

- There were eighteen (18) children with catastrophic claims ($50,000+) for SFY 2016; ten (10) were mental health/psychiatric related services.
- Psychiatric inpatient and medical outpatient accounted for more than half of the Institutional services.
- The most prevalent diagnoses for emergency room visits were abdominal issues and fractures and children ages 7 to 15 years old were the highest utilizers.
- The most frequently utilized pharmaceuticals include medications for attention deficit hyperactivity disorder, bacteria fighting medications, and anti-asthmatic medications.
- Overall, 64.5% of CHIP recipients utilized a CHIP benefit service (including prescription drugs).

* From the U.S. Census 2013 and 2014 Small Area Health Insurance Estimates (SAHIE)
** From the CHIP Membership by Age Report from Blue Cross Blue Shield and the CHIP Reconciliation Report
*** From the CHIP Annual Report from Blue Cross Blue Shield

Long Term Care and Assisted Living Facility HCBS Waiver Programs

Program Description

The Long Term Care (Home and Community Based Services) Waiver Program provides in-home services and the Assisted Living Facility (Home and Community Based Services) Waiver Program provides services in an Assisted Living Facility to Medicaid recipients 19 years of age and older that are aged, blind, or disabled who require services equivalent to a nursing home level care.

Program Expenditures and People Served*

	2014	2015	2016
Total Program Cost	$30,391,479	$32,797,710	$36,611,786**
People Served	1,955	2,140	2,348
Cost per Person	$15,546	$15,326	$15,593
Non-600 Series* **	2%	2%	2%

* Data is updated annually from the PMPM reports and past years may fluctuate slightly due to billing and TPL changes (providers have 12 months to bill for services and TPL can investigate claims up to 7 years old)
** Costs are to-date; providers have 12 months to bill.
*** 600 series is defined as direct service contracts.

Program Cost Notes

- This program is funded by 50% State General Funds and 50% Federal Funds.
- The SFY2016 budget for Long Term Care waiver services is $28,509,104 and $3,421,584 for the Assisted Living Facility waiver.
- Waiver recipients are eligible for Medicaid medical services (costs are included in the Program budget)

Program Staffing

- 3 FTE (6 positions)
- 0 AWEC
- 0 Other

Program Metrics

- 14 total individuals are waiting to transition to services as of 5/31/16.
  - 10 Long Term Care
  - 4 Assisted Living
- 628 participants chose the self-directed service delivery option in SFY 2016 as of 5/31/16.
- 144 providers were enrolled to provide services for the Long Term Care & Assisted Living Waiver Program as of 5/31/16.

Events that have Shaped this Program

- The LTC Waiver Program was last renewed with the Centers for Medicare and Medicaid Services (CMS) for a five year period to begin July 1, 2016. This renewed waiver will be known as the Community Choices Waiver Program.
- The ALF Waiver Program was last renewed with CMS for a five year period that began July 1, 2015

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Long Term Care and Assisted Living Facility HCBS Waiver

PROGRAM CORE PURPOSE

The purpose of this program is to offer and provide eligible individuals quality, cost-effective, community based services as an alternative to nursing home care.

OUTCOMES

Performance Metric		SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of Medicaid Nursing Home eligible recipients receiving support in the community		54%	57%	46.7%	45.9%	47.9%	51%	54.8%
% of returned participant satisfaction surveys that showed positive satisfaction and experience*		80%	80%	92%	88%	85%	82%	91%**
Waiver costs as a % of nursing home cost PMPM	LTC	<60%	<60%	47%	44%	44%	43%	39%
	ALF			44%	44%	46%	48%	43%
Mean LT-101 Scores (median)	LTC	***	***	16.8 (16)	17.1 (16)	17.1 (16)	16.8 (16)	16.8* (16*)
	ALF			17.3 (16)	17 (18)	17.6 (17)	17.3 (16)	17.8* (17*)
% of Enrollees receiving emergency room (ER) services	LTC	<40%	<35%	44.2%	44.1%	41.4%	42.5%	39.5%
	ALF			44.4%	42.1%	39.1%	33.3%	32.5%

*See the Efficiencies section of this document for information on survey response rates.
** Data as of 05/31/2016
*** Medical necessity for nursing home level of care is determined by a score of 13 or greater on the LT-101. The average LT-101 scores for other long-term care programs were as follows: Skilled Nursing Facility (mean 20.97, median 21) and Program of All-Inclusive Care for the Elderly (mean 18.25, median 17).

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of unique/unduplicated waiver recipients	1,920	1,926	1,953	2,143	2,348	N/A*	N/A*	N/A*	N/A*
Inpatient Utilization (admissions, including readmissions)	279	197	169	163	135	N/A*	N/A*	N/A*	N/A*
# of providers at end of SFY	118	120	117	138	144	N/A*	N/A*	N/A*	N/A*
# of participant satisfaction surveys mailed	N/A	2,216	1,948	102	375	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average cost PMPM (waiver)	$849	$861	$864	$853	$928	N/A*	N/A*	N/A*	N/A*
Average cost PMPM (waiver and medical)	$1,799	$1,676	$1,654	$1,658	$1,692	N/A*	N/A*	N/A*	N/A*
% of mailed satisfaction surveys returned by applicants	N/A	43%	56%	73%	55%	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- In July 2016, the LTC waiver program will begin a new five year cycle.
- A renewal application has been submitted to the Centers for Medicare and Medicaid Services (CMS). This application seeks to change the waiver name to Community Choices and add the ALF services.
- In July 2015, the ALF program began a new five year cycle which extended the ALF Waiver through Jun 30, 2019. An amendment has been submitted to CMS to phase out and close this waiver due to adding these services in the Community Choices Waiver
- In July 2014, wait lists for these programs were removed, as directed by Senate File 60. Individuals that are on the wait list are not ready to start the program by their own choice.
- In February 2012, in collaboration with the Behavioral Health Division, the program implemented a new waiver management system which allows for workflow tracking through the entire process including application, assessment, eligibility determination, plan of care development, approval, renewal, and discharge.

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Medicaid Behavioral Health (BH) Services

Program Description

This Program provides access to cost-effective, community-based behavioral health treatment resources for Wyoming Medicaid clients who are experiencing mental health and/or substance abuse disorders.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$31,995,615	$35,143,911	$36,205,842
People Served	13,838	14,713	15,466
Cost per Person	$2,312	$2,389	$2,341
Non-600 Series*	N/A	N/A	N/A

* 600 series is defined as direct service contracts. Not applicable to this program.

Program Cost Notes

- SFY 16 federal match is 50%
- SFY 16 Behavioral Health services account for 6.5% of the total Medicaid benefit claims expenditures

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In a given year, 56-59% of clients receiving behavioral health services are children.
- The top diagnosis by expenditure for all ages served is Depression ($4,049,486), and represents 13% of total SFY16 BH program expenditures.
  - Post Traumatic Stress Disorder was the second diagnosis by expenditure ($1,478,250, 5%).
  - Unspecified Mood Affective Disorder was the third diagnosis by expenditure ($1,138,670, 4%).

Events that have Shaped this Program

- The Medicaid Behavioral Health Services program utilizes the federal authority granted by the Centers for Medicare & Medicaid Services(CMS) under the Rehabilitative Services Option [42 U.S.C. § 440.130], Early Periodic Screening, Diagnosis and Treatment (EPSDT) [42 U.S.C. § 440.40(b)], and Targeted Case Management [42 U.S.C. § 440.169].

- July 1, 2014, Medicaid began independent enrollment of licensed mental health professionals, which include Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Addictions Therapists.

- July 1, 2015, Medicaid allowed provisionally licensed mental health professionals to enroll and practice under the supervision of a licensed mental health professional when serving Medicaid clients and to bill for those services.

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Medicaid Behavioral Health (BH) Services

PROGRAM CORE PURPOSE

This program provides access to cost-effective, community-based behavioral health treatment resources for Wyoming Medicaid clients who are experiencing mental health and/or substance abuse disorders.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
% of Licensed Mental Health Professionals and Provisional Mental Health professionals that are enrolled with Medicaid (enrolled/all providers)	40% (775)	65% (1,390)	N/A	N/A	N/A	29% (549/1,916)	51% (1,089/2,127)
Adult Intellectual Disabilities (ID) waiver client psychological service cost per recipient	<$5,000	<$5,000	$4,184	$5,088	$5,840	$7,668	$10,010
Average # of mental health visits per adult	N/A	15	N/A	N/A	N/A	N/A	16
% of adults receiving <20 visits % of adults receiving >20 visits	N/A	<85% (5,000) <15% (750)	N/A	N/A	N/A	N/A	70.3% (3,460) 29.7% (1,459)

(-) Indicates data not yet available
N/A indicates data not available due to creation of new metric or re-definition of metric methodology

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of BH recipients	12,946	13,101	13,838	14,713	15,466	N/A*	N/A*	N/A*	N/A*
% of total Medicaid enrolled clients who received a BH service	15%	15%	16%	16.5%	17.4%	N/A*	N/A*	N/A*	N/A*
% of total Medicaid expenditures for BH services	5.5%	5.7%	6.2%	6.7%	6.5%	N/A*	N/A*	N/A*	N/A*
Per Member Per Month for BH services*	$32.15	$33.63	$35.87	$37.62	$42.01	N/A*	N/A*	N/A*	N/A*
# of Adult intellectual disability (ID) waiver recipients who received a BH service	551	525	537	555	541	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
# of in-State BH providers	1,319	1,642	1,705	1,754	2,015	N/A*	N/A*	N/A*	N/A*
# of out-of-State BH providers	358	394	433	506	675	N/A*	N/A*	N/A*	N/A*
% of total BH expenditures for recipients served by a Community Mental Health Center and/or Substance Abuse Treatment Center	46%	49%	44%	42%	41%	N/A*	N/A*	N/A*	N/A*

* Per Member Per Month for BH services only includes expenditures paid to BH taxonomies and excludes
(-) Indicates data not yet available
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- The SFY 2016 goal of enrolling a minimum of 40% of licensed mental health professionals and provisional mental health professionals has been exceeded, with 1,089 enrolled due to legislation in SFY 2014 and 2015.
- There is a new federal mandate stating that Medicaid programs must provide medically necessary diagnostic and treatment services to beneficiaries with Autism Spectrum Disorder. This policy will be effective January 1, 2017.
- An initiative was started by the Medicaid Behavioral Health Manager in SFY 2012 to potentially reduce inappropriate behavioral health services being provided to the Adult Intellectual Disabilities Waivers, which may be leading to a significant increase in cost per recipient receiving psychological services in SFY 2016.
- Rehabilitative services will be limited to twenty (20) visits a year, unless additional services are determined to be medically necessary and rehabilitative. This policy will be effective January 1, 2017.

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Medicaid Dental

Program Description

The Medicaid dental program ensures recipients have access to dental services to prevent and treat dental conditions. Preventive and treatment services are available to Medicaid eligible children and adults in Wyoming.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$13,753,734	$14,473,863	$15,663,152
People Served	29,415	30,679	32,446
Cost per Person	$468	$472	$485

Program Cost Notes

- Dental expenditures were 3% of the total Medicaid expenditures for SFY 2016
- Expenditures for children account for 70% of the total Medicaid dental budget, with dental cleanings and stainless steel crowns being the top two codes billed.
- Adult dental services include cleanings, fillings, dentures/partials, extractions, and emergency treatments, with extractions being the top billed codes for adults.

Program Staffing

- 1 FTE
- 0 AWEC
- 1 Other-Orthodontic Consultant

Program Metrics

- In SFY 2016, 223 new orthodontic cases (Medicaid clients) were approved to participate in the Severe Malocclusion Program. An additional 62 clients were placed on a 1 year hold for improvement needed in home care or observation of growth patterns. Approximately 500 children are currently in orthodontic treatment for correction of severe malocclusions that impact function.
- In SFY 2016, only Niobrara County did not have an enrolled Medicaid dentist, however, Niobrara County does not have any practicing dentists available to enroll.

Events that have Shaped this Program

The children's dental benefits are a mandatory Medicaid service based on Early and Periodic Screening, Diagnostic, and Treatment (EPSTD) guidelines. Effective November 14th, 2016, the benefits for Adult Medicaid clients (ages 21 and older) will have a reduction in services due to the mandatory budget reductions for the 2017-189 biennium.

- In 2015 more preventive visits and deeper cleanings for developmentally disabled clients and pregnant mothers were added to ensure better overall health for these clients.
- In 2015 the qualifying criteria for the Severe Malocclusion program was revised to include younger clients to ensure that conditions that develop at earlier ages are treated sooner resulting in less complex and costly treatment later. Approximately 45 children have benefitted from the new Interceptive (phase 1) treatment option.
- Medicaid completed a Nursing Home Dental Pilot in February 2016 that studied the unmet needs and barriers to care among nursing home clients. This pilot will be used to address unmet opportunities to help Nursing Home residents receive needed dental care.
- In 2016 the Severe Malocclusion benefit is being transitioned to the THR (Total Health Record) system to track the clients receiving orthodontic care. In 2017 this database will be introduced to the orthodontic providers to be used to apply for approvals online. The providers and State staff will be able to track orthodontic clients more efficiently.

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Medicaid Dental

PROGRAM CORE PURPOSE

The purpose of the Medicaid Dental program is to ensure access to dental care so that recipients may receive preventive and routine dental services to support oral health and avoid emergency dental situations

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of practicing, licensed Wyoming dentists enrolled as a Medicaid provider	>85%	>85%	N/A	N/A	215/ 283 76%	232/ 295 78%	243/ 307 79%
# and % of eligible clients seen for a dental exam	36%	36%	26,864/ 90,037 30%	24,599/ 89,685 27%	27,308/ 86,188 32%	29,020/ 89,252 33%	30,061/ 83,453 36%
# and % of Medicaid children that received a dental cleaning	36%	39%	20,392/ 60,335 34%	20,506/ 59,822 34%	20,856/ 54,417 38%	21,578/ 55,589 39%	21,779/ 51,282 42%
# and % of nursing home clients seen for a dental visit	23%	23%	327/ 2,493 13%	334/ 2,523 13%	426/ 2,453 17%	398/ 2,490 16%	446/ 2,140 21%
# and % of clients taken to the hospital/ambulatory surgical center (ASC) for dental work	<1,000	<1,000	N/A	1,300/ 20,506 6.3%	1,344/ 20,856 6.5%	1,361/ 21,578 6.3%	1,291/ 21,779 5.9%

N/A* indicates data not available on a quarterly basis

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2014 Q1+Q2	2014 Q3+Q4	2015 Q1+Q2	2015 Q3+Q4
OUTPUTS									
# and % of unique children served (any dental service)	23,944/ 60,335 40%	23,969/ 59,822 40%	24,311/ 54,417 45%	24,929/ 55,589 45%	25,371/ 51,282 49%	N/A*	N/A*	N/A*	N/A*
# and % of unique adults served (any dental service)	5,243/ 31,858 16%	5,245/ 31,426 17%	5,395/ 33,450 16%	6,052/ 37,283 16%	7,075/ 32,171 22%	N/A*	N/A*	N/A*	N/A*
# and % of orthodontic applications approved	129/ 395 35%	103/ 373 28%	95/ 310 31%	128/ 397 32%	223/ 461 48%*	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis

EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2014 Q1+Q2**	**2014 Q3+Q4**	**2015 Q1+Q2**	**2015 Q3+Q4**
Average cost per recipient per year	$478	$471	$468	$472	$485	N/A*	N/A*	N/A*	N/A*
Per member per month- Dental	$15.97	$15.92	$15.93	$16.02	$18.80	N/A*	N/A*	N/A*	N/A*
Total Orthodontic $	$426,940	$416,420	$392,155	$394,135	$537,699	N/A*	N/A*	N/A*	N/A*
Total Dental Expenditures (millions)	$13.8M	$13.5M	$13.7M	$14.4M	$15.6M	N/A*	N/A*	N/A*	N/A*
N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

- The Medicaid Dental Program has increased the percent of Medicaid clients served each year.
- By enrolling new dental graduates each year we can continue to grow our provider participation (79%) and rank among one of the highest in the nation (national average 40-50%). This will ensure access to dental services for Medicaid clients.
- The Dental Program focuses on incentives to see underserved clients by offering dentists additional payments for seeing Nursing Home clients and children under the age of 3.
- Dental providers continue to reduce the number of children that are treated under general anesthesia in a hospital/ambulatory surgical center (ASC) setting by attempting dental services in their offices using nitrous oxide and other behavior management codes that are covered by Medicaid.
- The Severe Malocclusion program has increased the number of clients treated orthodonitcally in the past 3 years. By seeing clients at younger ages, providers are treating malocclusions earlier with phase 1 treatments which are reimbursed at a lower rate than full comprehensive treatment.
- Effective November 14th, 2016, the benefits for Adult Medicaid clients (ages 21 and older) will have a reduction in services due to the mandatory budget reductions for the 2017-18 biennium.

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Medicaid Pharmacy Program

Program Description

The Medicaid Pharmacy Program provides payment to outpatient pharmacies for the provision of covered outpatient drugs. Medicaid covers most prescription drugs and specific over-the-counter drugs. The Medicaid Pharmacy Program oversees the Drug Utilization Review (DUR) program which promotes the appropriate use of medications in Medicaid recipients. At the same time, the program strives to maximize cost saving for the state through manufacturer drug rebates, the preferred drug list, and sound reimbursement methodology.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost (Before Rebate)*	$46,190,410	$51,917,136	$50,905,606
Total Program Cost (Net of Rebate)**	$21,419,975	$28,956,198	$19,504,067
People Served	47,166	47,696	44,333
Cost per Person	$979	$1,088	$1,148

* 2016 Year to Date

Program Cost Notes

- Program costs noted above include funds spent for the direct service costs of drug coverage only.
- These expenditures are federally matched at a 50% rate.
- *Before Rebate: reflects reimbursement to pharmacies for outpatient drug claims
- **Net of Rebate: reflects the program cost once the program has collected rebates. This number is derived by subtracting rebate collected during the given fiscal year from the pharmacy reimbursement figure in the first row.

Program Staffing

- 3.25 FTE
- 0 AWEC
- 2 Contractors: Goold Health Systems (GHS) to manage pharmacy benefits and the University of Wyoming School of Pharmacy for drug utilization review (DUR)

Program Metrics

- All Medicaid enrollees are eligible for pharmacy coverage. Approximately 72% of enrollees used the pharmacy benefit in SFY 2015, while approximately 67% used the pharmacy benefit in SFY 2016.
- Pharmacy expenditures were approximately 9.0% of total Medicaid expenditures in SFY 2015 and 9.0% of total expenditures in SFY 2016.

Events that have Shaped this Program

- The Federal Manufacturer Drug Rebate Program (MDRP) requires pharmaceutical manufacturers to pay rebates to states in order for their medications to be covered by Medicaid.
- Supplemental rebates enhance the savings States realize, in addition to the required federal rebates. Rebates provide the opportunity to greatly reduce the overall cost of medications covered by the program.
- In February 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Outpatient Covered Drug Rule stipulating that States reimburse pharmacies for most drugs using a formula that combines average acquisition cost and a professional dispensing fee. States have until April 1, 2017 to adopt this reimbursement structure and must submit a state plan amendment (SPA) for CMS approval by June 30, 2017.
- An increase in the utilization of very costly specialty drugs, first in class blockbuster drugs, and the increased costs of generic drugs have contributed to the increased “Cost Per Person” in past years in the pharmacy program.

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Medicaid Pharmacy Program

PROGRAM CORE PURPOSE

The core purpose of the Medicaid Pharmacy Program is to monitor and provide payment for cost effective and clinically sound outpatient medications dispensed by enrolled pharmacies to Medicaid enrollees and to encourage safe prescribing habits by Medicaid Providers.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
Short Term Outcomes—Cost Effective Coverage							
Savings generated by Preferred Drug List and Prior Authorization [A]	$8,580,674	$9,009,708 (5% increase)	$6,008,904	$7,091,467	$7,844,047	$8,894,753	$9,821,265
State Maximum Allowable Cost Savings	$14,000,000	$12,000,000	$11,218,614	$16,937,324	$14,359,484	$15,085,685	$17,045,765
Intermediate Outcome—Clinically Sound Treatment							
# of Prior Authorizations approved/ # reviewed (% approved)	50-60%	50-60%	3,715/ 6,650 (55.9%)	3,994/ 7,038 (56.7%)	4,693/ 8,507 (55.2%)	4,520/ 9,471 (47.7%)	4,783/ 10,472 (45.7%)
# of prescriptions that changed due to Drug Utilization Review (DUR) edits/ # that hit DUR edits (% of prescriptions changed)	20-30%	20-30%	9,681/ 45,133 (21.4%)	12,236/ 46,733 (26.2%)	9,468/ 48,508 (19.5%)	8,572/ 49,055 (17.5%)	7,230/ 43,277 (16.7%)

(-) Indicates data not yet available
N/A indicates data not available due to creation of new metric or re-definition of metric methodology

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016***	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Number of clients served	48,263	50,783	47,166	47,696	44,333	35,148	37,151	32,020	34,035
Number of prescriptions paid	599,916	588,808	571,568	578,236	542,427	280,479	290,083	264,770	277,657
Average number of prescriptions per recipient per month	2.76	2.78	2.84	2.89	2.88	2.96	2.82	2.9	2.86
Number of medication classes managed on the Preferred Drug List (PDL)	109	108	119	123	123	N/A*	N/A*	N/A*	N/A*
Number of claims recovered on by Program Integrity	221	1,997 [B]	375	409	210	91	318	56	154
EFFICIENCIES									
Average cost per client served	$868	$860	$979	$1,088	$1,148	$703	$733	$797	$745
Average cost per prescription	$71.58	$69.87	$74.16	$80.81	$93.85	$88.06	$93.83	$96.43	$91.38
Supplemental Rebate Savings (Contract cost is $17,000 per year) [State Portion]	$2,350,870 [$1,175,435]	$1,080,980 [$540,490]	$1,778,267 [$889,134]	$1,396,316 [$698,158]	$1,442,741 [$721,371]	$672,007	$724,309	$805,110	$637,631
Total $ recovered through program integrity efforts [C]	$71,013	$108,026	$239,247	$380,732	$80,263	$39,700	$398,629	$52,006	$28,257
Program Integrity Cost Avoidance [D]	N/A	$41,748	$56,765	$57,597	$327,818	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

The Medicaid Pharmacy Program is governed by 42 CFR §440.120, §441.25, §447.520, §456, Subpart K, §447, Subpart I, and W.S. 42.4.103 (a)(xiii)

[A] This number reflects the difference between the projected cost of the program (if supplemental rebates were not collected and if all medications were covered equally without a preferred drug list) and the actual cost of the program (including supplemental rebates collected and requests that were denied due to not meeting the prior authorization criteria for non-preferred drugs). This was chosen as an outcome metric because it reflects the results of the annual decisions made regarding what classes of drugs should be managed on the preferred drug list and what specific drugs should be preferred.

[B] This increase was the result of an unusually large one-time recovery.

[C] These numbers reflect money that was recovered on claims that were originally submitted incorrectly by pharmacy providers and, therefore, overpaid by the State.

[D] These figures for SFY13-SFY15 include cost avoidance achieved by corrections that avoid filling prescriptions too soon or too often. In SFY16, the pharmacy program also collected and included in this number cost avoidance achieved through minimum day supply edits (which avoided incorrect claims that would have required correction) and SU recovery edits

Medicaid – Third Party Liability (TPL)

Program Description

As part of the Program Integrity Unit, third party liability (TPL) staff implement policy and review provider claims to ensure that Medicaid is the payor of last resort, as required by federal law. TPL staff concentrates on identifying when another individual, entity, insurer, or program has the responsibility to pay all or part of the cost of the claim prior to Medicaid making payment. Cost avoidance concerns recognizing the existence of other insurers' responsibility and then requiring that insurer to pay prior to Medicaid payment. Pay and chase, involves TPL staff attempting to recover money from the liable third party when a Medicaid payment has been made and third party liability is subsequently determined.

Program Expenditures and Total Dollars Recovered

	SFY 2014	SFY 2015	SFY 2016
Total Program Cost*	$666,856	$727,307	$802,404
Total TPL Dollars Recovered**	$5,140,669	$4,858,148	$5,188,976
Non-600 Series***	100%	100%	100%

* Program cost was based upon a Cost Allocation Model for 2014, 2015, and 2016. The TPL function is developing a mechanism to report actual costs of state staff, software, Fiscal Agent services, and Attorney General services.
**Includes estate recovery, TPL recovery and credit balances, but it does not include cost avoidance.
*** 600 series is defined as direct service contracts.

Program Cost Notes

- The Attorney General's office performs legal services for TPL and estate recovery.
- Medicaid's Fiscal Agent (contractual, Xerox) performs cost avoidance, pay and chase recoveries, pursues small personal injury recoveries involving medical payments coverage, tort recovery for criminal restitution, product liability, worker's compensation, and preliminary research for estate recovery.
- Recoveries made by TPL are reported on the CMS-64 report. Using the current FMAP rate of 50%, federal funds are returned to CMS for TPL services.

Program Staffing

- 0.9 FTE State Staff
- 0 AWEC
- 12.6 Other
  - 9.6 Contractual (Xerox)
  - 2 part-time senior/assistant attorney generals and 1 full-time paralegal at the Attorney General's office

Program Metrics

- Ensure cost avoidance, pay and chase recoveries, estate recoveries, third party liability recoveries, J-code rebate recoveries, and credit balance recoveries occur to ensure Medicaid is the payor of last resort.

Events that have Shaped this Program

- The Social Security Act and the United States Code mandate third party liability and estate recoveries.
- 42 C.F.R. § 433.36, 42 C.F.R. § 433.316 – 433.318 and 42 C.F. R. § 433.135 - 433.154 provide high level guidance for estate recovery and third party liability requirements. Chapter 3 of the State Medicaid Manual Sections 3257 – 3259.8, 3810 – 3812 and 3900 – 3910.15 also governs the program.
- The Federal Omnibus Budget Reconciliation Act of 1993 (OBRA '93) established rules for asset transfers by imposing penalties for individuals who transfer assets to qualify for Medicaid (look-back period). It is also set forth that states must, at a minimum, recover from assets that pass through probate and, at a minimum, states may recover any assets that a deceased client had a legal title to or interest in at the time of death.
- The Deficit Reduction Act of 2005 strengthened Medicaid's ability to pursue recovery from a health insurer by creating a timely filing deadline, establishing data matching requirements, stating that Medicaid claims may not be denied for claim format issues or procedural issues, increasing the duration of the look-back period, and making provisions for annuities, etc.
- Wyoming Statutes §§ 42-4-201 – 42-4-207 Medicaid Benefit Recovery
- Wyoming Medicaid Rules Chapter 35 Benefit Recovery.

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Medicaid – Third Party Liability

PROGRAM CORE PURPOSE

To reduce Medicaid costs by pursuing the maximum payment from other responsible parties by identifying and recovering from any individual, entity, or agency/program that is or may be obligated to pay all or part of the medical assistance costs.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Total TPL excluding Cost Avoidance*	>$7,000,000	>$7,000,000	$6,977,792	$7,943,632	$6,769,831	$5,931,231	$7,119,258
Total TPL including Cost Avoidance*	>$20,000,000	>$20,000,000	$20,135,106	$23,015,282	$19,519,229	$19,401,074	$22,159,944
% of Medicaid claims expenditures offset by total TPL**							
-Excluding Cost Avoidance	>1%	>1%	1.39%	1.54%	1.31%	1.12%	1.28%
-Including Cost Avoidance***	>3.75%	>3.75%	4.02%	4.45%	3.77%	3.68%	4.00%
Estimated return on investment*							
-Excluding Cost Avoidance	$9 to $1	$9 to $1	$9.36 to $1	$11.7 to $1	$10.2 to $1	$8.2 to $1	$8.9 to $1
-Including Cost Avoidance***	$27 to $1	$27 to $1	$27 to $1	$34 to $1	$29.3 to $1	$26.7 to $1	$27.6 to $1

* These figures include estate recovery, third party liability recoveries, credit balances, and J-Code rebates.
** Based on 5 year paid claims history in SFY 2016 Annual Report
*** Program Integrity- TPL is reviewing/auditing how cost avoidance dollars are being determined. The cost avoidance figure may be inflated as cost avoidance is currently calculated based on billed charges from providers (because these claims are not fully processed once TPL is identified), rather than the final amount Medicaid would have paid.
(-) Indicates data not yet available
N/A indicates data not available due to creation of new metric or re-definition of metric methodology

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016***	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Total Estate Recovery	$2,272,704	$2,297,295	$2,433,666	$2,618,230	$2,582,490	N/A*	N/A*	N/A*	N/A*
Total Third Party Liability	$3,223,431	$3,864,731	$2,433,598	$2,046,823	$2,474,959	N/A*	N/A*	N/A*	N/A*
Total Credit Balances	$82,883	$339,242	$273,405	$193,095	$131,527	N/A*	N/A*	N/A*	N/A*
Total J-Code Rebate	$1,398,774	$1,442,364	$1,629,162	$1,073,083	$1,930,282	N/A*	N/A*	N/A*	N/A*
Total Cost Avoidance*	$13,157,314	$15,071,650	$12,749,398	$13,469,843	$15,040,686	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
% of recovered estate recovery cases to current open and active cases	17.52%	18.53%	12.4%	10.32%	13.71%	N/A*	N/A*	N/A*	N/A*
% of recovered TPL cases to current open and active cases	55.74%	59.12%	46.5%	52.99%	67.59%	N/A*	N/A*	N/A*	N/A*
% of Medicaid clients with other insurance coverage identified (relates to TPL recoveries and cost avoidance potential)	8.56%	7.34%	5.25%	5.61%	5.64%	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis
* Program Integrity- TPL is reviewing/auditing how cost avoidance dollars are being determined. The cost avoidance figure may be inflated as cost avoidance is currently calculated based on billed charges from providers (because these claims are not fully processed once TPL is identified), rather than the final amount Medicaid would have paid.

STORY BEHIND THE PERFORMANCE

- **Estate recovery** – Wyoming Medicaid has an aggressive estate recovery program. Wyoming has elected to use the expanded definition of estate that extends beyond probate actions. Wyoming is a lien state and has the ability to impose a lien on real property. Wyoming is able to recover from any real or personal property that the client had legal title or interest in at the time of death or when s/he took their last breath to the extent of that interest, including such assets conveyed to a survivor heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship life estate, living trust or other arrangement.
- **Third party payer** is a person, entity, insurer, or government program that may be liable to pay, or that pays pursuant to the client's right of recovery arising from an illness, injury, or disability for which funds were paid or are obligated to be paid on behalf of the client. Third party payers may be Medicare, health insurance companies, worker's compensation, casualty insurance companies, a spouse or parent court order to carry health insurance, or a client's estate.
- **Credit balance** occurs when a provider's credits (take backs or adjustments) exceed their debits (pay outs or paid claims), resulting in the provider owing Medicaid money.
- **J-Code Rebate** – Rebate dollars from drug manufacturers for physician-administered drugs or injectable drugs. Collecting rebate dollars for physician-administered drugs is mandated by the Deficit Reduction Act of 2005.

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Wyoming Medication Donation Program

Program Description

The Wyoming Medication Donation Program is a comprehensive drug donation, re-dispensing, and disposal program that improves prescription access for Wyoming's low-income patients, up to 200% federal poverty level, who lack adequate prescription coverage, while reducing medication waste.

Program Expenditures and People Served

	CY 2014	CY 2015	CY 2016 (Jan-June)
Total Program Cost	$289,886	$252,452	$140,337
People Served[1]	1,558	2,948	2,085
Cost per Person	$186	$86	$67
Non-600 Series*	100%	92%	100%

* 600 series is defined as direct service contracts

[1] Number of people served in 2014 is a total of patients served via mail from the central location in Cheyenne and the 9 registered Dispensing Sites. Beginning 2015, data is an accurate count of unduplicated patients served by both mail and the dispensing sites.

Program Cost Notes

- Revenue: 9% grants in 2014, 13% in 2015, and 0% in 2016
- Return on Investment (Value of Rx's dispensed*/program cost):
  - 2013- ROI $4.73
  - 2014- ROI $6.09
  - 2015- ROI $10.77
  - 2016- $8.21

Program Staffing

- 2 FTE (0.75 pharmacist, 0.25 fill-in pharmacist, 1 pharmacy technician)
- 0 AWEC
- Other: 0.75 contract pharmacy technician, Health Care Volunteers (386 hours in 2015, 215 in 2016)

Program Metrics

- Improving Prescription Access: number of prescriptions filled, value of prescriptions filled (Average Wholesale Price- AWP), number of patients served, patient medication compliance rate
- Donations & Waste Management: pounds of medication and medical supplies donated, value of medication donated (AWP), number of public donation sites, pounds of unacceptable medication safely disposed via incineration

Events that have Shaped this Program

- Drug Donation Program Act passed in 2005 (W. S. § 35-7-1601 et seq.)
- Pilot program as Laramie County Centralized Pharmacy from 2007-2010
- Wyoming Medication Donation Program central processing site began serving patients state-wide in 2011.
- Strategic partner on the Wyoming Institute of Population Health's *CMS Health Care Innovation Award*: Creating Medical Neighborhoods to Transform Rural Healthcare Delivery. Grant period from 2012 to 2015.
- In January of 2015 resources became available to purchase needed medications to fill in the gaps of donated inventory via the Cheyenne Regional Medical Center (CRMC), Dispensary of Hope and Block Grant.

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Wyoming Medication Donation Program

PROGRAM CORE PURPOSE

The Wyoming Medication Donation Program reduces medication waste and improves prescription access for low-income Wyoming residents who lack adequate prescription coverage by re-dispensing donated medications.

OUTCOMES

Performance Metric	CY 2015 Target	CY 2016 Target	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016 (Jan-June)
Total patients served by re-dispensed medication[1]	>1,750	>1,500	1,916	1,704	1,558	2,948	2,085
Total value of re-dispensed prescriptions [1,2]	$1,500,000	$1,500,000	$1,332,355	$1,264,842	$1,765,148	$2,718,536	$1,152,532
Patient medication compliance rate on mailed prescriptions	n/a	>85%	n/a	59%	62%	86%	89%
Return on Investment (ROI) to communities (value of Rx's dispensed[2]/ program cost)	> $5.00	> $5.00	$5.34	$4.73	$6.09	$10.77	$8.21

(-) Indicates data not yet available
N/A indicates data not available due to creation of new metric
[1] Total number of patients served and total value of re-dispensed prescriptions in 2011-2014 is a combined total of the average number of patients served quarterly at the dispensing sites plus the number of unique patients served yearly via mail from the central location in Cheyenne. Beginning in 2015, data is an accurate count of unduplicated patients served via mail plus dispensing sites.
[2] All values shown are average wholesale price (AWP) which is the average value at which wholesalers sell drugs to physicians, pharmacies, and other consumers. It is a standard pricing benchmark for drug pricing and reimbursement throughout the healthcare industry.

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016 (Jan-June)	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of prescriptions filled using re-dispensed medication[1]	22,071	20,404	17,115	22,341	11,919	N/A*	N/A*	N/A*	N/A*
# of prescriptions mailed & value of Rx Mailed[2]	727 $90,950	1,255 $165,603	2,959 $510,022	6,215 $1,101,064	4,305 $639,743	N/A*	N/A*	N/A*	N/A*
# and % of patients served via mail	111 6%	167 10%	255 16%	611 21%	443 21%	N/A*	N/A*	N/A*	N/A*
Pounds / AWP value of medication donated	8,844 $1,808,992	13,410 $2,409,988	12,902 $3,198,712	15,948 $3,274,153	7,920 $1,522,623	N/A*	N/A*	N/A*	N/A*
# of public donation sites	10	17	25	28	30	N/A*	N/A*	N/A*	N/A*
Pounds (%) of donations received via totes*	n/a	434.8 (4.5%)	2,006 (15.5%)	3,486 (22%)	1,730 (22%)	N/A*	N/A*	N/A*	N/A*
Pounds of unacceptable medication properly disposed	1,921	3,161	3,167	4,101	2,076	N/A*	N/A*	N/A*	N/A*

EFFICIENCIES									
Performance Metric	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016 (Jan-June)**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
Average program cost per prescription dispensed	$11.30	$13.09	$16.93	$11.30	$11.77	N/A*	N/A*	N/A*	N/A*
Average AWP value per prescription dispensed	$60.37	$61.99	$103.13	$121.68	$96.70	N/A*	N/A*	N/A*	N/A*
Donation usage rate	73.7%	52.5%	55%	83%	76%	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis
* Provide free shipping for donation sites
[1] Total number of prescriptions filled is a combined total of the prescriptions dispensed at the dispensing sites plus via mail from the central location in Cheyenne.

STORY BEHIND THE PERFORMANCE

- Public donation sites are registered with the WMDP to accept donated medication from the public. Donations are sent to the WMDP central location for processing. Drug Drop Boxes, located in law enforcement agencies, provide drug disposal for the public; most do not donate usable items to the WMDP.
- Average program cost per prescription dispensed is rising due to the shift of prescriptions being filled and sent via mail vs. being filled at the dispensing sites. The WDH does not provide financial assistance to the dispensing sites.
- In mid-2013, the program partnered with the existing public health courier system to provide free shipping utilizing reusable shipping totes provided to participating donation sites and hospitals, thereby removing a cost barrier for donors.
- January-June 2015, grant funds from the Health Care Innovation Award were used to purchase medications to fill-in the gaps of the donated inventory. This allows the Program to fill a prescription even if the medication has not been donated in sufficient quantity. This has been key to improving the patient medication compliance rate. This funding expired June 30, 2015.
- In September 2015, Block Grant funds were used to purchase needed mental health medications.
- In July 2015, medications became available via the Dispensary of Hope. The first 12 month subscription fee was $7,500. The value dispensed in the first 12 months was $208,609 AWP (28:1 ROI). For the second year and beyond, the subscription fee will be $12,500.
- Nearly all of the dispensing sites provide donated medications to only patients seen by a provider at their clinic, limiting the clients who can receive help. Therefore, mailed prescriptions are vital in providing access for patients who are seen at other sites of care. The increased volume of mailed prescriptions is a direct reflection of improved prescription access state-wide. This resulted from strategies implemented to improve coordination with hospitals and patient centered medical homes to send referrals. An online inventory, updated daily, is available to assist referrals and prescribing. The program is not actively trying to expand the number of dispensing sites at this time.
- In August of 2016 the Prescription Drug Assistance Program (PDAP) was closed due to budget cuts. The Medication Donation Program expects to see an increase in demand due to closure of the PDAP.

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Medicaid: Nursing Homes

Program Description

Wyoming Medicaid covers nursing home admissions as a mandatory service as defined by federal regulation. Wyoming has two types of nursing facilities: 1) Skilled Nursing Facilities (SNF), a nursing home certified to participate in, and be reimbursed by, Medicare and Medicaid, and 2) Nursing Facilities (NF), a nursing home certified to participate in, and be reimbursed by, Medicaid. In SFY 2016 Wyoming had 36 enrolled in-state SNF's and 1 enrolled in-state NF. There are also two Transitional Care Units in Wyoming.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost*	$72,866,933	$70,354,260	$82,425,487
People Served	2,387	2,357	2,451
Cost per Person	$30,527	$29,849	$33,629
Non-600 Series**	0.3%	0.3%	0.6%
Total Provider Tax Paid	$31,074,080	$30,438,174	$29,379,786

*Costs include Nursing Home & Swing Bed taxonomies, does not include Provider Tax,
**600 series is defined as direct service contracts, does not include claims processing or eligibility costs that are shown on other HealthStat forms.

Program Cost Notes

- Nursing Homes are paid a per diem rate based on an updated rate model that went into effect 7/1/15.
- Wyoming Retirement Center and Morning Star Manor are paid outside of rate model- WRC is paid 100% of their audited costs; Morning Star is paid a fixed IHS rate.
- Extraordinary Care Clients have severe conditions that require a special negotiated rate- there are currently 7 cases.
- Nursing facility provider assessment is approximately $30 million per year, Funding is 50% FF, 50% Provider Match.

Program Staffing

- 0.25 FTE
- 0 AWEC
- Other: Contractor, Myers and Stauffer, LC (CPA firm), to provide rate setting and auditing functions

Program Metrics

- Ensure access to nursing home services by covering provider allowable costs as close to 100% as possible.
- Medicaid covers 64% of the nursing home occupancy as measured in bed days.
- Extraordinary Care Clients are approved for additional funding based on clinical documentation which meets medical criteria. Currently there are three (3) extraordinary clients in Wyoming and four (4) out of state.

Events that have Shaped this Program

- After an extensive public process, an updated NH Rate Model was approved and implemented effective July 1, 2015. The new rate model is a hybrid price, cost, and acuity adjusted model for 4 cost categories to include exempt costs, property costs, healthcare costs subject to acuity adjustments, and operating costs (including laundry, housekeeping, routine supplies, etc.)
- Nursing homes became eligible through a WY State Plan Amendment for provider assessment payments beginning April 2011. A provider assessment allows the Nursing Facilities to pay the state portion through an assessment, the federal funds are drawn down, and additional payments are made to the nursing homes. (Note: NF reimbursement is based on a federal fiscal year (FFY).)
- The NH Gap Payment Program was approved by the Legislature with an effective date of July 1, 2016. The current model allows for an additional $11 million to NH providers, per the remaining upper payment limit (UPL) gap for each.

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Medicaid: Nursing Homes

PROGRAM CORE PURPOSE

To reimburse Nursing Homes (NH) for inpatient services provided to eligible Wyoming residents.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
# of Nursing Homes (NH) achieving 95% cost coverage reimbursement with upper payment limit (UPL)	>50%	>50%	N/A	N/A	10 out of 37 (27%)	20 out of 35 (57%)	17 out of 35 (49%)
Average Medicaid Patient Acuity Score	>0.87	>0.86	0.91	0.92	0.90	0.87	0.86
Cost coverage weighted average history (including provider assessments)	85-100%	85-100%	92%	89%	87%	91%	91%
% of Wyoming Nursing Facilities that accept Medicaid residents	100%	100%	100%	100%	100%	100%	100%

Outputs and Efficiencies									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
Outputs									
# and % of Wyoming Medicaid recipients served in a NH or swing bed	2,410 3%	2,445 3%	2,387 3%	2,357 3%	2,451 3%	1,880	1,983	1,939	2,066
Total Cost for Extraordinary Care Clients (% of Total NH Costs)	$531,893 (0.7%)	$873,421 (1%)	$1,436,290 (2%)	$1,470,960 (2%)	$1,481,129 (2%)	$608,105	$862,854	$607,226	$873,903
# of Member Months of NH Program Enrollment	20,569	20,232	20,071	19,632	20,218	N/A*	N/A*	N/A*	N/A*
Efficiencies									
Cost per Nursing Home Recipient	$30,625	$30,100	$30,527	$29,849	$33,629	$18,249	$18,178	$20,069	$21,061
Per Member Per Month (PMPM) for Nursing Home (without UPL)	$3,889.24	$3,864.46	$3,765.33	$3,790.43	$4,312.62	N/A*	N/A*	N/A*	N/A*
Average Length of Stay (months)*	8.6	8.5	8.8	8.3	8.2	N/A*	N/A*	N/A*	N/A*
# and % Nursing Home Bed Days Paid by Medicaid (based on FFY)	547,739 63%	537,013 61%	547,206 61%	529,319 62%	502,155 60%	N/A*	N/A*	N/A*	N/A*

*Average Length of Stay calculated by dividing member months by unique recipient count

STORY BEHIND THE PERFORMANCE

- In order to ensure the quality of care and to avoid inappropriate institutionalization of persons with a mental illness or mental retardation, Congress, via the Nursing Home Reform Act of 1987, has mandated that all State Medicaid Agencies serve as the oversight authority for Pre-admission Screenings and Resident Review (PASRR). By ensuring that the State has provided the resources and opportunity for clients to be served in the most appropriate setting, PASRR helps ensure that clients are served appropriately at home, in a waiver program, in a nursing facility, or in another setting.
- The Documentation and Reimbursement Technology (DART) chart project that began in SFY15 ensures that all residents with Medicare remain Medicare primary to the full maximum allowable days using Resource Utilization Groups (RUGS) based methodology.
- The Long Term Care Advisory Group replaced the Nursing Home Advisory Group (NAG) in SFY15. The nursing home providers combined with the hospice, home health, and long term care waiver providers to ensure there is a broader base of knowledge and expertise surrounding long term care, and to assist the State with policy, coverage, rates, and other Medicaid issues and decision-making.

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PRTF- Psychiatric Residential Treatment Facility

Program Description

Wyoming Medicaid covers psychiatric residential treatment for individuals under age 21 in a Psychiatric Residential Treatment Facility (PRTF) who meet medical necessity for a PRTF level of care.

Program Expenditures and People Served*

	SFY2014	SFY2015	SFY2016
Total Program Cost	$15,618,134	$13,898,099	$11,758,859
People Served	344	348	305
Cost per Person	$45,402	$39,937	$38,554

* Program costs and clients include both Medicaid and State General Funds

Program Cost Notes

- Medicaid youth are funded by 50% federal funds, 50% general funds.
- Medicaid costs were $11,719,350 in SFY 2016 and $13,575,847 in SFY 2015
- State General Fund (SGF) costs have been falling.
  - SFY 2016: $39,509
  - SFY 2015: $322,252
  - SFY 2014 $711,702

Program Staffing

- 0.25 FTE
- 0 AWEC
- 1 Other: Contractor, WY Health

Program Metrics

- In SFY 2016 300 unique clients were served (Medicaid only)
- The Program currently has 20 PRTFs enrolled
  - 2 in-state
  - 18 out-of-state
- The average length of stay in SFY 2016 was 131 days (calculated from discharged clients)

Events that have Shaped this Program

- Enrolled Act No. 57, House of Representatives became effective July 1, 2013. This specifies that any order regarding potential placement at a PRTF shall not specify a particular PRTF or level of care for the placement of the child.
- Payment is no longer made using 100% SGF for any clients with an incorrectly worded court order after July 1, 2013.
- SGF are only used for clients who are court ordered, no longer meeting PRTF criteria, and awaiting discharge.

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PRTF (Psychiatric Residential Treatment Facility)

PROGRAM CORE PURPOSE

This program manages psychiatric residential treatment facility-based services and treatment provided to Wyoming Medicaid eligible children under age 21 for appropriateness and cost-effectiveness.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of PRTF placements w/a previous PRTF or residential treatment center (RTC) admit	25%	30%	41% (107/264)	30% (97/319)	36% (121/336)	55% (184/334)	63% (188/300)
Average length of stay (in days)	120	120	95	123	147	130	131
# and % of recipients with a length of stay exceeding 6 months	20%	20%	42 16%)	81 25%	100 30%	99 30%	89 30%
# of new PRTF admits	150	150	205	244	224	200	176

All data is based on Medicaid Chart A client information

OUTPUTS AND EFFICIENCIES

Performance Metric		SFY 2012	SFY 2013	SFY 2014	SFY 2014	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS										
# of Onsite Compliance Review (OSCR) visits completed		N/A	N/A	N/A	N/A	7	N/A	N/A	4	3
# of recipients	Medicaid	264	319	336	334	300	240	235	203	216
	SGF	137	115	22	14	5	N/A*	N/A*	N/A*	N/A*
# of placements	In-state	130	153	143	165	186	98	118	115	123
	Out-of-state	157	189	159	194	131	152	125	95	98
# of Medicaid paid days		26,256	41,102	50,352	44,558	38,807	23,263	21,295	19,748	19,059
# of PRTF continued stay reviews completed		N/A	2,537	2,287	1,826*	-	938*	888*	N/A	N/A
EFFICIENCIES										
% of PRTF placements in-state/out-of-state	In-state	49%	48%	43%	49%	62%	41%	50%	57%	57%
	Out-of-state	59%	59%	47%	58%	44%	63%	53%	47%	45%
Average cost per Medicaid Client**		$30,246	$37,777	$44,364	$40,646	$39,065	$28,309	$27,191	$29,398	$26,627

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis
* is taken from WYHealth Quarterly Reports based on calendar year
**Average cost per Medicaid client does not include clients funded using state general funds (SGF). As such, this average will differ from the Cost Per Person listed on the Program Snapshot, which includes both Medicaid-funded clients and SGF clients.

STORY BEHIND THE PERFORMANCE

- A PRTF is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21. The facility must be accredited by the Join Commission or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements in §441.51 through 441.182 of the code of federal regulations (CFR).
- The majority of state general fund youth were previously Medicaid funded but have converted to general funds following a peer reviewed medical necessity denial.
- The Onsite Compliance Review process (OSCR) began in May 2015. The purpose is to verify that the PRTF is in compliance with all applicable state and federal requirements for mental health treatment and to monitor the quality of treatment being provided to Wyoming Medicaid beneficiaries. All in-state and out-of-state PRTFs where WY clients are placed will be visited in the upcoming year(s) by the OSCR team.

WDH | Behavioral Health Division

Information contained in this section includes:

- Acquired Brain Injury (ABI) Waiver
- Comprehensive Waiver
- Court Supervised Treatment (CST) Programs
- Early Intervention and Education Program (EIEP)
- Mental Health Outpatient Treatment
- Mental Health Residential Treatment
- Recovery Supports – Peer Specialists
- Substance Abuse Outpatient Treatment
- Substance Abuse Residential Treatment
- Supports Waiver
- Veteran Outreach and Advocacy Program

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Acquired Brain Injury Waiver

Program Description

The Acquired Brain Injury (ABI) Waiver serves adults ages 21 and older with qualified brain injuries who are deemed eligible.

Program Expenditures and People Served

	2014	2015	2016
Total Medical & Waiver Cost	$8,630,560	$7,749,311	$7,957,560
Total Waiver Cost	$7,377,150	$6,633,780	$6,744,637
Total Medical Costs	$1,253,410	$1,115,531	$1,212,923
Total People Served	184	172	163
Cost per Person (Waiver and Medical)	$46,905	$45,054	$49,507
Non-600 Series*	4.31%	5.4%	4.09%

* 600 series is defined as direct service contracts

Program Cost Notes

- Participants are eligible for Medicaid medical services and Waiver services.
- Program staffing for all three Behavioral Health Division (BHD) waivers is based upon the number of BHD-Developmental Disability (DD) Section staff proportional to the number of participants active in the program.

Program Staffing

- 1.75 FTE
- 0 AWEC
- 0 Other

Program Metrics

- ABI waiver recipients received medical services under Medicaid at an average cost of $8,507/person in of SFY16.
- The ABI waiver average cost per participant was $41,400 as of the end of SFY16.
- Some participants on the waiver use waiver services only, medical services only, or both. Therefore, the calculations for average medical expenditures and average waiver expenditures when summed will not equal the overall cost per person (medical & waiver).
- 15 participants received some self-directed waiver services in SFY16.
- Individuals on the waitlist for the ABI waiver have been added to the Supports Waiver waitlist as of 3/31/2015.
- 424 providers, certified and monitored by BHD, were available to provide services for the ABI Waiver Program at the end of SFY15.

Events that have Shaped this Program

- **New Waivers.** In March of 2013, the Wyoming Legislature passed Senate Enrolled Act (SEA) 82, a law requiring two new redesigned waivers to serve more people with the existing budget. The new law set a goal to end the former Child DD and Adult DD Waivers, and eventually the ABI Waiver, and serve everyone on the Comprehensive Waiver who was already in services, but fund new people onto the capped Supports Waiver.
- **Conflict Free Case Management.** The 2013 law (SEA 0082) also required BHD to implement conflict free case management, which also became a federal law in 2014. This allows case managers to have more authority and advocacy for overseeing the implementation of participants' plans of care.
- **Wait list funding.** The 2014 legislature appropriated $20.2 million (50% State General Funds and 50% Federal Funds) for waiting list reduction. The wait list has continued to periodically be reduced as funds are approved.
- **New federal Home and Community Based (HCB) services rules.** In March of 2014, the federal government passed new rules for waiver settings and services to ensure people in HCB services are truly integrated into their communities and not isolated or receiving services that seem institutional in nature. All service settings must be in compliance by March 2019 and many providers will need to make changes over the next few years.
- **Employment First.** The 2014 House Enrolled Act (HEA) 53 passed an Employment First law that requires Employment First to be a state policy and for changes to state agency and provider policies in order to get more people with disabilities employed in the state.
- **Cost saving measures.** BHD issued changes in July of 2013 to carry out cost containment measures required by the legislature, which included tightening the definition for skilled nursing, implementing a daily respite rate, and decreasing all service rates and IBAs by 1%.
- **ABI Waiver ending.** The current ABI Waiver participants will start transitioning in April of 2017 to the Comprehensive Waiver, and the ABI waiver will end June 30, 2017.

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Acquired Brain Injury Waiver

PROGRAM CORE PURPOSE

The Acquired Brain Injury (ABI) Waiver serves adults ages 21 and older with qualified brain injuries who are deemed eligible, so they can strive to live healthy, safely, and as independently as possible, and receive individualized support in reintegrating with the friends, family, and job skills they had prior to their brain injury.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
# and % of waiver participants that are employed	42/172 (24.4%)	36/163 (22.7%)	16	53/184 (28.8%)	42/168 (25.0%)	37/172 (21.5%)	34/163 (20.9%)
# and % of waiver participants living in a place they own or lease	80/172 (46.5%)	77/161 (48%)	16	78/191 (40.8%)	82/184 (44.6%)	76/172 (44.2%)	74/161 (46.0%)

N/A indicates new metric- data not collected.
(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of people who are using waiver employment services	15	19	20	14	15	15	14	14	11
# of participants on the waiver	201	191	184	172	163	169	164	157	160
EFFICIENCIES									
Average cost per participant (waiver and medical)	$41,074	$45,520	$46,905	$45,054	$49,507	$23,402	$23,137	$25,573	$25,159
Average cost per participant (waiver only)	$36,855	$41,247	$40,758	$39,534	$41,400	$20,733	$20,256	$21,085	$21,486

N/A New metric- data not collected.
(-)Data not yet available
Information based on the most current status at the time data was run. YTD totals and QTR totals may not match.

STORY BEHIND THE PERFORMANCE

- **ABI Waiver ending.** The ABI waiver is scheduled to close on June 30, 2017. Participants began transitioning to the Supports waiver in 2015 and will begin transitioning to the Comprehensive Waiver in April of 2017. Participants remaining on the ABI waiver at the end of 2016 will choose whether to transition to the Supports Waiver or the Comprehensive Waiver. As a result of these combinations, much of the work towards increasing Independent Living and Employment is also integrating with similar efforts for the Supports and Comprehensive Waivers.

- **Wait list funding.** The ABI population did not get added to the Supports Waiver until October of 2015.

- **New federal Home and Community Based (HCB) services rules.** Under the new rules, states will not be allowed to use federal Medicaid dollars to pay for HCB services in settings that isolate people from the community or that do not show respect for people's right to privacy, dignity, and self-determination. The new rules also require participants to have leases or residency agreements if receiving residential services. The Centers for Medicare and Medicaid Services (CMS) allows states, until March 2019, to ensure all provider settings are in compliance with the new rule. Each waiver has an approved transition plan by CMS that explains how the state will work with providers to achieve and maintain compliance with the new rules.

- **Employment First.** 2014 HEA53 requires agencies to support competitive and integrated employment, requires state agencies working with HCB waiver service providers to implement employment first policies, requires state agencies to report on employment data, and provides definitions. BHD is working with an interagency taskforce to implement the legislation statewide. The policy impacts this waiver by requiring BHD to ensure that waiver employment services are offered annually and encouraged over the use of day services.

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Comprehensive Waiver

Program Description

The Comprehensive Waiver provides services for eligible individuals of all ages who meet the criteria for a developmental disability or a related condition and meet financial eligibility for Medicaid. The Comprehensive Waiver serves persons who have high support needs and require intensive services, such as residential habilitation.

Program Expenditures and People Served

	2014 (child & adult)^	2015	2016
Total Medical & Waiver Cost	$58,993	$72,164,952	$110,276,268
Total Waiver Cost	$45,176	$63,883,371	$88,539,448
Total Medical Costs	$13,817	$8,281,581	$21,736,820
Total People Served	38	1,832	1,927
Cost per Person (Waiver and Medical)	$1,552	$39,391	$58,678
Non-600 Series*	$0	$1,719,756	$2,922,910

^ Information on the low numbers in 2014 is provided under the 1st bullet of Events that shaped this Program
* 600 series is defined as direct service contracts

Program Cost Notes

- Participants receive Medicaid medical services and waiver services
- Program staffing for all three Behavioral Health Division (BHD) waivers is based upon the number of BHD-Developmental Disability (DD) Section staff proportional to the number of participants active in the program.

Program Staffing

- 19.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Comprehensive waiver recipients received Medicaid medical services at a cost of $12,815/person in SFY16.
- The Comprehensive waiver average cost per participant in SFY16 was $45,863.
- Some participants on the waiver use waiver services only, medical services only, or both. Therefore, the calculations for average medical expenditures and average waiver expenditures when summed will not equal the overall cost per person (medical & waiver).
- 281 participants received some self-directed waiver services in SFY16.
- 602 providers, certified and monitored by the BHD, were available to provide services for the Comprehensive Waiver at the end of SFY16.

Events that have Shaped this Program

- **New Waivers.** In March of 2013, the Wyoming Legislature passed Senate Enrolled Act (SEA) 82, a law requiring two new redesigned waivers to serve more people with the existing budget. The new law set a goal to end the former Child DD and Adult DD Waivers, and eventually the ABI Waiver. Everyone already receiving services from these waivers would transition to the new Comprehensive Waiver, and people being funded off the wait list would be placed in the capped Supports Waiver. These waivers went live on 4/1/2014. All Adult DD Waiver participants transitioned to the Comprehensive Waiver before 8/27/2014 and Child DD Waiver participants transitioned by 6/30/2015.
- **Conflict Free Case Management.** The 2013 law (SEA 0082) also required BHD to implement conflict free case management, which became a federal law in 2014. This allows case managers to have more authority and advocacy for overseeing the implementation of participants' plans of care.
- **Wait list funding.** The 2014 legislature appropriated $20.2 million (50% State General Funds and 50% Federal Funds) for waiting list reduction. The wait list has continued to periodically be reduced as funds are approved.
- **New federal Home and Community Based (HCB) services rules.** In March of 2014, the federal government passed new rules for waiver settings to ensure people in HCB services are truly integrated into their communities and not isolated or receiving services that seem institutional in nature. All service settings must be in compliance by March 2019 and providers will need to make several changes over the next few years.
- **Employment First.** The 2014 House Enrolled Act (HEA) No. 53, Employment First, requires employment first to be a state policy and for changes to state agency and provider policies in order to get more people with disabilities in the state employed.
- **Cost saving measures.** BHD issued changes in July of 2013 to carry out cost containment measures required by the legislature, which included tightening the definition for skilled nursing, implementing a daily respite rate, and decreasing all service rates and individual budget amounts (IBAs) by 1%.

Comprehensive Waiver

PROGRAM CORE PURPOSE

The Comprehensive Waiver provides services for eligible individuals of all ages who meet the criteria for a developmental disability, or a related condition, and meet financial eligibility for Medicaid, so they can live as safely, independently, and self-sufficiently as possible, be an integral part of their community, and live according to their own choices and preferences. The Comprehensive waiver serves persons who have high supports needs and require intensive services, such as residential habilitation.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
# and % of participants ages 18+ living independently or semi-independently[1]	380/ 1,441 (26.4%)	410/ 1,632 (25.1%)	N/A	N/A	N/A	351/ 1,441 (24.4%)	375/ 1,632 (23.0%)
# and % of participants ages 18+ working in competitive and community integrated settings earning at least minimum wage[1]	272/ 1,469 (18.2%)	308/ 1,593 (19.3%)	N/A	N/A	N/A	258/ 1,469 (17.2%)	296/ 1,593 (18.6%)
# of physical, mechanical, and chemical restraints used	1,108 (5% reduction from SFY 2015)	1,633	N/A	N/A	N/A	1,166	1,647

N/A indicates a new metric due to creation of a new waiver

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015[2]	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of participants	N/A	N/A	38	1,832	1,927	1,433	1,832	1,918	1,884
# of participants ages 18+ living in residential services or with family[1]	N/A	N/A	N/A	1,090	1,257	N/A	1,090	1,210	1,214
# of participants ages 18+ using waiver supported employment services [1]	N/A	N/A	N/A	165	176	170	165	170	175
EFFICIENCIES									
Average cost per participant (waiver and medical)	N/A	N/A	$1,552	$39,391	$58,678	$18,278	$25,140	$29,641	$29,770
Average cost per participant (waiver only)	N/A	N/A	$1,882	$36,380	$45,863	$16,668	$23,055	$23,147	$23,345

[1] Participants are added and removed from the waiver throughout the year. Some participants are counted in both the first and second halves of the year, while some are counted in only one of the halves.
N/A indicates a new metric due to the creation of a new waiver

STORY BEHIND THE PERFORMANCE

- **New federal Home and Community Based (HCB) services rules.** Under the new rules, states will not be allowed to use federal Medicaid dollars to pay for HCB services in settings that isolate people from the community or that do not show respect for people's right to privacy, dignity, and self-determination. The new rules also require participants to have leases or residency agreements if receiving residential services. The Centers for Medicare and Medicaid Services (CMS) allows states, until March 2019, to ensure all provider settings are in compliance with the new rule. Each waiver is has an approved transition plan by CMS that explains how the state will work with providers to get into compliance and maintain compliance with the new rules.
- **Employment First.** 2014 HEA53 requires agencies to support competitive and integrated employment, requires state agencies working with HCB waiver service providers to implement employment first policies, requires state agencies to report on employment data, and provides definitions. BHD is working with an interagency taskforce to implement the legislation statewide.

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Court Supervised Treatment Programs

Program Description

The Court Supervised Treatment (CST) Programs exist to provide alternative sentencing options to jail or prison within the judicial system by providing judicial supervision, probation, and substance use treatment to individuals who have committed crimes stemming from their addiction to drugs and/or alcohol. These individuals are at high risk for reoffending and in high need of substance use treatment services.

Program Expenditures and People Served

	SFY 2014	SFY 2015	SFY 2016
Total Program Cost	$3,911,271	$3,775,897	$3,761,001
People Served	636	635	610
Cost per Person	$6,150	$5,946	$6,166
Non-600 Series*	11%	7%	19.7%

* 600 series is defined as direct service contracts

Program Cost Notes

- Biennium funding: $3,768,644 State General Funds and $4,800,607 State Tobacco Funds
- All funds reside in Fund 558, established in accordance to Wyo. Stat. Ann. § 7-13-1605
- Program contracts for SFY17 were cut 8.3% ($600,000)

Program Staffing

- 1 FTE
- 1 AWEC (SFY16 only)
- 0 Other

Program Metrics

- There were 19 funded CST Programs in SFY16 (11 adult, 2 juvenile, 1 driving under the influence (DUI), 3 adult/juvenile combined, and 2 tribal wellness).
- Ancillary services include: education, medical/dental, life skills, 12-Step programs, church, etc. These services support completing treatment services, reduce recidivism, and increase the duration of sobriety. 30,819 units of ancillary services were provided in SFY 2016.
- Supervision services: Probation officers conduct home visits, verify that a participant is on their agreed upon program schedule, and assure that participants are spending time with program approved contacts only. These services provide monitoring of compliance and identify violations of program requirements. 38,218 units of supervision services were provided in SFY 2016.
- 30,452 units of treatment services were provided in SFY 2016.
- 32,080 battery drug tests were performed in SFY 2016.

Events That Have Shaped This Program

- Funding for this program comes from House Enrolled Act (HEA) 67 (2001); HEA 42 (2002); Substance Abuse Division Budget (2005, 2006); and HEA 21 (2006).
- The current CST Program Act, Wyo. Stat. Ann. §§ 7-13-1601 through-1615, was placed into law on July 1, 2009 and repealed previous CST Program statutes.
- The Chapter 8 Rules and Regulations for State Funding and Certification of CST Programs governing CST Programs were promulgated in January of 2010 and repealed previous CST Program Rules.
- The CST Funding Panel makes all funding decisions for the programs. The Panel consists of the Attorney General, Directors of the Department of Health, Department of Family Services, and Department of Corrections, the Chairman of the Governor's Advisory Board on Substance Abuse and Violent Crimes, and the State Public Defender, or their designees, per Wyo. Stat. Ann. § 7-13-1605 (d).

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Court Supervised Treatment Programs

PROGRAM CORE PURPOSE

The core mission of the Court Supervised Treatment (CST) Programs is to provide sentencing alternatives for the judicial system by combining ancillary services, probation managed supervision, substance abuse treatment services, and substance abuse testing for substance offenders in order to increase durations of sobriety, graduate from the CST Program, and to reduce recidivism.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of participants who graduate (retention rate)* Adult (A) Juvenile (J)	A: 67% J: 48%	A: 68% J: 67%	A: 69% J: 67%	A: 64% J: 51%	A: 70% J: 57%	A: 64% J: 63%	A: 77% J: 80%
% of participants having at least 120 days sobriety prior to graduation	90%	A: 99% J: 90%	84%**	86%**	A: 90% J: 75%	A: 99% J: 97%	A: 87% J: 76%
% of participants having re-arrest during their program participation (In-Program Recidivism Rate)	<12%	A: 5% J: 10%	15%**	7%**	A: 8% J: 12%	A: 7% J: 18%	A: 5% J: 11%

* New method used for calculating retention, see "Story Behind the Performance"
**Sobriety and recidivism were not broken out by population prior to FY14

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 QI+Q2	2016 Q3+Q4
# of unique participants Adults (A) Juveniles (J)	710*	668*	636 A: 539 J: 97	635 A: 551 J: 84	610 A: 545 J: 65	485	497	467 A: 415 J: 52	470 A: 419 J: 51
# of ancillary services per month, per participant	5	5	A: 5 J: 2	A: 5 J: 2	A: 4 J: 2	A: 7 J: 3	A: 6 J: 3	A: 6 J: 3	A: 6 J: 3
# of supervision contacts per month, per participant	5	5	A: 5 J: 6	A: 5 J: 6	A: 5 J: 10	A: 7 J: 8	A: 6 J: 8	A: 6 J: 13	A: 6 J: 14
# of substance abuse tests per month, per participant	4.8	4.5	A: 5 J: 4	A: 5 J: 4	A: 4 J: 5	A: 6 J: 5	A: 6 J: 5	A: 6 J: 6	A: 5 J: 6
Units of service per month, per participant	19	19	A: 20 J: 16	A: 19 J: 16	A: 17 J: 22	A: 27 J: 21	A: 22 J: 22	A: 22 J: 29	A: 24 J: 29
EFFICIENCIES									
Cost per unit of service(ancillary, treatment, supervision, drug test)	$24.69	$26.79	A: $25.63 J: $32.03	A: $26.08 J: $30.97	A:$30.23 J: $23.36	N/A*	N/A*	N/A*	N/A*
Program cost per participant (cost per day per participant)	$5,551 ($15.21)	$6,108 ($16.73)	$6,150 ($16.85)	$5,946 ($16.29)	$6,166 ($16.90)	N/A*	N/A*	N/A*	N/A*

* Metrics were not broken out by population prior to FY14
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- It is anticipated in SFY17 that the WyCST database will be evaluated and enhancements added. Areas identified for review include recidivism calculation, bulk entries to save user time, more transparency, and a revised user manual so everyone is entering the mandatory data components consistently.

- The CST program manager vacated the role in March 2016. A staff member in the Community Systems Unit assumed routine activities through the rest of the year.

- The new Program Manager is working on defining reporting in WyCST to gain consistency across the courts and their reporting.

- Staff went to Laramie and met with WyCST developers at WYSAC to get a better understanding of the reports produced by that data system, and to discuss any additional reports needed to perform program management.

- Due to staff vacancies and budget cuts, program changes include implementation of self-evaluation assessments in lieu of on-site reviews. On-site reviews will be conducted as warranted by contract non-compliance issues and/or technical assistance requests.

- The SFY17 Behavioral Health Division functional alignment restructure has increased the staff to two for CST functions supportive of the program, effective October 1, 2016. This change effectively replaces the AWEC position lost in SFY16 with a staff skill level better aligned for program needs.

- Retrospective review of reported totals identified inconsistencies between reporting periods due to sites retroactively updating or correcting data. Future WyCST database improvement includes closing previous period fields for editing after sufficient time for data entry to maintain data integrity.

- The retention rate formula has been evaluated and revised for all reporting years. The previous formula did not appropriately consider participants who were in a program longer than a year. The new formula considers total program participants and terminated participants, which better assesses program retention.

- The cost per unit of service for adults increased because the number of units served per adult decreased in SFY16. The cost per unit of service for juveniles decreased because the number of units served per juvenile increased in SFY16.

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Early Intervention & Education Program

Program Description

The Early Intervention & Education Program (EIEP) provides oversight of 14 Regional Child Development Centers that are contracted to provide early intervention, special education, and related services to children from birth through age five years who are identified with developmental delays and/or disabilities. It is a state mandated program according to W.S. §21-2-701-706.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$38,070,705	$38,243,987	$38,489,931
People Served	4,014	3,937	3,961
State per child amount	$8,452	$8,812	$8,814
Non-600 Series*	10%	10%	10%

* 600 series is defined as direct service contracts

2016 Program Cost Notes

- Total State general funds birth through five years: $31,999,477
  - State Part C (birth through two years): $10,270,301
  - State Part B (three through five years): $21,729,176
- Federal Part C funds birth through two years: $2,247,675
- Federal Part B funds three through five years: $2,000,012

Program Staffing

- 4 FTE
- 0 AWEC
- 0 Other

Program Metrics

- 14 Regional Child Development Centers with 41 locations statewide
- Annual Focused Monitoring of both Part C and B programs based on results of federal compliance indicators from State Performance Plan(s)
- Annual parent survey data, which indicates the level of involvement and satisfaction families feel from early intervention or special education programs
- Child Outcomes Summary data, which indicates growth a child shows from receiving early intervention or special education services

Events that have Shaped this Program

- Individuals with Disabilities Education Act (IDEA), 1997 and IDEA Improvement Act, 2004
- Wyoming Department of Education (WDE), Chapter 7, Services for Children with Disabilities: Rules, Policies, and Procedures
- The 2004 IDEA Improvement Act re-authorized and continues to require children, ages 3 through 21 years, to have access to Free Appropriate Public Education (FAPE) and also continues to fund early intervention services for children from birth through age two.
- Office of Special Education Programs: 2010 on-site monitoring of the Department of Education and Behavioral Health Division services for children ages three through five with disabilities
- State Performance Plan and Annual Performance Report for both Part C and Part B
- Resolution to Maintenance of Effort that ensures state level of fiscal support for services for children from birth through age five meets all federal requirements
- Wyoming Department of Health (WDH) is the lead agency for Part C and directly receives a federal grant to fund early intervention programs
- WDE is the State Education Agency who receives federal grants for Part B Section(s) 611 & 619; WDE grants a portion of 611 funds to WDH and provides all 619 funds to WDH.

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Early Intervention & Education Program

PROGRAM CORE PURPOSE

The purpose of the Early Intervention & Education Program (EIEP) is to improve child outcomes by providing early intervention, special education, and related services to children, birth through five years of age, with developmental delays and/or disabilities.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015[2]	SFY 2016
Part C: The percent of children who substantially increased[1] their rate of growth in Social-Emotional skills	82%	88%	50%*	67.5%*	81.9%	80.3%	86.4%
Part C: The percent of children who substantially increased[1] their rate of growth in Acquiring and Using Knowledge and skills	81%	85%	56.7%*	68.6%*	80.7%	79.7%	83.8%
Part C: The percent of children who substantially increased[1] their rate of growth in Taking Appropriate Action to Meet Needs	82%	88%	61.4%*	76.0%*	81.6%	81.8%	86.8%
Part B: The percent of children who substantially increased[1] their rate of growth in Social-Emotional skills	93%	93%	76.4%	85.3%	88.5%	91.2%	90.9%
Part B: The percent of children who substantially increased[1] their rate of growth in skills Acquiring and Using Knowledge and skills	93%	94%	81.4%	88.2%	89.9%	92.1%	92.7%
Part B: The percent of children who substantially increased[1] their rate of growth in Taking Appropriate Action to Meet Needs	94%	94%	79%	87.5%	90.4%	92.77%	91.5%

*For Part C, prior to 2014, children's exit ratings were not included in the "substantially increased" formula, instead exit scores for children in Part C were based on their entry scores for Part B. Beginning in 2013, the scores from children who demonstrated progress on exit from Part C were included in the formula thus increasing the percentage of children who "substantially increased" in all three areas. Therefore, in 2012 and 2013 the exit scores were automatically lower because of the higher, developmentally appropriate age expectations for 3 year olds for Part B.

[1] Substantially increased: Formula based on the children functioning at a level nearer to same-aged peers but did not reach it plus the children functioning at a level comparable to same-aged peers divided by all children in the category

[2] Targets for Part C are created for the Part C Federal Fund application prior to the calculation of SFY15 metrics in June of 2015.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Part C: Number of children served based on November 1st count	1,188	1,219	1,210	1,207	1,266	N/A*	N/A*	N/A*	N/A*
Part C: Number of children served annually (unduplicated)	1,932	1,917	1,896	1,196	2,231	N/A*	N/A*	N/A*	N/A*
Part B: Number of children served based on November 1st count	2,804	2,823	2,804	2,730	2,695	N/A*	N/A*	N/A*	N/A*
Part B: Number of children served annually (unduplicated)	3,771	3,794	3,621	3,972	3,548	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted	$8,743	$8,743	$8,643	$8,812	$8,814	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually	$5,983	$6,193	$6,288	$8,323	$6,041	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Part C: Allows states to apply and receive federal funds to ensure services are provided to families and their children from birth through age two who have developmental delays under IDEA.
- Part B: Provides assistance to states for the education of all children with disabilities under Section 611 of the IDEA, provides federal funding to a State Education Agency (SEA) to ensure children ages three through 21 receive FAPE; Section 619 of the IDEA is specific to funding children ages three through five.
- All children who are suspected of having a developmental delay or disability are evaluated through a series of research-based and professionally recognized assessment instruments.
- All children are evaluated using the child outcome summary at strategic points: upon entering the program, when transitioning from Part C to Part B, and on exiting the program. This data is used to measure a child's progress throughout their participation in the program.
- EIEP received the highest program determination from the U.S. Department of Education. The determination of "meets requirements" is based on the results submitted in the Program's Annual Performance Plan (APR) which specifically reviews the progress made in meeting measurable and rigorous targets established in the State Improvement Plan (SIP).
- The Legislative Service Office began a program audit on behalf of the Management Audit Committee in SFY 2016. The audit has focused on eligibility rates, funding, and the appropriate state Department location for both the Part C and Part B/619 programs.
- With the assistant Attorney General's approval, the EIEP unit required an individual education plan (IEP) or individual family service plan (IFSP) to be in place by November 1st of each year in order for the student to be included on the count for state funds.
- EIEP used stakeholder involvement to develop a new process for reporting child progress.

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Mental Health Outpatient Treatment

Program Description

The purpose of the Mental Health Outpatient treatment program is to provide access to effective outpatient treatment services.

Program Expenditures and People Served

	2014	2015	2016*
Total Program Cost	$21,865,991	$20,750,476	$20,548,194
People Served	17,477	17,934	17,534*
Cost per Person	$1,251	$1,157	$1,172*
Non-600 Series**	0%	0%	0%

* SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered. Data is expected to be finalized by mid-December 2016.
**600 series is defined as direct service contracts

Program Cost Notes

- Funding: $20,548,194 SGF SFY 2016

Program Staffing

- 6 FTE (shared with Mental Health Residential, Substance Abuse Outpatient and Residential)
- 0 AWEC
- 0 Other

Program Metrics*

- A total of 322,984 hours of mental health outpatient service were delivered in SFY16 with an average of 18.42 hours of service per client.
- Populations served: 43.55% adults with Serious Mental Illness (SMI); 11.74% youth with Severe Emotional Disturbance (SED), and 44.71% not SMI or SED.

Events that have Shaped this Program

- 2002: The Chris S. Lawsuit Settlement Agreement signed in 2002 stipulated the development of community based treatment and supports for adults with SMI.
- 2002 HEA 42 established the Substance Abuse Control Plan.
- 2006: The Select Committee on Mental Health and Substance Abuse produced the 2006 House Enrolled Act (HEA) 21, which provided enhancements to the community based mental health and substance abuse treatment systems.
- 2007 Senate Enrolled Act (SEA) 77 continued system enhancements initiated with 2006 HEA 21.
- 2008 SEA 24 provided increased funding for expanding mental health services including early intervention, group homes, psychiatric, and nursing supports, and promoted the concept of regionalization of services.
- 2014 HEA 41 enacted a "Payer of last resort" footnote and then was revised in 2015 (SEA 56, Section 048, Footnote 13) which mandated "any payment made by the Department of Health from general funds or tobacco settlement trust income account funds appropriated shall not be applied directly to Medicaid services rendered for mental health care services to Medicaid recipients, and the department shall not count billable Medicaid services provided to Medicaid recipients towards mental health service contract requirement for annual performance hours." The footnote was removed during the 2016 Legislative Session.

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Mental Health Outpatient Treatment

PROGRAM CORE PURPOSE

The purpose of the Mental Health Outpatient treatment program is to provide access to effective outpatient treatment services to improve the levels of personal functioning for those consumers who need treatment.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016*
Wait time for services (days) (14 of 14 providers met this target)^	≤ 2	≤ 2 days	N/A	10	5.32	2.79	2.25 days
Treatment completion (12 of 14 providers met this target) ^	72%	72%	41%	50%	51%	65%	67%
% of clients who were homeless at admission who were not homeless at discharge (2 of 14 providers met this target)	80%	80%	28%	35%	56%	50%	57%
% of clients who are employed upon admission who were unemployed at discharge (2 of 12 providers met this target)**	2%	2%	N/A	N/A	4%	2%	4%
% of clients who are unemployed upon admission who were employed at discharge (5 of 14 providers met this target)	40%	40%	10%	13%	20%	17%	31%

* SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered.
N/A indicates data not available due to the creation of a new metric
^ The Contract Target information is listed in the Story Behind the Performance.
** Two programs did not have any homeless at admission.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Number of persons served	17,202	17,131	17,477	17,934	17,534	10,537	10,523	13,077	12,789
Number of persons homeless (at admission)	201	213	217	358	234	N/A*	N/A*	N/A*	N/A*
Number of persons not Employed (at admission)	2,216	1,982	1,868	2,461	2,175	N/A*	N/A*	N/A*	N/A*
Amount of outpatient services delivered (hours)	360,003	351,746	370,948	349,426	322,984	174,487	174,940	173,202	149,781
EFFICIENCIES									
Average cost per client	$1,207	$1,383	$1,251	$1,157	$1,172	N/A*	N/A*	N/A*	N/A*
Average service cost per hour	$64	$64	$60	$59	$64	N/A*	N/A*	N/A*	N/A*

N/A indicates data not available due to the creation of a new metric
N/A* Indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

Quality management activities have focused on wait times, prioritization of adults with serious mental illness (SMI) and youth with serious emotional disturbance (SED), and increasing supported employment. Division staff provided notice to providers of non-compliance when applicable, developed strategies, and requested performance improvement plans to address non-compliance issues.

SFY 16 contracts require a wait time of seven (7) days or less, however Division staff chose a more ambitious wait time target of two (2) days or less. Strategies to achieve the target included a series of "spotlight" discussions with providers during which providers with low wait times shared their processes and policies with other providers. Discussions then took place, particularly about open access processes and how to modify the open access model for smaller centers. An open access webinar was sponsored by the Division on November 9, 2015. Five agencies were represented during the webinar, all of which were identified as experiencing issues with wait time. Division staff tracked wait time and prioritization monthly, and notified providers if wait times exceeded contract requirements.

Data indicated that some providers, although their overall wait time for all clients met contract requirements, were not prioritizing the priority SMI and SED populations for treatment. Division staff and providers together developed a series of questions, to be included in intake assessments, to determine more clearly if a person presenting or calling for treatment meets the criteria for a priority population.

Evidence-based supported employment was also chosen as an area of focus for Division staff. Northern Wyoming Mental Health Center was selected to receive funding to demonstrate the development of an evidence-based supported employment model in one of Wyoming's smaller communities. The funding also required the development of policies and procedures to be included in a "how to" manual, which other providers can use to implement the service. The project was successful, with a total of twenty-five (25) persons served and contract deliverables completed within six (6) months. However, participation with the Division of Vocational Rehabilitation at the local level was minimal. The manual was completed and distributed to all providers.

The Division did not engage in activities directed at treatment completion or homelessness, however, requirements for both were included in the SFY 16 contracts. Contracts required a treatment completion rate of sixty percent (60%) or higher. Providers met the contract requirement, but did not meet the target of seventy-two percent (72%) established internally. Contracts required the tracking of homelessness, but did not specify a target requirement. Based on incomplete data, housing improved by over seven percentage points (from 50% to 57% housed) during SFY16.

Contracts also included requirements to improve functioning; upon completion of treatment and discharge, average functioning was to improve by five (5) points or more as measured by the Global Assessment of Functioning (GAF) scale among sixty-five percent (65%) of clients who do not meet the criteria for SMI or SED.

Since the SFY 16 data is not complete, it is difficult to ascertain, or provide explanation for differences between the SFY 15 and SFY 16 outputs and efficiencies data. Incomplete data included on this report indicates that the number of persons served decreased by 400 and the number of hours of service provided decreased by 26,442. It also appears costs increased by $15 per client served and $5 per service hour. Analysis of the data will be completed once all data is submitted.

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Mental Health Residential Treatment

Program Description

The Mental Health Residential Treatment program is a conduit for access to effective community-based mental health outpatient treatment services for seriously mentally ill individuals whose level of functioning requires 24/7 supports. Community housing services is a cost-effective mechanism to prevent individuals from needing a more costly and restrictive level of care.

Program Expenditures and People Served

	2014	2015	2016*
Total Program Cost	$6,102,954	$6,218,682	$6,405,232
People Served	437	214	476*
Cost per Person	$13,965	$29,059	$13,456*
Non 600 Series**	0%	0%	0%

* SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered. Data is expected to be finalized by mid-December 2016.
**600 series is defined as direct service contracts

Program Cost Notes

- 100% State General Funds

Program Staffing

- 6 FTE (Shared with Mental Health Outpatient, Substance Abuse Outpatient and Substance Abuse Residential Programs)
- 0 AWEC
- 0 Other

Program Metrics

- 248 Wyoming residents resided in Community Housing (group homes and supervised living environments) in SFY16.
- 228 Wyoming residents received Crisis Stabilization services in SFY16.

Events that have Shaped this Program

- 2002: The Chris S. Lawsuit Settlement Agreement required the development of community-based treatment and supports for adults with serious mental illness (SMI).
- 2002 HEA 42 established the Substance Abuse Control Plan.
- 2006: The Select Committee on Mental Health and Substance Abuse produced the 2006 House Enrolled Act (HEA) 21, which provided enhancements to the community-based mental health and substance abuse treatment system.
- 2007 Senate Enrolled Act (SEA) 77 continued system enhancements initiated with 2006 HEA 21.
- 2008 SEA 24 provided increased funding for expanding mental health services including early intervention, group homes, psychiatric, and nursing supports, and promoted the concept of regionalization of services.

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Mental Health Residential Treatment

PROGRAM CORE PURPOSE

The purpose of the Mental Health Residential Treatment program is to provide a conduit for access to effective community-based mental health residential treatment services for seriously mentally ill individuals whose level of functioning requires 24/7 supports. Community housing services is a cost-effective mechanism to prevent individuals from needing a more costly, and restrictive level of care.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016***
Utilization rate of crisis stabilization beds	85%	85%	9.23%	0%**	9.20%	30.47%	55.06%
Utilization rate of group home beds	90%	95%	67.62%	85.71%	83.26%	83.99%	91.32%
Utilization rate of supervised living beds	95%	95%	56.67%	65.07%	69.04%	86.35%	93.01%

*SFY 16 data has not been finalized due to a system error preventing final data from being uploaded/entered
** Providers did provide crisis stabilization services, but the services were not reported correctly.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016***	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
# of persons served by crisis stabilization	121	0**	156	50	228	N/A*	N/A*	N/A*	N/A*
# of persons served by group homes	25	46	77	80	116	N/A*	N/A*	N/A*	N/A*
# of persons served by supervised living	77	50	77	84	132	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average cost per client for crisis stabilization	N/A	N/A	$11,353	$35,422	$7,768	N/A*	N/A*	N/A*	N/A*
Average cost per client for group home and supervised living***	N/A	$31,862	$28,128	$27,119	$18,686	N/A*	N/A*	N/A*	N/A*

* SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered.
** Providers did provide services to crisis stabilization clients however the data was reported incorrectly
N/A* indicates data not available on a quarterly basis
N/A indicates data not available
*** Funding for Supervised Living and Group Homes is bundled together

STORY BEHIND THE PERFORMANCE

The quality management focus during the year was limited to outpatient wait time and supported employment. However, Division staff engaged in activities which may have improved utilization. Efforts included the facilitation of discharges from the Wyoming State Hospital (WSH) into community beds via conference calls conducted twice a month with community partners and WSH staff. Clients ready for discharge are discussed during the conference calls, and if there are beds available, providers and WSH staff problem-solve to enable movement into the community. In recent months, beds have not been available except in crisis stabilization. Although some persons can temporarily be placed in a crisis stabilization facility, this placement is not optimal without permanent housing plans or availability. Providers were also kept informed of their utilization rates via conversations at monthly provider meetings and technical assistance was provided. These activities contributed to the increased utilization of mental health residential and community living environments.

With increased utilization, numbers of persons served and costs per client have been reduced.

During the year, quality management activities included the provision of training on the Level of Care Utilization System (LOCUS) assessment tool, utilization of which was required in SFY 16 contracts. Analysis of the LOCUS data indicates that levels of care needed by clients, particularly those discharged from the WSH, are not available in the community, particularly Level 5, medically monitored residential services. Plans to redesign or refocus existing mental health residential options were put on hold, pending payment reform within the Division's Mental Health and Substance Abuse Program.

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Recovery Supports: Peer Specialists

Program Description

Peer Specialists are persons with their own experience of recovery who work as fully integrated treatment team members. Because of their experience and training, they provide recovery supports, advance advocacy, provide a "consumer" perspective within the agency where they work, and demonstrate that recovery is possible (promote hope).

Program Expenditures and People Served

	2014	2015	2016*
Total Program Cost	$541,875	$558,899	$585,000
People Served	926	967	1,032
Cost per Person	$585	$578	$567
Non-600 Series**	0%	0%	0%

*A system error has prevented final data from being uploaded/entered; thus, FY2016 data will be finalized by December 2016.
**600 series is defined as direct service contracts

Program Cost Notes

- Funding:
  - 59% Federal block grants ($342,750)
  - 41% State General Funds ($242,250)

Program Staffing

- 0.25 FTE (Program Manager)
- 0 AWEC
- 13 Other (contract peer specialists at 6 community mental health centers)

Program Metrics

- The use of peer specialists has increased in Wyoming and nationwide because research indicates the addition of this approach can increase treatment engagement and can yield results that are as good as, if not better than, traditional care with less cost[1].
- Average time spent in all treatment services is used as a proxy measure to show increased treatment engagement (hope that treatment will result in recovery).
- Average increased Global Assessment of Functioning (GAF) scores upon treatment discharge are used as a measure to show treatment results.

[1]Davison L, Bellamy C, et al. Peer support among persons with severed mental illness: a review of evidence and experience. *World Psychology 2012; 11: 125-128.*

Events that have Shaped this Program

- This approach is grounded in historic events such as the Olmstead decision, Wyoming Chris S. settlement agreement, and efforts to promote civil rights emphasizing that persons with mental illness and/or substance use disorder diagnosis are ensured voice, choice, self-determination, and a life in the community similar to that of others.
- Following demonstration by insurance providers and others of the approach's efficacy, peer specialist services became billable to Medicaid in 2007. Since then, states, including Wyoming, have prioritized training, credentialing, and workforce development.
- Program funding ended as of June 2016 due to budget reductions during the 2016 legislative session.

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Recovery Supports: Peer Specialists

PROGRAM CORE PURPOSE

The Peer Specialist initiative provides funding and resources to hire, train, and retain persons in recovery to help persons with mental illness and/or substance use disorders to increase treatment engagement, improve functioning, and demonstrate that recovery is possible (e.g. increase hope).

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016^**
Average # of hours spent in treatment services for persons with a Serious & Persistent Mental Illness (SPMI) diagnosis: Persons receiving peer specialist services/persons in treatment not receiving peer specialist services	24 13	Program eliminated	N/A	N/A	167 (with peer specialist) 18 (without)	180 (with peer specialist) 16 (without)	154 (with peer specialist) 15 (without)
Percentage of persons discharged from treatment who have received peer specialist services who also show improved functioning as measured on the GAF Scale, as compared to persons who did not receive peer specialist services	85%	Program eliminated	N/A	77% (with peer specialists) 74% (without)	79% (with peer specialists) n=245 82% (without) n=5,320	88% (with peer specialists) n=219 81% (without) n= 3,496	85% (with peer specialists) n=302 69% (without) n= 3,393

^ SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY^ 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016^ Q1+Q2**	**2016^ Q3+Q4**
OUTPUTS									
# of peer specialists working within the state funded treatment system*	20	14	14	14	13	13	13	13	13
EFFICIENCIES									
% of clients who have a diagnosis of: SPMI Substance Use Disorder (SUD) Other who received peer specialist services**	N/A	10% 10% 1%	12% 14% 1%	12% 12% 1.5%	13% 16% 2%	9.4% 10.9% 1.0%	10.6% 11.6% 1.4%	10.4% 12.7% 1.3%	9.6% 12.6% 1.2%
# of clients served per peer specialist**	N/A	58	71	74	79	64	76	77	74
# of peer specialists who have completed the Wyoming training*	N/A	N/A	N/A	N/A	15	N/A	N/A	N/A	15

^SFY 16 data has not been finalized due to a system error preventing final data from being uploaded/entered.
* Services provided by agencies with contracts canceled during the FY are not included.
** This metric reports the average for the combined quarters and annual total.
N/A indicates data not yet available due to the creation of a new metric
* Training program to be established by September of 2016

STORY BEHIND THE PERFORMANCE

- Program funding ended June 30, 2016 due to legislative budget cuts. While providers are still urged to include this best practice in serving clients with the highest needs, budget cuts resulted in realignment of most of the peer specialists to other roles and waning effort during the last quarter of SFY2016.
- The Division began tracking numbers of persons served, total treatment services, and Global Assessment of Functioning (GAF) scores for Peer Specialist Services via the Wyoming Client Information System (WCIS) in SFY 2013. Utilizing the WCIS allows for demonstration that client level outcomes are achieved. The Division worked with peer specialists and their agency directors to focus attention towards recovery outcomes resulting in steady upward trends.
- Wyoming participated in a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Policy Academy to find a more solid way to measure client-level outcomes related to Peer Specialist services provided in community centers and to obtain more consistent inputs via a Wyoming training. This federally funded initiative directly and significantly involves consumers in the project planning and implementation. Research and documents from other states indicate that peer specialist training is positively associated with better outcomes for the persons they serve.
- The Peer Specialist initiative complements and supports treatment activities to improve outcomes and enhance the recovery of persons with mental illness and/or substance use disorders.
- Evaluation efforts and the body of literature have continued to increase. During SFY2016, Wyoming conducted the first statewide review of client level treatment outcomes using the Daily Living Activities Assessment (DLA-20) Anchor data. This analysis confirms that Wyoming peer specialists are serving clients most in need of supports.

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Substance Use Outpatient Treatment

Program Description

Funding is contracted to community substance use treatment centers for Outpatient Treatment Services that assist Wyoming residents in achieving and maintaining recovery from alcohol and drug dependency. The program is authorized by W.S. § 9-2-102 *et seq.* and W.S. § 9-2-2701 *et seq.*

Program Expenditures and People Served

	2014	2015	2016*
Total Program Cost	$9,897,546	$9,504,035	$9,504,018
People Served	6,560	6,672	6,386
Cost per Person	$1,509	$1,424	$1,488
Non-600 Series**	0%	0%	0%

* SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered.
**600 series is defined as direct service contracts

Program Cost Notes

- SFY 2016 Funding:
  - 50% State Tobacco Funds ($4,791,602)
  - 40% State General Funds ($3,824,738)
  - 10% Federal Funds ($887,678)

Program Staffing

- 6 FTE (shared with Mental Health Outpatient, Residential, and Substance Use Residential programs)
- 0 AWEC
- 0 Other

Program Metrics*

- A total of 182,807 hours of outpatient services were delivered by community substance use providers, with an average of 28.63 hours of service per client in SFY 2016.
- 53% of persons served in SFY16 were admitted for alcohol dependency, 20% for marijuana/hashish, 15% for methamphetamine, 2% for heroin, and 10% related to other drugs.

Events that have Shaped this Program

- 2002 House Enrolled Act (HEA) 42 established the Substance Abuse Control Plan. The Substance Abuse Control Plan, authorized by Wyo. Stat. Ann. § 9-2-2701 et seq. requires a comprehensive plan to address substance use, including prevention, intervention, and treatment methodologies.
  - The Department of Health, in consultation with the Departments of Education, Family Services, Workforce Services, and Corrections, established standards for effective treatment and prevention of substance use.
  - The Department of Health certifies all programs, providers, and facilities which receive state funds for substance use treatment, and those serving court referred individuals.
- The Select Committee on Mental Health and Substance Abuse produced the 2006 HEA 21, 2007 SEA 77, and 2008 SEA 24, resulting in substantial increases in funding for substance abuse residential programs and promoted the concept of regionalization of services.
- 2012 Senate Enrolled Act (SEA) 29 requires the Behavioral Health Division to promulgate rules requiring reimbursement of State funds only to providers with a national accreditation for mental health and substance abuse treatment services.

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Substance Use Outpatient Treatment

PROGRAM CORE PURPOSE

The Substance Use Outpatient Treatment Program provides access to effective outpatient substance use treatment services, decreases alcohol and drug use among those individuals engaged in substance use outpatient treatment services, and increases levels of personal functioning through employment, stable housing, and treatment completion.

OUTCOMES							
Performance Metric	**SFY2016 Target**	**SFY2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016***
% of clients who are employed upon admission who were unemployed at discharge (4 of 15 providers met the target)	2%	≤ 2%	4.76%	3.72%	5.35%	3.54%	3.61%
% of clients who are unemployed upon admission who were employed at discharge (4 of 15 providers met the target)	40%	40%	N/A	17.05%	26.46%	16.06%	23.91%
% of clients who were homeless at admission who were not homeless at discharge (3 of 11 providers met the target)**	80%	80%	N/A	31.25%	42.96%	42.26%	48.57%
% of clients completing treatment (10 of 15 providers met this target)^	60%	72%	51%	53%	59%	66%	66%
Average wait time (in days) for services (15 of 15 providers met this target)^	<2	≤ 2	N/A	12	5.69	2.46	2.02

* SFY2016 data has not been finalized due to a system error preventing final data from being uploaded/entered.
N/A indicates data not available due to the creation of a new metric
** 4 providers reported no clients homeless at admission
^ Contract target information is listed in the Story Behind the Performance

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016* Q1+Q2**	**2016* Q3+Q4**
OUTPUTS									
Number of persons served	6,964	6,878	6,560	6,672	6,386	2,930	3,129	4,222	4,179
Number of persons admitted	5,328	5,140	4,372	5,314	3,847	2,613	2,701	2,008	1,839
Number of persons discharged	6,317	6,037	5,236	5,923	4,943	2,850	3,073	2,397	2,546
# of hours of outpatient services delivered	200,433	211,862	209,729	199,863	182,807	100,495	99,364	92,043	90,764
EFFICIENCIES									
Average cost per client	$1,437	$1,464	$1,509	$1,424	$1,488	N/A*	N/A*	N/A*	N/A*
Average service cost per hour	$49	$48	$47	$48	$52	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

Quality management activities focused on wait time, prioritization for treatment of specific mental health populations, and supported employment. Division staff provided notice of non-compliance to providers when applicable, developed strategies, and requested performance improvement plans to address non-compliance issues.

The SFY 16 contract and internal Division targets require a wait time of seven (7) days or less. To achieve the target, Division staff hosted a series of "spotlight" discussions with providers during which providers with low wait times shared their processes and policies with other providers. Discussions then took place, particularly about open access processes and how to modify the open access model for smaller centers. An open access webinar was sponsored by the Division on November 9, 2015. Five agencies were represented during the webinar, all of which were identified as experiencing issues with wait time. Division staff tracked wait time and prioritization monthly, and notified providers if wait times exceeded contract requirements.

Although a focus was placed on the prioritization for treatment of mental health populations, Division activities also had an impact on substance use populations. Division staff and providers together developed a series of questions, to be included in intake assessments, to determine more clearly if a person presenting or calling for treatment meets the criteria for a priority population. Questions developed included those which assist identification of a person as a member of a substance use priority population. This focus on priority populations contributed to the overall goal attainment for wait time.

Evidence-based supported employment efforts focused on the mental health population, although some recipients of the service had co-occurring mental illness and substance use disorders. Northern Wyoming Mental Health Center was selected to receive funding to demonstrate the development of an evidence-based supported employment model in one of Wyoming's smaller communities. The funding also required the development of policies and procedures to be included in a "how to" manual, which other providers can use to implement the service. The project was successful and contract deliverables were completed within six (6) months. However, participation with the Division of Vocational Rehabilitation at the local level was minimal. The manual was completed and distributed to all providers. This effort contributed to an improved employment rate at discharge of persons unemployed at admission.

The Division did not engage in activities directed at treatment completion or homelessness, however, requirements for both were included in SFY 16 contracts. Contracts required a treatment completion rate of sixty percent (60%) or higher, which was achieved by ten (10) of sixteen (16) providers. Contracts required the tracking of homelessness, but did not specify a target requirement. Based on incomplete data, housing improved by over six percentage points (from 42% to 48%) during SFY16.

Contracts also included requirements to improve functioning; upon completion of treatment and discharge, average functioning was to improve by five (5) points or more as measured by the Global Assessment of Functioning (GAF) scale among sixty-five percent (65%) of adults who do not meet the criteria for serious mental illness (SMI) or youth with serious emotional disturbance (SED).

Since the SFY 16 data is not complete, it is difficult to ascertain or provide explanation for differences between the SFY 15 and SFY 16 outputs and efficiencies data. Incomplete data included on this report indicate the number of persons served decreased by 286 and the number of hours of service provided decreased by 17,056. It also appears costs increased by $64 per client served and $4 per service hour. Analysis of the data will be completed once all data is submitted.

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Substance Use Residential Treatment

Program Description

Funding is contracted to community substance use treatment centers for Residential Treatment Services that assist Wyoming residents in need of 24 hour intensive services to achieve and maintain recovery from alcohol and drug dependency. The program is authorized by W.S. § 9-2-102 *et seq.* and W.S. § 9-2-2701 *et seq.*

Program Expenditures and People Served

	2014	2015	2016*
Total Program Cost	$12,928,533	$ 13,457,334	$12,860,588
People Served	1,117**	1,174**	1,082**
Cost per Person	$11,574	$11,463	$11,886
Non-600 Series* **	0%	0%	0%

* FY16 data has not been finalized due to a system error preventing final data from being uploaded/entered.
** This includes only primary residential clients. Transitional living and social detoxification clients are not included.
***600 series is defined as direct service contracts

Program Cost Notes

- SFY16 Program Funding:
  - 86% General Funds ($10,998,729)
  - 14% Federal Funds ($1,861,859)

Program Staffing

- 6 FTE (shared with Substance Use Outpatient program staffing, mental health Outpatient and Residential programs)
- 0 AWEC
- 0 Other

Program Metrics*

- A total of 75,440 days of residential treatment were delivered statewide with an average of 69.72 days of service per client in SFY 2016
- 43% of persons served in SFY16 were admitted for alcohol dependency, 11% for marijuana/hashish, 30% for methamphetamine, 4% for heroin, and 12% were related to other drugs.

Events that have Shaped this Program

- 2002 HEA 42 established the Substance Abuse Control Plan. The Substance Abuse Control Plan authorized by Wyo. Stat. Ann. § 9-2-2701 et seq. requires a comprehensive plan to address substance use, including prevention, intervention, and treatment methodologies.
  - The Department of Health, in consultation with the Departments of Education, Family Services, Workforce Services, and Corrections, established standards for effective treatment and prevention of substance use.
  - The Department of Health certifies all programs, providers, and facilities which receive state funds for substance use treatment and those serving court-referred individuals to be in compliance with State rules and regulations.
- 2006: Select Committee on Mental Health and Substance Abuse produced the 2006 House Enrolled Act (HEA) 21, 2007 Senate Enrolled Act (SEA) 77, and 2008 SEA 24, resulting in substantial increases in funding for substance abuse residential programs and promoted the concept of regionalization of services.
- 2012 SEA 29 requires the Behavioral Health Division to promulgate rules requiring reimbursement of State funds only to providers with a national accreditation for mental health and substance abuse treatment services.

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Substance Use Residential Treatment

PROGRAM CORE PURPOSE

The Substance Use Residential Treatment Program provides access to effective treatment services, decreases alcohol and drug use, and increases levels of personal functioning.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016***
Utilization rate (7 of 9 providers met the target)^	85%	95%	N/A	85%	87%	88%	90%
Treatment completion rates (4 of 5 providers met the target)^	60%	80%	62%	60%	64%	73%	75%
% of clients showing a one point or more improvement in Global Assessment of Functioning (GAF) scores from admission to discharge (3 of 5 providers met the target)	65%	90%	49%	73%	84%	91%	85%

Primary Residential Treatment Beds only, Transitional and Detox beds are not included.
* SFY16 data has not been finalized due to a system error preventing final data from being uploaded/entered.
N/A indicates data not available due to the creation of a new metric
^The contract target information is listed in the Story Behind the Performance
NOTE: There are only these three contracted outcomes for SA Residential services.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016* Q1+Q2**	**2016* Q3+Q4**
OUTPUTS									
# of persons served	1,106	1,165	1,117	1,174	1,082	517	503	697	617
# of persons admitted	881	902	921	1,044	1,009	520	524	553	456
#of persons discharged	948	973	930	1,033	1,081	515	518	562	519
# of days of residential services delivered	79,262	79,267	81,057	81,795	75,440	40,292	38,827	39,368	36,072
EFFICIENCIES									
Average cost per client	N/A	$11,113	$11,574	$11,463	$11,886	N/A*	N/A*	N/A*	N/A*
Average service cost per day	N/A	$184	$189	$165	$170	N/A*	N/A*	N/A*	N/A*

N/A indicates data not available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

Outcomes in SFY 16 for substance use residential services exceeded established targets. Although the quality management focus during the year was limited to outpatient wait time and supported employment, the Division engaged in peripheral activities which may have prompted improved outcomes in substance use residential services.

SFY 16 contracts required a utilization rate of eighty-five percent (85%). Increased attention was paid to utilization during the course of the year, especially among mental health residential providers, as a mechanism to move people from the Wyoming State Hospital (WSH) into the community. During discussions with providers about mental health residential utilization, substance use residential utilization was discussed as well, which brought increased attention to utilization and the necessity of accurate reporting. Division staff also reconciled the number of beds under contract with the number of beds reported in the Wyoming Client Information System (WCIS) and found some providers were reporting utilization on beds that were not supported by the contract. It is unknown whether this activity directly affected utilization rates, however, data quality has improved.

The Division did not engage in activities directed at treatment completion or improvement in Global Assessment of Functioning (GAF) scores in substance use residential facilities, however, requirements for both were included in SFY 16 contracts. Contracts required a treatment completion rate of sixty percent (60%) or higher, and an average improvement of functioning upon completion of treatment and discharge of five (5) points or more as measured by GAF scores among sixty-five percent (65%) of clients receiving substance use disorder residential services.

Since the SFY 16 data is not complete, it is difficult to ascertain or provide explanation for differences between the SFY 15 and SFY 16 outputs and efficiencies data. Incomplete data included on this report indicate the number of persons served decreased by 92 and the number of residential service days decreased by 6,355. It also appears costs increased by $423 per client served and $5 per day. Analysis of the data will be completed once all data is submitted.

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Supports Waiver

Program Description

The Supports Waiver is a stipend-based program for those who meet the criteria for a developmental disability or an acquired brain injury and Medicaid financial eligibility. This waiver provides a stipend of $12,500 to eligible children and $16,500 per eligible adult per year, plus case management services.

Program Expenditures and People Served

	2014^	2015	2016
Total Medical & Waiver Cost	$568	$1,237,755	$4,821,928
Total Waiver Cost	$454	$821,675	$2,783,016
Total Medical Costs	$114	$416,080	$2,038,912
Total People Served	2	203	425
Cost per Person (Waiver and Medical)	$284	$6,097	$11,629
Non-600 Series*	0%	15.32%	12.45%

^ Information on the low numbers in 2014 is provided under the 1st bullet of Events that shaped this Program
* 600 series is defined as direct service contracts; each program should be prepared to defend how it chooses to report these dollars.

Program Cost Notes

- Participants receive Medicaid medical services in addition to waiver services.
- Program staffing for all three Behavioral Health Division (BHD) waivers is based upon the number of BHD-DD Section staff proportional to the number of participants active in the program.

Program Staffing

- 3.75 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Supports waiver recipients received Medicaid medical services at a cost of $5,087/person in SFY16.
- The Supports waiver average costs per participant in SFY16 was $6,542.
- Some participants on the Waiver use waiver services only, medical services only, or both. Therefore, the calculations for average medical expenditures and average waiver expenditures when summed will not equal the overall cost per person (medical & waiver).
- 25 participants self-directed some of their waiver services in SFY16.
- 202 eligible individuals were on the waiting list for the Supports Waiver as of 06/30/2016.
- There were 523 certified providers monitored by the Behavioral Health Division (BHD) as of 06/30/2016.

Events that have Shaped this Program

- **New Waivers.** In March of 2013, the Wyoming Legislature passed Senate Enrolled (SEA) Act 82, a law requiring two new redesigned waivers to serve more people with the existing budget. The new law set a goal to end the former Child DD and Adult DD Waivers, and eventually the ABI waiver, and serve everyone on the Comprehensive Waiver who was already in services, but fund new people onto the capped Supports Waiver. This waiver went live 4/1/2014 with a one year transition period for all existing plans.
- **Conflict Free Case Management.** The 2013 law (SEA 0082) also required BHD to implement conflict free case management, which also became a federal law in 2014. All participants successfully transitioned to a conflict free case manager by June 30, 2015, which will allow case managers to have more authority and advocacy for overseeing the implementation of participants' plans of care.
- **Wait list funding.** The 2014 legislature appropriated $20.2 million (50% State General Funds and 50% Federal Funds) for waiting list reduction. The wait list has continued to periodically be reduced as funds are approved.
- **New federal Home and Community Based (HCB) services rules.** In March of 2014, the federal government passed new rules for waiver settings and services to ensure people in HCB services are truly integrated into their communities and not isolated or receiving services that seem institutional in nature. All service settings must be in compliance by March of 2019 and providers will need to make several changes over the next few years.
- **Cost saving measures.** BHD issued changes in July 2013 to carry out cost containment measures required by the legislature, which included tightening the definition for skilled nursing, implementing a daily respite rate, and decreasing all service rates and individual budget amounts (IBAs) by 1%.

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Supports Waiver

PROGRAM CORE PURPOSE

The Supports Waiver is a stipend-based program for those who meet the criteria for a developmental disability or an acquired brain injury and Medicaid financial eligibility. This waiver provides a stipend of $12,500 to eligible children and $16,500 to eligible adults each year, plus case management services. The Supports Waiver is designed to reduce the Medicaid Waiver waitlist by providing services so individuals can remain living in their current home as safely as possible and live according to their own choices and preferences.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Average utilization of the Individual Budget Amount (IBA), children & adults combined	32%	32%	N/A	N/A	N/A	21.8%	37.3%

N/A indicates data not available due to the creation of a new waiver

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4[2]
OUTPUTS									
# of total participants	N/A	N/A	47	203	425	102	202	329	414
# of participants, all ages, using respite services	N/A	N/A	0	2	73	N/A*	N/A*	N/A*	N/A*
# of participants, all ages, using community integrated services	N/A	N/A	0	2	34	N/A*	N/A*	N/A*	N/A*
# of participants, all ages, using supported living services	N/A	N/A	1	3	107	N/A*	N/A*	N/A*	N/A*
# of participants ages 18+ using waiver supported employment services	N/A	N/A	0	3	7	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average cost per participant (waiver and medical)	N/A	N/A	$284	$5,375	$11,629	$2,469	$4,267	$5,501	$7,329
Average cost per participant (waiver only)	N/A	N/A	$454	$3,749	$6,542	$1,677	$2,952	$3,320	$4,077

STORY BEHIND THE PERFORMANCE

- **New federal Home and Community Based (HCB) services rules.** Under the new rules, states will not be allowed to use federal Medicaid dollars to pay for HCB services in settings that isolate people from the community or that do not show respect for people's right to privacy, dignity, and self-determination. The new rules also require participants to have leases or residency agreements if receiving residential services. The Centers for Medicare and Medicaid Services (CMS) allow states until March of 2019 to ensure that all provider settings are in compliance with the new rule. Each waiver is working towards having an approved transition plan by CMS that explains how the state will work with providers to get into compliance and maintain compliance with the new rules.
- **Employment First.** 2014 HEA53 requires state agencies to support competitive and integrated employment, requires state agencies working with HCB waiver service providers to implement employment first policies, requires state agencies to report on employment data, and provides definitions. BHD is working with an interagency taskforce to implement the legislation statewide.

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Veterans' Outreach & Advocacy Program

Program Description

The Veterans Outreach and Advocacy Program provides Gulf War, Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) veterans with assistance in addressing reintegration challenges by connecting them with community resources, which results in improved functioning and integration back into their families and community.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$185,303*	$236,791*	$212,455*
Quality of Life Funds*	$46,486	$63,152	$55,123
People Served	232	155	136
Cost per Person	$574	$1,528	$1,562
Non-600 Series**	0%	0%	0%

* Quality of Life funds are included in the total program cost. They have been separated out for tracking purposes.
**600 series is defined as direct service contracts

Program Cost Notes

- 100% State General Funds.
- $650,000 biennium budget

Program Staffing

- 0.30 FTE (Program Manager)
- 0 AWEC
- 2 Contract

Program Metrics

- The Program provides outreach, case management, and advocacy services to a total of 136 veterans and their families, with 53 of those being served in the third and fourth quarters of the SFY2016.
- The veterans self-identify the reintegration challenges for which they need assistance. Changes also occurred on how information was collected at intake and discharge.

Events that have Shaped this Program

- Quality improvement tools were used to determine if veterans were not completing treatment once they receive Quality of Life assistance and how this deficit could be impacted. The process indicated there was a need for discharge follow-up data on treatment, housing, and employment status after 60 and 120 days.
- Changes to the Wyoming Client Information System (WCIS) to capture the follow-up data was requested and is now in WCIS. The follow-up data on whether veterans are still in treatment is minimal due to the short time frame since the data element was included in the WCIS and the small number of veterans who have been discharged since that date.
- Two metrics, percentage of veterans who report improved functioning and percentage of veterans who report they are in a better position, have now been removed from the Performance Report due to consistently reaching 93% - 100% of the targeted goal for the last two years.
- Even though the war on terror has officially ended, there are continued deployments of Wyoming National Army Guard, Wyoming National Air Guard, and other service members, which means Wyoming's service members may need services and assistance upon their return.
- State budget reductions eliminated the Veterans' Advocacy Program at the end of SFY 16.

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Veterans' Advocacy Program

PROGRAM CORE PURPOSE

To provide case management services to veterans and their families who are experiencing challenges to reintegration into civilian, family, and community life.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
% and # of veterans served who went from being homeless at intake to being housed at discharge.	90%	Program eliminated	N/A	N/A	75% 24/32	82% 27/33	90% 27/30
% and # of veterans served who went from being unemployed at intake to being employed at discharge.	96%	Program eliminated	N/A	N/A	92% 46/50	94% 50/53	94% 61/65
% and # of veterans served who are also in treatment	70%	Program eliminated	N/A	N/A	33% 77/232	60% 93/155	63% 85/136

N/A indicates data not available due to creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of veterans' advocates statewide	5	2	2.5	2	2	2	2	2	1.5
# of veterans admitted by veterans' advocates	192	163	232	155	136	94	61	83	53
# of veterans who received Quality of Life (QOL) Assistance	51	52	18	36	44	24	12	18	26
# of veterans in treatment	N/A	75	77	93	85	56	37	51	34
EFFICIENCIES									
Average cost per veteran served	$1,364	$1,515	$574	$1,329	$1,562	$1,313	$1,528	$1,494	$1,645

N/A indicates data not yet available due to the creation of a new metric

STORY BEHIND THE PERFORMANCE

- State budget reductions eliminated the Veterans' Advocacy Program at the end of SFY 16.

- Significant changes were made in data collection, to include the implementation of a follow-up process at sixty (60) days and one hundred twenty (120) days after discharge for veterans who received Quality of Life assistance. Data fields were created in the Wyoming Client Information System (WCIS) in February of 2016 to capture this data; advocates began entering data July 1 of 2016. This information was to be used to better determine the participation in continued treatment among veterans discharged from the program. Prior to February of 2016, advocates were conducting informal follow-up processes, but there was no mechanism to record the follow-up data. Another milestone was the direction and focus placed on the program, through quarterly advocate trainings and to targeting persons with substance use disorders and mental illness.

- Numbers of persons served declined during the third and fourth quarters of SFY 2016, and final numbers show a decrease of nineteen (19) persons served. Contracted advocate changes impacted the number of people served in the final two quarters of SFY 2016.

WDH | Public Health Division

Information contained in this section includes:

- Adolescent Health Program
- Child Health
- Chronic Disease Prevention
- Communicable Disease Prevention Program
- Communicable Disease Treatment Program
- Community Medical Access and Capacity (CMAC) Program
- Community Services Program
- Emergency Medical Services
- End State Renal Disease (ESRD)
- Healthcare Workforce Recruitment, Retention and Development (HWRRD)
- Healthy Baby Home Visitation Program
- Hospital Preparedness Program (HPP)
- Immunization Program
- Infectious Disease Epidemiology
- Injury Prevention
- Integrated Cancer
- Office of Health Equity
- Oral Health Program

- Public Health Emergency Preparedness (PHEP)
- Public Health State Laboratory
- Public Health Nursing
- Substance Abuse and Suicide Prevention Program
- Tobacco Prevention and Control Program
- Trauma Program
- Women and Infant Health
- Women, Infants and Children (WIC) Program

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Adolescent Health

Program Description

The Adolescent Health Program provides leadership and support for the design, implementation, and evaluation of state and local policies and programs that address the health needs of adolescents ages 12 to 24 years and promotes healthy development within the adolescent and young adult population, including adolescents and young adults with special health care needs.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$337,464	$605,923	$443,383
People Served*	102,475	101,318	99,529
Cost per Person	N/A	N/A	N/A
Non-600 Series**	66%	23%	22%

* People served includes all adolescents in Wyoming ages 12-24; not a count of direct service recipients
**600 series is defined as direct service contracts.

Program Cost Notes

- Adolescent Health uses blended funding:
  SGF, Title V, Rape Prevention Education (RPE), & Personal Responsibility Education Program (PREP)
- Adolescent Health also works closely with the Women & Infant and Health Baby Home Visitation programs as teens also benefit from home visits and family planning.

Program Staffing

- 2.9 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In 2015, 10.1% of Wyoming high school students reported during the past 12 months that someone they were dating or going out with forced them to do sexual things they did not want, a slight decrease from 11.5% in 2013.
- In 2015, there were 29 births per 1,000 women ages 15 to 19 years. This is not a statistically significant change from the 30.3 births per 1,000 women ages 15 to 19 years recorded in 2014.
- In 2015, 11.1% of Wyoming high school students reported that they attempted suicide within the last 12 months. This is a slight increase from 8.6% in 2013.

Events that have Shaped this Program

- The Maternal Child Health section created the Adolescent Health Program in 2013
- For 2011 – 2015: Three national performance measures and five state performance measures are directly related to adolescent health and are reported annually for the Title V grant.
- For 2016 – 2020: New MCH priorities have been identified and include adolescent-specific priorities of Healthy and Safe Relationships and Preventive and Quality Care for Adolescents.
- The Adolescent Health Program manager has established collaborations with several partners within the Wyoming Department of Health, including Immunizations, Suicide Prevention, HIV/STD, Public Health Nursing (PHN), and Behavioral Health, lending adolescent expertise and educating programs on best practices and evidence-based interventions for the adolescent population.

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Adolescent Health Program

PROGRAM CORE PURPOSE

The purpose of the Adolescent Health Program is to improve the physical, emotional, and reproductive health outcomes of Wyoming adolescents ages 12 to 24 years.

OUTCOMES

Performance Metric	CY2016 Target	CY2017 Target	CY2012	CY2013	CY2014	CY2015	CY 2016
Rate of births (per 1,000) among 15 - 19 year old girls[1](Wyoming and National Vital Statistics Service)	29	28	WY: 34.6 US: 29.4	WY: 29.8 US: 26.6	WY: 30.3 US: 24.2	WY: 29.0 US: 22.3	-
% knowledge increase of WyPREP participants in correctly identifying effective methods of protection from STDs, HIV, and pregnancy.[2](PREP post-assessment)	15%	17%	N/A	N/A	N/A	12% (214/308)	-
% of high school students reporting that they were forced to do sexual things they did not want to by someone they were dating or going out with[3](YRBS)	10%	N/A*	N/A*	WY: 11.5% US: 10.4%	NA*	WY: 10.1% US: 10.6%	-
% of high school students reporting that they attempted suicide during the last 12 months[4](YRBS)	8%	N/A*	N/A*	WY: 8.6% US: 8.0%	N/A*	WY: 11.1% US: 8.6%	-

(-) indicates data not yet available
N/A indicates data not available due to the creation of a new metric
N/A*: The Wyoming Youth Risk Behavior Survey (YRBS) is collected every two years. Budget cuts during the 2016 Legislative Session removed State funding for the YRBS.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of adolescents receiving contraceptives funded by Title V through Public Health Nursing offices[6]	N/A	N/A	154	418	565	154	264	287	278
# of communities participating with Rape Prevention Education (RPE) grant[3]	6	8	10	13	14	10	13	13	14
# of communities participating in comprehensive reproductive health education (WyPREP)[2]	N/A	N/A	N/A	4	10	N/A	N/A	4	10
# of health care providers trained in "Unlocking the Mysteries of the Adolescent Brain for Health Care Providers"[5]	N/A	N/A	90	117	195	117	0	60	135
EFFICIENCIES									
Cost per Title V funded hormonal contraceptive visit	N/A	N/A	$64 ($26,104 /405)	$60 ($67,938 /1135)	$58 ($67,864 /1178)	$64 ($26,104 /405)	$60 ($32,753 /547)	$60 ($35,185 /588)	$56 ($32,769 /590)
Cost per youth receiving comprehensive reproductive health education	N/A	N/A	N/A	$2,272 ($204,475 /90)	$96 ($42,000 /439)	N/A	$2,272 ($204,475 /90)	0	$96 ($42,000 /439)
(-) Indicates data not yet available N/A indicates data not yet available due to the creation of a new metric N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

Negative health outcomes for the adolescent population are often due to preventable causes and risky behavioral choices, rather than natural causes. Increased risky behavior leads to increased rates of sexually transmitted disease, pregnancy, substance use/misuse, death by suicide, and injury.

[1]The Adolescent Health Program partners with Public Health Nursing (PHN) and the Communicable Disease Prevention (HIV/STD) Program in activities to reduce the teen birth rate in Wyoming through evidence-based activities and increasing the availability of services.

[2]The Adolescent Health Program partners with the Communicable Disease Program to administer the Personal Responsibility Program (PREP) program in Wyoming. PREP trains facilitators and provides funding to deliver evidence-based comprehensive reproductive health education curriculum to adolescents in middle and high school. The goal of PREP is to prevent teen pregnancy and reduce the rate of STD/HIV.

[3]The Rape Prevention Education (RPE) grant focuses on primary prevention of sexual violence among adolescents, e.g. stopping the behavior before it happens. The Wyoming Coalition against Domestic Violence and Sexual Assault (WCADVSA) is conducting the work within counties.

[4]The Adolescent Health Program Manager has an active role on the Wyoming Suicide Prevention Advisory Council and works closely with the Suicide Prevention Program on youth suicide.

[5]The Adolescent Health Program Manager works to further the integration of Public Health and Primary Care. The purpose of the training is to engage Wyoming providers in current evidence-based practice models for adolescent communication, assessment, transition, and youth friendly practices with the goal of increasing immunization rates, adolescent well visits, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits, and satisfaction of families of youth with special health care needs with transition services.

[6]Maternal and Child Health (MCH) partners with PHN to provide a gap-filling contraceptive program in counties that receive little to no Title X funding. The goals are to increase access to family planning services and reduce teen births. These counties include: Converse, Crook, Goshen, Johnson, Platte, Teton, and Weston. These numbers are tracked per state fiscal year, not calendar year. This program is administered under Wyoming Statute 42-5-101 Family Planning and Birth Control.

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Child Health

Program Description

The Child Health Program provides leadership and support for the design, implementation, and evaluation of state and local policies and programs that address the health needs of children ages 1 – 11 and promotes healthy development within the child population, including children with special healthcare needs.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$467,544	$518,322	$410,423
People Served*	N/A	86,948	85,916
Cost per Person	N/A	N/A	N/A
Non-600 Series*	28.75%	32%	40%

* People served is calculated as the total number of Wyoming residents ages 1 to 11 years.
** 600 series is defined as direct service contracts; each program should be prepared to defend how it chooses to report these dollars.

Program Cost Notes

- Child Health uses blended funding: SGF and federal funds under Title 5, Maternal & child Health Services Block Grant, and the Early Childhood Comprehensive Systems Grant
- Child Health also works closely with the Women & Infant program as the early childhood/ECCS population (birth to age 8) through home visiting services.

Program Staffing

- 2.9 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In 2013, Wyoming met its objective of no more than 3.0 deaths per 100,000 children ages 14 years and younger caused by motor vehicle crashes. Wyoming has experienced a statistically significant decrease in youth deaths from motor vehicle crashes in the time period 2001 to 2013.
- In 2013, the all-cause mortality rate for children ages 1 to 14 years was 22 per 100,000. Wyoming continues to rank poorly as the 8th highest state in the nation on this metric.

Events that have Shaped this Program

- In 2015, the leading causes of death in Wyoming children ages 1-11 were: 1) Motor Vehicle Crashes, 2) Poisonings, 3) Falls.
- The 2013-2016 Early Childhood Comprehensive Systems (ECCS) Grant will:
  - Expand developmental screening activities in early care and education sites while linking training opportunities, which will increase appropriate referrals among medical homes, early intervention, and child care providers;
  - Provide updated parent completed screening tool kits (Ages and Stages Questionnaire 3rd Edition, including the Social-Emotional tool) for child care providers, including Child Development Centers, center-based and home-based child care centers, and with medical home providers; and,
  - Provide initial funding to implement the Help Me Grow system to link families to services.

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Child Health

PROGRAM CORE PURPOSE

The purpose of the Child Health Program is to facilitate access to appropriate screenings and promote physical health for children ages 1-11 years.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Screening (SFY) % and # of failed vision screenings that result in a visual impairment diagnosis[1]	96%	98%	94% (187/199)	95% (128/135)	96% (106/110)	88% (191/217)	97% (326/335)
Screening (CY) % and # of children (10 months to 5 years old) screened for developmental, behavioral, and social delays in the past 12 months*	40%	45%	28.8% CY 2011/12	-	-	-	-
Physical Health (CY) Rates of death (per 100,000, calendar year) due to unintentional injuries among children aged 1-11 years in Wyoming	10.0	8.0	13.9	8.3	12.7	15.1	-
Physical Health (SFY) Rates of hospitalizations due to nonfatal injuries (per 100,000) among children aged 1-11 years and younger in Wyoming***	15	12	39.7	26.7	23.1	20.7	-
Physical Health (FFY) % of inspected Child Safety Restraints displaying one or more critical misuses **** (national rate)	85%	90%	89.58%	91.48%	93.85%	89.84% (80%)	91.94%

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric
*National Survey of Children's Health – data to be released Spring 2017
**Vital Statistics System
***Hospital discharge data
****Safe Kids USA

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of children screened for vision using photo screening machines as reported by the WY Lions Vision Screening Project	4,370	4,011	4,794	2,302	2,726	1,173	1,129	1,501	1,225
Ages and Stages Developmental Screenings Distributed (# ASQ3/SE and SE2)	N/A	N/A	N/A	117 (61/56)	0*	37 (16/21)	80 (45/35)	0	0
Ages and Stages Developmental Screenings Completed (# ASQ3/SE)	N/A	N/A	N/A	1,360 (1,149/211)	962**	N/A	N/A	N/A	N/A
# of car seats distributed (D) & inspected (I) through Safe Kids Wyoming	D:689 I:1,600	D:724 I:1,406	D:646 I:1,501	D:675 I:1,293	D:521 I:1,184	D:280 I:562	D:395 I:731	D:249 I:521	D:272 I:663
# of statewide educational injury prevention efforts focused on leading causes of injury/hospitalization of children in Wyoming	N/A	N/A	N/A	449	908	108	341	509	399
EFFICIENCIES									
Cost per individual person participating in Safe Kids events per contracted $ invested (federal fiscal year)	$4.66 ($115,000/ 24,656) FFY12	$4.70 ($115,000/ 24,461) FFY13	$1.12 ($94,842.96/ 84,879) FFY14	$1.30 ($135,157.04/ 103,698) FFY15	$1.85 ($104,487/ 56,493) FFY16	$0.74 ($36,753/ 49,800)	$2.77 ($98,404/ 53,898)	$0.76 ($28,536/ 37,365)	$3.98 ($75,951/ 19,065)

"N/A"" - not previously collected.
(-) Indicates data is not yet available; data missing for SFY 2016 will be available in 2017.
VSS – Vital Statistics Services
NSCH- National Survey of Children's Health. The survey will be conducted again by the Census Bureau in 2016-17, with initial data expected in 2017
ASQ3/SE – Ages & Stages Developmental Questionnaire, Third Edition (ASQ3)/Ages & Stages Questionnaire: Social-Emotion (ASQ:SE)
*No ASQ kits distributed in 2016. Kits will be distributed
**Data currently only reflective of screenings completed by Public Health Nurses

STORY BEHIND THE PERFORMANCE

MCH contracts with the following organizations to provide services directly affecting this population: Safe Kids Wyoming, Cheyenne Regional Medical Foundation, and the Wyoming Vision Collaborative, through the Wyoming Institute for Disabilities (WIND) at the University of Wyoming.

[1] Annual vision screening for children beginning at age 6 months up to school entry is critical. The Wyoming Vision Collaborative works with Child Development Centers, Preschools, Lions Clubs, and Public Health Nursing offices to offer vision screening expertise, training, support, and follow-up services. In SFY 2015 the increased number of referrals without appropriate diagnosis was reportedly due to technical equipment issues. When the vendor was notified, corrective adjustments were identified and made to machines not only in Wyoming but nationally. Additional trainings in SFY 2016 helped ensure rates rebeounded and increased.

[2] Data for death due to unintentional injuries among children comes from Vital Statistics death certificates. Unintentional injuries include causes such as drowning, falls, fires, burns, firearms, motor vehicle injuries, bicycle injuries, poisonings, suffocations, bites, stings, overexertion, etc.

[3] ASQ screening data was collected for October 1, 2014 to September 30, 2015. This data will be collected again in October 2016.

[4] In 2014, the re-certification rate for Child Passenger Safety Technicians was 53.9% nationally and 61.4% in Wyoming.

Abbreviations:

ASQ: Ages & Stages Questionnaire
EPSDT: Early, Periodic, Screening, Detection and Treatment, also known as Medicaid Health Check, Well-Child Visit, Well-Baby Checks
MCH: Maternal Child Health
WIND: Wyoming Institute for Disabilities

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Chronic Disease Prevention Program

Program Description

The Chronic Disease Prevention Program coordinates and implements research-based policies, practices, and programming at the state and community level to address the growing burden of chronic disease. The program is dedicated to promoting and supporting health and wellbeing for Wyoming's residents through cross-sector partnerships and collaborative efforts, health systems improvement, workforce development efforts, strategic communication, and continuous quality improvement.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost*	-	$295,882†	$665,509
People Served	-	582,658	582,658
Cost per Person	-	$0.51†	$1.14
Non-600 Series**	-	93.3%	99%

† Grant award was not fully expended in SFY 2015.
* Data from actual expenditures; previous Snapshots reported grant award amounts rather than actual expenditures.
(-) indicates data not available
**600 series is defined as direct service contracts.

Program Cost Notes

- 100% Federal funds (Centers for Disease Control & Prevention (CDC))
- The CDC limits the use of grant funds to policy, systems, and environmental strategies and does not provide funding for client level education or services.
- The population of Wyoming (census data) is used as people served. The program reach is statewide and impacts prevention of chronic disease at all age levels as well as mitigation of complications among people who already have been diagnosed with cardiovascular conditions or diabetes.

Program Staffing

- 2.0 FTE
- 0 AWEC
- 0.4 Other

Program Metrics

- The State of Wyoming currently has 11 Diabetes Self-Management Education Programs and 3 Diabetes Prevention Programs.
- The Chronic Disease Prevention Program contracts with 3 Certified Diabetes Educators to provide professional development to providers, nurses, and other health workers in chronic disease self-management best practices in 10 counties throughout the State.
- In the past year, 176 Early Childhood Education Center providers have been trained in strategies to increase physical activity in their organizations.
- The program focuses on strategies for policy and systems change related to chronic disease and healthy lifestyles in early childcare centers, schools, worksites, community settings, and healthcare systems based on targeted, evidence-based interventions.

Events that have Shaped this Program

The direction of the program changed in 2013-14 to reflect an approach to chronic disease prevention that addresses policy, systems, and environmental approaches, rather than patient outreach and education interventions. Through provision of training in evidence-based practices, such as established protocols, the reach of the program has become more focused.

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Chronic Disease Prevention Program

PROGRAM CORE PURPOSE

The purpose of the Chronic Disease Prevention Program is to reduce the impact of chronic disease by promoting the implementation of evidence-based strategies at the systems level through statewide partnership engagement, environmental approaches to healthy living, health systems interventions, and improvement of community-clinical linkages.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Number of ECEs[1] that adopt strategies to increase physical activity	10	20	0	0	0	6	-
Percentage of schools that do not sell less healthy foods and beverages[2]	45%	50%	-	28.4%	-	37.4%	-
Number of people with diabetes in targeted settings who have at least one encounter with DSME[3]	1,800	2,000	N/A	1,526	N/A	1,767	1,675
Prevalence of hypertension in Wyoming (national average)	30.0%	30.0%	-	28.7% (31.4%)[4]	-	29.8%	-
Prevalence of people with self-reported diabetes (national average)	9.0%	9.0%	9.1%	8.6%	8.4% (10%)[5]	8.5%	-

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric
[1] Early Childhood Education
[2] Less healthy foods and beverages are defined in the School Health Profiles as chocolate candy, other candy, and salty snacks not low in fat, cookies, crackers, cakes, pastries, other baked goods, soda pop, fruit drinks, and sports drinks
[3] Diabetes Self-Management Education
[4] Most recent data available
[5] Most recent data available

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Number of providers or clinical staff members trained on diabetes and hypertension self-management strategies	N/A	N/A	N/A	N/A	357	N/A*	N/A*	-	-
Number of ECE providers that received professional development to adopt policies to increase physical activity	N/A	N/A	N/A	N/A	178	58	108	-	-
Number of local education agencies that received professional development or technical assistance on strategies to create a health school nutrition environment	N/A	N/A	N/A	15	46	6	40	-	-
EFFICIENCIES									
Cost per provider or clinical staff member trained in hypertension and diabetes management	N/A	N/A	N/A	N/A	$309.50	N/A*	N/A*	-	-

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

The Chronic Disease Prevention Program is funded by the federal State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (SPHA) grant. This grant provides funding to reduce risk factors associated with childhood and adult obesity, diabetes, heart disease and stroke. SPHA funds work in workplaces, schools, early childhood education facilities, and communities with a focus on systems, polic,y and environmental change.

According to the American Diabetes Association, approximately 28% of people who have diabetes are undiagnosed nationally and the number of people with prediabetes is on the rise. Prevention strategies, early diagnosis, and intervention are critical in promoting better management, fewer complications, and reduced costs for those living with diabetes. According to the National Institute for Health's National Center for Biotechnology, training in evidence-based protocols and a team-based approach to healthcare for all chronic conditions results in earlier diagnoses and improved treatment as well as reduced costs due to hospitalizations and treatment for complications.

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Communicable Disease Prevention Program

Program Description

The Communicable Disease Prevention Program provides sexual and behavioral health education, outreach, and interventions to individuals and communities throughout the state of Wyoming. The program ensures that healthcare, education, and community-based providers have the skills necessary to implement evidence-based sexual and behavioral health interventions. Communicable diseases addressed include HIV/AIDS, Hepatitis B and C, Tuberculosis, Chlamydia, Gonorrhea, and Syphilis.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$1,207,503	$2,343,159	$1,681,960
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	35.7%	21%	56%

* 600 series is defined as direct service contracts.

Program Cost Notes

- CY – 16 HIV Prevention Grant – CDC Federal
- CY – 16 STD Prevention Grant – CDC Federal
- CY – 16 Hepatitis Prevention Grant – CDC Federal
- CY – 16 TB Prevention & Control Grant – CDC Federal
- CY – 16 Personal Responsibility Education Program – HHS Federal
- Adult Hepatitis A/B vaccination – State General Fund

Program Staffing

- 7.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Deliver and evaluate the community health education campaign: knowyo.org
- Increase the number of individuals receiving a standard behavior based risk assessment prior to screening for communicable diseases at both public and private healthcare providers.
- Working with Department of Corrections (DOC) and Public Health Nursing (PHN), provide adult hepatitis A and B vaccinations to high-risk adults over the age of 19
- Reduce disease transmission through targeted interventions with at-risk positives & high-risk negatives.
- Provide targeted, evidence-based education to collaborating agencies serving high-risk populations including internal and external programs such as DOC, PHN, Immunizations, Behavioral Health, Medicaid, Department of Education, Department of Family Services, and the Wyoming Health Council.

Events that have Shaped this Program

- The Healthy People 2020 Objectives include HIV, STD, Immunization, and Infectious Disease
- 2011/2012: Implementation of common Public Health Nursing Guidelines and Orders for Communicable Disease Programs
- 2011/2012 Major efforts to integrate across disease prevention and control programs resulting in implementation of a common behavioral risk screening recommendation and tools for use in public and private healthcare provider settings; establishment of integrated community advisory committees to inform evidence-based prevention activities and ensure community participation per grant guidance (Care and Prevention Planning Alliance (CAPPA) & TB Advisory Committee)
- 2012: Establishment of National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP); strategic priorities include prevention through healthcare and promoting health equity.
- 2012/2013 Completion/adoption of the 2012-16 Comprehensive Prevention and Care Planning Document
- State Funding to support adult hepatitis A and B vaccination
- 2013: Re-established Personal Responsibility Education Program (PREP) funds to decrease unintended teen pregnancy and STDs

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Communicable Disease Prevention Program

PROGRAM CORE PURPOSE

To prevent the occurrence of communicable disease for individuals and persons living in communities at-risk in Wyoming.

OUTCOMES

Performance Metric	CY 2016 Target	CY 2017 Target	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
% and # of Department of Corrections (DOC) inmates completing the hepatitis A & B vaccine series[1]	80%	80%	45% 1,166/ 2,585	75% 902/ 1,200	81% 1,040/ 1,278	78% 1,183/ 1,513	77%* 1,477/ 1,923
% of WyPREP participants correctly identifying effective methods of protection from STDs, HIV, and pregnancy in the Reducing the Risk (RTR) Knowledge Survey	75%**	82%**	N/A	N/A	N/A	69%** (214/308)	-
Rates of gonorrhea infections per 100,000 persons[3]	N/A	28.0	7.7	11.5	19.9	29.7	-
Active TB case rate per 100,000 population statewide[4]	<1	<1	0.5	0	0.4	0.7	-
Rates of hepatitis C infection per 100,000 persons[5]	80.0	80.0	82.3	81.6	99.7	82.1	-

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric
**This measure is for State Fiscal Year as WyPREP programming is based on school year not calendar year.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016* Q3+Q4**
OUTPUTS									
# of condoms provided to high risk populations[6]	21,400	199,740	362,987	275,448	222,245*	137,724	137,724	137,436	53,628*
# of condom dispenser sites	N/A	N/A	77	102	116	74	78	113	116*
# of WyPREP participants	N/A	N/A	N/A	90	N/A	0	90	19	-
EFFICIENCIES									
Cost per voucher distributed through knowyo.org[7]	$51.25 ($115,000 /2,244)	$31.16 ($115,000 /3,691)	$33.04 ($115,000 /3,481)	$27.22 ($115,000 /4,225)	$28.53 ($115,000/ 4,031)	$27.30 ($57,500 /2,106)	$24.79 ($57,500 /2,319)	$24.85 ($57,500 /2,314)	$33.49* ($57,500 /1,717)

(-) Indicates data not yet available
*Calendar Year-to-Date (January – November)
N/A indicates data not yet available due to the creation of a new metric

STORY BEHIND THE PERFORMANCE

Healthy People (HP) 2020 goals and objectives and HIV/AIDS Bureau Standards are the benchmarks for the Communicable Disease Prevention and Treatment Programs. Community evidence-based interventions are supported by the literature compiled in the Community Prevention Service Guide.

[1]The program targets the Department of Correction (DOC) inmate population because HIV infection is nearly five (5) times as high for incarcerated populations as compared to those who were not incarcerated (http://www.cdc.gov/hiv/group/correctional.html). Incarcerated individuals often report behaviors that place them and their partners at considerable risk for communicable diseases, including unprotected sex, multiple partners, injection drug use, and needle sharing.

[2]The Wyoming Personal Responsibility Education Program (WyPREP) provides funding for schools and community-based organizations to provide relationships and sexual health education to 7th – 12th grade youth. The goals of WyPREP are to delay initiation of sexual activity, prevent teen pregnancy, and prevent STDs, including HIV, through evidence-based curricula.

[3]Gonorrhea infection has been rising in Wyoming and the United States. Gonorrhea infection increases the risk of acquiring HIV. The unit prioritizes those with gonorrhea infection for partner services, prevention messaging, and to ensure they are given proper treatment.

[4]The World Health Organization standard for TB Prevention and Control is for states and territories to meet less than one (1) case of Active TB per 100,000 people.

[5]Approximately 3.5 million persons in the United States have chronic hepatitis C Virus infection. (http://www.cdc.gov/hepatitis/hcv/cfaq.htm#cFAQ22). The CDC recommends that individuals chronically infected with Hepatitis C be vaccinated for Hepatitis A and B; of the 2.2 million people in U.S. jails and prisons, about 1 in 3 of have Hepatitis C.

[6]Condom distribution programs are considered to be an effective behavioral intervention to decrease communicable disease transmission and unintended pregnancy rates in communities. They are cost-effective structural interventions that provide communities with the resources they need to ensure access to materials that are essential in preventing the spread of HIV and other STDs.

[7]The unit's health education campaign, WWW.KNOWYO.ORG goal is to establish/reinforce a call to action for the specific target population (defined by the WDH Integrated HIV Prevention and Comprehensive Care Plan, 2012) to get tested for HIV/STD/viral Hepatitis and know their status. This campaign began in May 2010 and is managed by the contractor, Adbay.com Inc. and all metrics are measured in Google analytics. The metrics outlined are correlated with the influence the campaign has on the consumer and evaluates the main call to action of the campaign.

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Communicable Disease Treatment Program

Program Description

The Communicable Disease Treatment Program provides treatment for individuals diagnosed with a communicable disease. This program provides a safety net of healthcare services for diagnosed individuals. Core services include support for other social determinants of health such as housing, transportation, mental health, and other supportive services.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$1,511,467	$1,665,990	$1,540,350
People Served	829	1374	1599
Cost per Person	$1,823	$1,213	$963
Non-600 Series*	11.97%	16.42%	14%

* 600 series is defined as direct service contracts.

Program Cost Notes

- FY 15-16 Ryan White Part B/AIDS Drug Assistance Program (ADAP) Grant—HRSA, Federal
- FY 15-16 Ryan White Part C Grant—HRSA, Federal
- FY 15-16 Housing Opportunities for Persons with AIDS Grant, HUD
- FY 15-16 TB Prevention & Control Grant—CDC, Federal
- FY 15-16 Substance Abuse Block Grant Dollars—SAMHSA, Federal
- FY 15-16 Preventative Health and Health Services—CDC, Federal
- FY 15-16 General Fund HIV Medical/Medications

Program Staffing

- 3.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Number of individuals receiving Standards of Care medical services through HIV Services, STD, viral Hepatitis B and C, Tuberculosis-Active/Latent (TB)
- Clients who adhere to a medical case management care plan developed per Standards of Care (HIV/TB)
- Reduce healthcare associated costs by increasing access to preventive care and wellness services for underserved and at-risk populations
- Number of individuals receiving treatment for latent TB Infection and active TB Disease
- Number of individuals who received treatment or preventive treatment for STD infections, specifically Chlamydia
- Purchasing of insurance for enrolled HIV positive individuals

Events that have Shaped this Program

- Healthy People 2020 objectives include HIV, STD, Immunization, and Infectious Disease
- 2011/2012: Implementation of HIV Services enrollment package completed by program case managers which includes identification of risks related to social determinants (housing/supportive services) and high-risk health outcome indicators (sexual health, alcohol, substance use)
- Adoption and implementation of baseline HIV/AIDS Bureau (HAB)/CDC Standards of Care measures
- 2011/2012: Implementation of common Public Health Nursing Guidelines and Orders for Communicable Disease case management, screening and treatment services
- 2016: Completion of a statewide comprehensive communicable disease needs assessment and submission of the Integrated HIV Statewide Coordinated Statement of Need/Prevention and Care Plan

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Communicable Disease Treatment Program

PROGRAM CORE PURPOSE

The Communicable Disease Treatment Program reduces disease incidence and improves the health of individuals diagnosed with communicable diseases living in Wyoming.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
% and # HIV clients enrolled in the HIV Services Program, AIDS Drug Assistance Program who are taking anti-retroviral medications[1]	95%	95%	93% 74/80	91% 75/82	89% 75/84	67% 92/138	81%* 111/137
% and # of Latent TB clients enrolled in TB Program completing at least 6 months of preventive therapy[2]	81%	81%	81% 130/161	62% 47/76	39% 50/129	58% 53/92	93%* 54/58
% of newly identified HIV positive clients linked into primary care within 3 months of their diagnosis[3]	95%	95%	100% 12/12	80% 12/15	70% 9/13	73% 11/15	82%* 14/17
% of clients enrolled in the HIV Services Program with a suppressed HIV viral load[4]	75%	75%	66% 100/151	73% 119/163	65% 106/164	61% 94/153	79%* 132/168
% of new HIV infections considered a late diagnosis[5]	50%	70%	41.7% 5/12	46.7% 7/15	67% 8/12	31% 5/16*	29%* 5/17

*Year-to-date (January – November)

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q 2**	**2016 Q3+Q4**
OUTPUTS									
# of HIV clients enrolled in care with a documented CD4/Viral Load	136	147	164	135	178	98	67	122	178
# of individuals in the TB Program enrolled for latent or active TB disease treatment	170	151	152	92	-	51	41	47	-
EFFICIENCIES									
Cost avoidance for program by provider reimbursement at the Medicaid rate[6]	$78,186	$87,184	$67,033	$33,514	$17,771	$21,366	$12,148	$6,718	$11,053
(-) Indicates data not yet available									

STORY BEHIND THE PERFORMANCE

- Healthy People (HP) 2020 goals and objectives and HIV/AIDS Bureau Standards of Care are the benchmark for the Communicable Disease Treatment Program
- The HIV Services Program provides payment for medical services to approximately 170 clients currently living with HIV/AIDS in Wyoming.
- Statutory requirements are in W.S.§ 35-4-101-113.

[1] Adherence to an HIV treatment regimen allows anti-retroviral medications to work effectively to reduce the amount of HIV in the body and thus reduce transmission. Adherence to an HIV treatment regimen also helps prevent disease resistance. Drug resistance develops when the virus mutates (changes form), becoming 'resistant' to certain anti-retroviral medications.

[2] Treatment of latent TB infection (LTBI), which is not communicable, prevents conversion to active TB disease, which is communicable. National objectives aim to ensure at least 85% completion of treatment in LTBI cases. The WDH TB Program provides medication to the 'safety net' population free of charge.

[3] Per MMWR-Vital Signs, Weekly, December 2, 2011, 77% of HIV positive individuals are linked into care nationally.

[4] An individual with a suppressed viral load has small amounts of virus in their blood reducing the risk of transmission (<200 copies/mL). Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months during the measurement year. The measurement is calculated by dividing the number of patients with a suppressed viral load at their most recent test during the time period by number of patients enrolled in the HIV Services Program.

[5] Late diagnosis = Progression to AIDS within one year. National average between an HIV diagnosis and an AIDS diagnosis is 6-7 years.

[6] Physicians have a set billing rate. For example, a regular office visit charge is $211.00 and the Medicaid reimbursement rate is $95.57. A chest x-ray for TB varies from $100 - $273 and the Medicaid reimbursement varies from $11.65 - $33.89.

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Community Medical Access and Capacity Program

Program Description

The Community Medical Access and Capacity Program provides education and infrastructure support to improve the quality of hospitals and provides technical assistance and support for the expansion of community health centers and rural health clinics.

Program Expenditures and People Served

	SFY 2014	SFY 2015	SFY 2016
Total Program Cost	$1,622,880	$382,846	$818,516*
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series**	7.15%	32%	17%

*$253K in FF were paid out in SFY 2016
** 600 series is defined as direct service contracts.

Program Cost Notes

- 12% SGF and 88% FF in SFY 2016
- Medicare Rural Hospital Flexibility (FLEX) Grant, 100% FF ($464,345)
- Small Rural Hospital Improvement Program (SHIP) Grant, 100% FF ($142,361)
- Community Assessment, 100% SGF ($125,000)
- Primary Care Support Act (PCSG), 100% SGF ($1.2M)
- Small Rural and Critical Access Hospital Technology grants, 100% SGF ($1M-expended 2013 and 2014)

Program Staffing

- 1.3 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The FLEX Grant provides Critical Access Hospitals (CAH) support for quality, operational, and financial improvements, health system development, and community engagement.
- The SHIP Grant provides small rural hospitals support in developing value-based purchasing, bundled payments, prospective payment system, and accountable care organizations.
- The Community Assessment fund supports a variety of special projects, such as community health needs assessments, recruitment and retention assessment, and improvement strategies.
- The PCSG grant received seven applications in SFY 13; four awards were distributed in SFY 14. An additional $200,000 was added to the program and awarded in SFY2016.

Events that have Shaped this Program

- W.S. § 9-2-117 created the Office of Rural Health in 1993, which is charged with oversight of the Program.
- An amendment to Section 355 of the WDH budget in the 2011 General Session provided funds to critical access and rural hospitals to purchase technologies to move them toward meaningful use of electronic health records per the American Recovery and Reinvestment Act of 2009.
- Federal funding streams require activities to address quality improvement.
- W.S. § 9-2-127 created the Primary Care Support Act (2011). The Primary Care Support Act provided $1M for new rural health clinics (RHCs) or community health centers (CHCs) and/or expanding services in existing RHCs and CHCs. An additional $200,000 was allocated to the program for awards in SFY2016.

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Community Medical Access and Capacity Program

PROGRAM CORE PURPOSE

The Community Medical Access and Capacity Program provides education and infrastructure support for quality improvement in Critical Access Hospitals (CAHs), small rural hospitals, rural health clinics, and community health centers.

OUTCOMES

Performance Metric	FFY 2016 Target	FFY 2017 Target	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016
% and # of CAHs participating in the Medicare Beneficiary Quality Improvement Program (MBQIP)[1]	93.75%	93.75%	37.5% (6/16)	87.5% (14/16)	93.75% (15/16)	93.75% (15/16)	93.75% (15/16)
% and # of CAHs reporting Emergency Department Transfer Communication measures (EDTC)[2,3]	93.75%	93.75%	N/A	N/A	63% (10/16)	31% (5/16)	86.7% (13/15)
% and # of CAHs reporting HCAHPS[1,6]	93.75%	93.75%	N/A	N/A	81% (13/16)	88% (14/16)	93.75% (15/16)
# of new RHC/CHCs as a result of Primary Care Support Grant funding[4]	0	1	N/A	N/A	N/A	1	0
# of CAHs participating in billing & coding/chart audits/provider documentation	9	9	N/A	N/A	5	0	5

N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of technical assistance calls hosted[7]	18	18	16	5	5	3	2	4	1
# of CAHs participating in annual stakeholder meeting	N/A	5	6	8	6	8	0	6	0
# of CAHs responding to FLEX activities menu for participation	N/A	N/A	N/A	12	11	12	0	11	0
# of awards issued for RHC & CHCs under the Primary Care Support Grant[4] (SFY)	0	0	4	0	1	0	0	0	1
# of CAHs utilizing QHi benchmarking database[1] (not cumulative)	8	6	6	4	6	4	4	4	6

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

Performance Metric	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
EFFICIENCIES									
Average cost per CAH participating in FI/OI initiatives[3]	N/A	N/A	$21,575	$12,525	$15,678	N/A*	N/A*	N/A*	N/A*
Average cost per CAHsparticipating in QI initiatives[3]	N/A	N/A	$4,889	$1,680	$4,965	N/A*	N/A*	N/A*	N/A*
Cost per CAH to participate in QHi[1]	$1,700	$2,267	$2,200	$3,400	$1,250	N/A*	N/A*	N/A*	N/A*

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

1. Both the Medicare Beneficiary Quality Improvement Project (MBQIP) and Quality Health Indicators (QHi) have been voluntary quality improvement data systems available to CAHs in the past. MBQIP collects data on different quality of care indicators and trends over time. MBQIP was established by the federal Office of Rural Health Policy and is part of a publically reported national data set. During the spring of 2016 the Health Resources and Services Administration (HRSA) relaxed the mandatory participation in MBQIP for funding eligibility. CAHs must report data in one quarter in one domain of the core quality improvement initiatives to receive funding. Core initiatives include Hospital Consumer Assessment of Healthcare Providers (HCAHPS), Inpatient/Outpatient measures, and Emergency Department Transfer Communication (EDTC) measures. QHi utilizes data, benchmarking, and networking to drive quality improvement in CAHs. QHi provides CAHs with additional areas of benchmarking including measures related to clinical quality, patient satisfaction, financial operations, and human resource measures. Participation in QHi is not required to receive funding.
2. During 2013/14 ten CAHs participated in an EDTC pilot project through the regional Quality Improvement Organization (QIO). Following the pilot, technical support through the QIO was eliminated; CAH EDTC data collection dwindled and reporting to the state office has been reduced to a handful of reports. Flex 15-16 pushed hard for CAHs to report EDTC measures and reached the highest number of participation with 13 CAHs reporting.
3. Initiatives/activities are chosen each year by the CAH leaders at the annual stakeholder planning meeting. The focus in 2017 will be to provide resources to support CAH financial and operational improvement (FI/OI). This will include charge master review and revenue cycle improvement.
4. Grant awards issued for infrastructure support include Critical Access and Rural Hospital Technology Grants, Small Rural Hospital Improvement Program (SHIP) grants to hospitals, pass-through sub-recipient grants to Critical Access Hospitals for activities related to the objectives of the Federal Medicare Rural Hospital Flexibility Grant Program, grants to Rural Health Clinics to support attendance at annual Rural Health Clinic conferences, and financial feasibility study grants to prospective Rural Health Clinics and Community Health Centers. The Primary Care Support Grant Program, W.S. §9-2-127, was created by the Wyoming Legislature in 2011 to support infrastructure. The purpose is to provide grants to new Community Health Centers (CHCs) and Rural Health Clinics (RHCs) for the one-time start-up costs of a new clinic or to existing CHCs and RHCs to expand the population served, initiate new services, or facilitate compliance with quality criteria. The Program was given $1M in grant funding and four awards were issued in Fall 201,; which are currently working on projects, one of which resulted in the opening of a new CHC in September 2015 in Powell. No awards were issued in FY15. In FY16 an additional $200K was given to the program and one award was issued.
5. All outcomes, outputs, and efficiencies are reported on a Federal Fiscal Year (FFY).
6. Percent of WY CAHs reporting HCAHPS data vs CAHs nationally: FFY 2011 62.5% vs 41.3%; FFY2013 68.8% vs 49%, FFY2014 68.8% vs 59%. FFY2015 75% vs 70.6%.
7. Due to low participation in the bi-monthly QHi Users Group meeting it has been changed to a quarterly meeting and renamed the Quality Improvement Roundtable to incorporate not only QHi benchmarking needs and trends but any state-wide quality improvement needs, questions, and initiatives.

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Community Services Program

Program Description

The Community Services Program (CSP) administers the Community Services Block Grant (CSBG) through local governments, community action agencies, and neighborhood-based non-profit corporations who provide services directly or subcontract with local service providers to assist low-income individuals and families with a vast array of anti-poverty related health and human services, empowering them to move towards self-sufficiency.

Program Expenditures and People Served

	SFY 2014	SFY 2015	SFY 2016
Total Program Cost	$3,882,241	$3,271.112	$3,017,665
People Served	30,282	23,402	31,503
Cost per Person	$128.20	$131.50	$95.79
Non-600 Series*	5%	9%	6%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 100% Federal Funding
- The Community Services Program Manager position was vacant for three months of SFY2016.

Program Staffing

- 1.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- CSBG Programs are statutorily required to collect, maintain, and report client demographic information, programmatic statistics, and fiscal data to CSP.
- During FFY 2014, CSP program participant characteristics indicated that typical clients were single, white (non-Hispanic) females between the ages of 24-44, who were without a disability, had graduated from high school or obtained a GED, were employed, had no health insurance, rented their housing, and fell between 51% – 75% of the Federal Poverty Level (FPL) (FPL for 1 person during 2014 was $11,490). In FFY 2016, the same characteristics remained true nation-wide, with one exception – more CSBG clients had health insurance.

Events that have Shaped this Program

- CSBG allocations are determined for each county through a poverty formula which considers 7 factors including the low-income population, number of people unemployed, and number of people receiving Supplemental Nutrition Assistance Program (SNAP) benefits in that county.
- Each county makes funding decisions through a Tripartite Board which consists of 1/3 elected officials, 1/3 members of the local community, and 1/3 representatives of the low-income population. As a requirement, Comprehensive Community Needs Assessments are conducted once every 3 years and Public Hearings are held annually regarding CSBG funding.

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Community Services Program

PROGRAM CORE PURPOSE

The Community Services Program (CSP) administers funding to support local entities providing services and activities addressing the unmet needs of low-income individuals and families, empowering them to overcome the social and economic factors that influence health, their well-being, and their path to becoming self-sufficient.

OUTCOMES

Performance Metric	FFY 2016 Target	FFY 2017 Target	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016
% of emergency rent/ mortgage assistance provided (# of individuals helped / # who requested assistance)[3]	>30%	>30%	52% (2,109/ 4,075)	40% (1,886/ 4,774)	26% (2,002/ 7,797)	33% (1,537/ 4,647)	-
% of emergency medical care provided (# of individuals helped / # who requested assistance)[3]	>80%	>80%	87% (2,215/ 2,541)	89% (1,673/ 1,876)	78% (1,341/ 1,726)	77% (1,941/ 2,531)	-
% of emergency food provided (# of individuals helped / # who requested assistance)[3]	>95%	≥99%	91% (33,933/ 37,419)	99% (34,867/ 34,875)	99% (14,313/ 14,526)	99% (6,002/ 6,047)	-
% of Wyoming's eligible families receiving CSBG services[1,5]	>30%	>30%	54% (11,721/ 21,590)	42% (10,584/ 25,054)	28% (7,141/ 25,120)	-	-

(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric		SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS										
# of low-income and/or homeless people receiving Services[4]	Total	62,748	57,288	30,282	23,402	31,503	11,063	12,339	12,466	19,037
	CSBG	54,370	51,062	24,292	23,402	31,503	11,063	12,339	12,466	19,037
	ESG*	8,378	6,226	5,990	-	-	-	-	-	-
% and # of Tripartite Boards meeting 75% or more of the CSBG Organizational Standards[7]		N/A	N/A	N/A	63% (10/16)	56% (9/16)	N/A*	N/A*	NA*	NA*

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis
(-) Indicates data not available
* The Emergency Services Grant was transferred to the Department of Family Services as of January 1, 2014

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
% and # of service providers conducting activities in the top 3 areas of greatest need according to the Needs Assessment	N/A	N/A	N/A	57% (49/86)	55% (47/86)	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per person	$72.87 ($4,928,258 /67,630)	$59.44 ($3,729,794 /62,748)	$59.85 ($3,428,609 /57,288)	$128.20 ($3,882,241 /30,282)	$131.50 ($3,271,112 /23,402)	$101.84 ($2,019,926 /19,835)	$178.26 ($1,862,315 /10,447)	$107.72 ($1,342,799 /12,466)	$71.30 ($1,357,320 /19037)

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

1. Funded by the U.S. Department of Health and Human Services through the Community Services Block Grant (CSBG) ($3.3M annually). 90% of funding is distributed directly into Wyoming communities to assist low-income individuals and families and empower them to move towards self-sufficiency.

2. CSBG services and activities are conducted in all 23 counties and on the Wind River Reservation addressing factors including education, emergency services, employment, health, housing, income management, linkages among service providers, nutrition, and self-sufficiency.

   Examples: a food basket from the local food bank, rental assistance to prevent homelessness, eye glasses for someone lacking insurance, or work boots to start a new job.

   An example of Wrap-Around Services: A victim of Domestic Violence moving away from his/her abuser is assisted with a security deposit, 3 months' paid rent and utilities, food vouchers, and a medical voucher for a broken bone. Typically, case management continues for 6-12 months to assist the victim in continuing his/her path to becoming self-sufficient.

3. Emphasis is placed on education, employment, health, and housing.

4. The Emergency Solutions Grant (ESG), formerly Emergency Shelter Grant, received approximately $180,000 annually from the US Department of Housing and Urban Development. This program transferred to the Wyoming Department of Family Services in January 2014.

5. For this outcome, we are using 100% of the Federal Poverty Level (FPL) and the average household size. The FPL is a set minimum amount of gross income that a family needs for their basic necessities (food, shelter, clothing, transportation, etc.). This level is determined annually by the U.S. Department of Health and Human Services and varies according to household size. The average household size in Wyoming is 2.5, as reported by the U.S. Census Bureau.

6. All outcomes are reported on a Federal Fiscal Year (FFY) and all outputs and efficiencies are reported on state fiscal year (SFY). Starting with the current FFY2016-17, outcomes and outputs will be reported on a FFY starting October 1st and ending September 30th.

7. The Office of Community Services (OCS) developed CSBG Organizational Standards to provide a foundation of organizational capacity for all CSBG Eligible Entities across the nation.

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Emergency Medical Services

Program Description

The Office of Emergency Medical Services (OEMS) operates under a statutory requirement to develop a comprehensive EMS and trauma system pursuant to W.S. § 33-36-101 and W.S. § 35-1-801. This implies two key tasks: ensuring compliance within existing infrastructure and developing new components. To this end, the OEMS oversees various activities, to include the EMS educational system, compliance, investigations, the EMS for children program, the collection of data, and the provision of technical and other assistance to local communities throughout the state.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$ 1,112,541	$ 1,105,798	$ 1,066,263
People Served	582,658	584,153	586,107
Cost per Person	$1.91	$1.89	$1.82
Non-600 Series*	94%	95%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 71% General Funds
- 29% Federal Funds from the Health Resources and Services Administration (HRSA), National Highway Traffic Safety Administration (NHTSA), and Preventive Health & Health Services Block Grant Funding

Program Staffing

- 6 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Ensures available manpower for local EMS agencies by providing community-based emergency medical training at five different certification levels. 31 EMT courses were provided in FY2016.
- 59% of Wyoming's population resides in a community with an identified ambulance service.
- 30% of Wyoming EMS agencies are fully compensated, 23% are partially compensated, and 47% are strictly volunteer.
- Approximately 75,289 requests were recorded in CY2015 for service statewide (approximately nine requests per hour).

Events that Shaped this Program

- The Wyoming Emergency Medical Services Act of 1977 created OEMS within the Department of Health.
- National trends and legislation, such as the National Emergency Medical Services Education Standards (2011).
- W.S. § 35-1-801 created the "comprehensive emergency medical services and trauma system."
- Frontier and rural communities have few resources to allocate to these functions.
- Remote areas and heavy reliance on Critical Access Hospitals create a demand for EMS to transport patients to specialty hospitals.

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Emergency Medical Services

PROGRAM CORE PURPOSE

The Office of Emergency Medical Services (OEMS) develops and regulates the statewide, comprehensive Emergency Medical Services system.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # services reporting to WATRS[1]	90%	95%	N/A	69% (52/75)	82% (63/77)	91% (77/85)	89% (91/102)
% and # services submitting complete data[2]	90%	90%	N/A	81% (42/52)	85.7% (54/63)	84% (65/77)	76% (69/91)
% and # chute times <10 minutes[3]	>95%	>95%	N/A	97% (11,218/ 11,584)	90.4% (22,564/ 24,945)	84% (42,542/ 50,919)	91% (41,992/ 46,145)
% and # of responses ≤ 8:59 minutes[4]	60%	60%	N/A	48% (5,505/ 11,584)	52% (13,095/ 24,945)	43% (22,068/ 50,919)	52% (23,995/ 46,145)

(-) Indicates data not yet available
N/A Indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of supported EMT classes	19	23	27	19	31	3	16	7	24
# of WATRS records (911 only)	28,724	30,335	45,897	50,952	50,437	25,916	25,036	27,270	23,167
# of completed records (911 only)	N/A	11,584	35,989	47,436	46,145	24,036	23,400	25,112	21,033
# of WATRS trainings	8	1	9	16	20	3	13	16	4
Minutes of WATRS customer support	N/A	5,569	9,466	11,758	24,744	5,571	6,187	6,552	18,192
EFFICIENCIES									
cost per successful student	$247 ($49,622/ 201	$209 ($54,153/ 259)	$184 ($33,525/ 182)	$122 ($32,988/ 270)	$218 ($55,755/ 255)	$206 ($18,941/ 92)	$79 ($14,057/ 178)	$483 ($22,205/ 46)	$161 ($33,550/ 209)
class completion rate	78% (201/257)	82% (259/317)	69% (182/262)	87% (270/322)	87% (255/294)	94% (92/98)	79% (178/224)	96% (46/48)	85% (209/246)

(-) Indicates data not yet available
N/A Indicates data not available due to the creation of a new metric

STORY BEHIND THE PERFORMANCE

The OEMS is both a developmental and regulatory agency. In this dual capacity, the OEMS must determine the status of the many elements that comprise a comprehensive EMS and Trauma System, adapt what currently exists or create new solutions, and then ensure that EMS agencies are compliant and functioning in a coordinated effort. Healthy People 2020 identified the objective of increasing the proportion of persons who are covered by basic or advanced life support. In this context, we would define the term "covered" as "response reliability," or the degree of reliability to which Wyoming's EMS can respond promptly and deliver appropriate care. There are many factors that must flow in close coordination to ensure this reliability. For example, Wyoming's EMS agencies must comply with both rule and industry standards for response and provide a competent workforce that can meet the standard of care. To accomplish this, the OEMS must measure the current response reliability, develop a system that maximizes Wyoming's capabilities, and provide oversight to an entire system of education, based on valid, relevant curricula.

[1]The Wyoming Ambulance Trip Reporting System (WATRS) is a web-based patient reporting system for EMS agencies. The OEMS began implementation of the system in 2010. This system is provided at no cost to all ambulance services and fire agencies operating in Wyoming. It is compliant with the National EMS Information System (NEMSIS) requirements, is accessible by receiving facilities, and interfaces with the Trauma Patient Registry. Efforts are underway to link the system with the Wyoming Department of Transportation highway traffic data.

[2]Following the 2012 Program Performance report, the OEMS assigned a validity score to specific data fields within the WATRS and began tracking the completeness of reporting within the system. This validity report does not measure the accuracy of the data that is entered; only whether or not data was entered into a field. The accuracy of reporting will continue to be a goal of the OEMS.

[3]"Chute time" is the time interval between the time patient location, problem and callback number are known and the time the ambulance begins to respond to the location. Because this interval is included in the overall response time, EMS should strive to make this interval as short as possible. In large, urbanized systems, the goal is to achieve chute times of 90 seconds or less with 90% reliability. Currently, the only requirement in rule regarding chute time is that an ambulance must respond in less than 10 minutes. No distinction is made regarding variations in the design of the local system. A chute time standard of 10 minutes may be all that is realistically achievable in some areas, while other urbanized areas with full-time paid staff can achieve quicker chute times.

[4]"Response time" is the time interval between the time the patient location, problem and callback number are known, to the time that the ambulance reports that it is on scene. In large, urbanized systems, the benchmark is to achieve response times of eight minutes and 59 seconds or less with 90% reliability. While the measurement of response time reliability is valid as it relates to an ambulance service, it is also subjectively dependent on the particular service in question. It would be inappropriate to apply the same standard to all of Wyoming's services as there is no standardized response time benchmark for rural and frontier volunteer services. Each system should determine what response times *are* achievable and their reliability in meeting those times.

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End Stage Renal Disease

Program Description

End Stage Renal Disease (ESRD) is a benefit program to assist low-income Wyoming residents diagnosed with and receiving treatment for end stage renal disease with the costs associated with their condition. ESRD pays medical co-payments, Medicare B, D, and health insurance premium reimbursements, prescription costs, and transportation expenses to 1) improve quality of life by promoting regular dialysis treatments and 2) improve kidney transplant candidacy by paying the cost of immunosuppressant drugs.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$563,313	$505,590	$523,056**
People Served	138	136	114
Cost per Person	$4,082	$3,718	$4,588**
Non-600 Series*	15%	15%	11%

* 600 series is defined as direct service contracts.
**Costs may change, as claims can be paid up to 12 months after the service date.

Program Cost Notes

- SGF of $700K for SFY 2016
- $40,000 per year, per client cap on supports (Program rules)

Program Staffing

- .90 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In SFY 2016, the cost per client was: Dialysis: $3,125, Transplant: $1,475, Combined: $2,775 (average for direct services)

Medical payments	$68,793	$4,046 cost per client	17 clients
Insurance	$26,632	$1,158 cost per client	23 clients
Medicare B	$38,023	$927 cost per client	41 clients
Transportation	$119,359	$2,131 cost per client	56 clients
Medicare D	$7,079	$337 cost per client	21 clients
RX/Supplies	$27,605 (dialysis) $36,878 (transplant) Total $64,483	$1,024 cost per client	63 clients

Events that have Shaped this Program

- Changes implemented since 2009:
  - Regular visits to dialysis centers by ESRD staff for training and support of social workers
  - Adjustment of travel expense reimbursement and per diem rate to 50% of GSA rate for Wyoming
  - Addition of reimbursement of Medicare Part D premiums
  - Rules updated July 2014 to clarify program benefits and procedures
  - In 2015 piloted a Nutrition Program; pilot program was not successful since clients had to pay out of pocket for food and wait for reimbursement
  - Entire program was eliminated at the end of SFY 2016 due to budget reductions.
- ESRD was created by legislation in 1971. In 1996 the program became almost non-existent due to budget cuts by the legislature. Due to intense public demand, HB233 was passed during the 2001 legislative session, providing W.S. § 42-4-117 for the End Stage Renal Disease Program and re-establishing funding similar to the pre-1996 level.
- ESRD has a very fluid, diverse clientele, ages 12 to 85, encompassing all ethnicities. Turnover of ESRD clients tends to be high due to death, leaving the state for family support, financial ineligibility, and/or simply making the choice to decline renewal of ESRD benefits.

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End Stage Renal Disease

PROGRAM CORE PURPOSE

The End Stage Renal Disease (ESRD) program assists low-income Wyoming residents diagnosed with and being treated for end stage renal disease with costs associated with dialysis treatment and the cost of anti-rejection drugs for eligible kidney transplant recipients.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of dialysis clients with health coverage other than Medicare B[1]	≥ 77%	Program Eliminated	58% 70/121	77% 87/113	79% 89/113	76% 84/111	82% 75/92
% and # of dialysis clients using the co-payment benefit[2]	≤ 23%	Program Eliminated	33% 39/121	24% 27/113	22% 24/113	25% 27/111	19% 17/92
%and # of ESRD dialysis clients who received a kidney transplant[3]	≥ 7%	Program Eliminated	5% 6/121	7% 8/113	6% 6/113	3% 3/111	7% 6/92

Outputs and Efficiencies									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
Outputs									
Total # of Clients[4]	151	138	138	136	114	124	136	101	114
% and # of clients in transplant section[3]	20% 30/151	25% 34/138	22% 31/138	20% 27/136	23% 26/114	26	27	21	26
% and # of approved program applications[5]	47% 32/68	48% 32/67	54% 42/78	43% 29/67	39% 27/70	45% 16/36	42% 13/31	35% 14/41	34% 13/29
# of trainings for dialysis social workers[6]	4	3	3	3	4	2	1	3	1
Efficiencies									
Insurance cost per dialysis benefit user[2]	$1,905 (62,851 /33)	$1,767 (68,930 /39)	$1,733 (55,442 /32)	$1,991 (59,731 /30)	$1,190* (27,377 /23)	$861 (22,380 /26)	$1205 (37,351 /31)	$803 (16,062 /20)	$707* (11,315 /16)
Co-payment cost per dialysis benefit user[3]	$3,487 ($135,985 /39)	$4,478 ($120,893 /27)	$4,911 ($127,677 /26)	$5,401 ($135,033 /25)	$4,203* ($71,455 /17)	$2,068 ($39,292 /19)	$3,546* ($95,741 /27)	$2,359 ($25,945 /11)	$3,793* ($45,510 /12)
Service cost per ESRD client	$3,221 ($486,484 /151)	$3,586 ($494,830 /138)	$3,429 ($473,181 /138)	$4,960 ($674,529 /136)	$3,975* ($453,104 /114)	$1,967 ($243,939 /124)	$3,166* ($430,590 /136)	$1,639 ($165,572 /101)	$2,522* ($287,532 /114)
*Costs may change as claims can be paid 12 months after the service date.									

STORY BEHIND THE PERFORMANCE

1. ESRD has made successful efforts to encourage clients to increase independence by participating in insurance plans other than Medicare Part B. This includes supplemental coverage, private insurance, the Wyoming Health Insurance Pool, and Medicaid. This allows the client the opportunity to gain benefit for other conditions and a pay source for the 20% Medicare Part B coinsurance. Because of the high turnover in ESRD clients, this is an ongoing process.

2. In 2009/2010, typical co-payment costs after Medicare part B were $400 - $600 per client per month or $4,800 - $7,200 per year. The typical co-payment cost after Medicare Part B for SFY 2016 was $638 per month or $7,656 per year per client. Medical co-payment is the highest dollar per client benefit offered by ESRD. ESRD will continue to encourage clients to utilize private and supplemental Medicare insurance plans to keep this cost to a minimum

3. For dialysis patients who are physically able, a kidney transplant is the best option, from both a health and financial standpoint. ESRD assists dialysis clients with costs associated with dialysis to assure regular treatments to keep the client as healthy as possible. This increases the likelihood the client will be healthy enough to undergo a transplant procedure. When a kidney transplant is received, ESRD will assist the client with the cost of anti-rejection (immunosuppressant) drugs, for as long as he/she remains in Wyoming and is financially eligible for the program. Nationally, about 5% of dialysis patients received a kidney transplant in 2010/2011. In SFY 2016, 7% of Wyoming ESRD clients received a kidney transplant.

4. There were 337 Wyoming residents on dialysis in 2014. ESRD provided benefits to 111 of these individuals, or about 33%. As of the 2010 census, 24% of Wyoming households fell below 185% of the Federal Poverty Level (FPL). Because ESRD adjusts income by dialysis related expense, it is expected that the target population is represented by 30% to 40% of those on dialysis. This suggests that the ESRD program is known to and used by almost, if not all, of those who are eligible.

5. Eligibility for ESRD is based on three criteria: 1) must be a Wyoming resident; 2) household income must be at or below 185% of FPL adjusted by ESRD related expenses; and 3) must be diagnosed with and receiving treatment for End Stage Renal Disease or have received a kidney transplant.

6. ESRD provides training to any new Wyoming dialysis social worker who wishes to have it. If an already trained social worker has an increase in rejected applications, ESRD offers refresher training. Since the social workers are not employed by ESRD, there is no control over the rate of social worker turnover nor does ESRD have any direct control over the quality of applications received.

   **In 2016, ESRD hosted the first Wyoming Dialysis Social Worker Meeting. Four of nine Wyoming social workers attended. The presenter was the Executive Director of the National Association of Social Workers, Wyoming Chapter, who presented on "Cultural Competency in Clinical Practice."

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Healthcare Workforce Recruitment, Retention, and Development

Program Description

Healthcare Workforce Recruitment, Retention, and Development (HWRRD) aids Wyoming's underserved communities in providing access to care through activities that support the recruitment, retention and development of the healthcare workforce in Wyoming, including awards made under the Wyoming Healthcare Professional Loan Repayment Program (WHPLRP), W.S. § 9-2-118 and 9-2-119, the Wyoming Provider Recruitment Grant Program (PRGP), W.S. § 35-1-1101, the Research and Explore Awesome Careers in Healthcare (REACH) Program, and the Wyoming State Loan Repayment Program (WY-SLRP).

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$618,788	$699,742	$751,497
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	14.37%	18.72%	16%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 72% SGF and 28% FF
- WHPLRP 15-16 award budget: $1M (100% tobacco funds); funding eliminated for 17-18
- PRGP award budget: $400,000 SGF for 15-16; reduced to $244,000 SGF for 17-18
- Decrease in program expenditures/increase in non-600 series in SFY15 due to rework of WHPLRP payments

Program Staffing

- 0.88 FTE
- 0.50 AWEC
- 0 Other (Contractor)

Program Metrics

- The WHPLRP awards physicians, dentists, and other health professionals. A total of 286 awards have been issued since 2006. Five awards were issued in 2016.
- The REACH Program provides grants for hosting educational programs to expose students in grades 5-8 to healthcare careers. Three were hosted in 2016 with 38 participants.
- 2015 was WY-SLRP's first year. Four awards were issued (two physicians, two physician assistants) in 2015, and five (two physicians, two physician assistants, and one nurse practitioner) in 2016.

Events that have Shaped this Program

- W.S. § 9-2-118 and 9-2-119 created the WHPLRP in 2005, and W.S. § 35-1-1101 created the PRGP in 2008. House Bill 88 passed during the 2015 General Legislative Session, modifying W.S. § 9-2-119 to increase the maximum allied healthcare professional award and modifying W.S. § 35-1-1101 to expand the PRGP to non-physicians.
- Activities also provide support for federal workforce programs, as required by the federal State Offices of Rural Health Grant (SORH) and the State Primary Care Offices Grant (PCO).
- The Office of Rural Health (ORH) lost its AWEC Data Manager in October 2015 and has contracted with JSI Research and Training Institute, Inc. to conduct health professional shortage area designation activities beginning July 1, 2016. The AWEC Data Manager was replaced with an AWEC Program Specialist to assist with program activities beginning April 2016.
- The ORH applied for and was awarded a State Loan Repayment Program (SLRP) grant from HRSA in 2015. SLRP awards follow the requirements of the federal National Health Service Corps Loan Repayment Program with state-level flexibility. The WY-SLRP will provide approximately 16 awards over a four-year grant period (approximately eight physicians and eight mid-level). Funding is 50% federal and 50% state matching funds.

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Healthcare Workforce Recruitment, Retention, and Development

PROGRAM CORE PURPOSE

To increase the number of healthcare professionals in underserved areas of Wyoming.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of Loan Repayment applicants receiving awards [1]	5%	67%	9.4% (19/ 203)	4.6% (10/ 219)	7.9% (13/ 165)	5.82% (11/ 189)	6.45% (12/ 186)
% and # of Loan Repayment awardees successfully completing obligation (all Program years combined)[2]	≥90%	≥90%	91% (225/ 248)	90% (233/ 258)	90% (245/ 271)	90% (254/28 2)	90% (264/ 294)
% and # of Loan Repayment 3-year post-service obligation retention rate (all Program years combined)[3]	≥80%	≥80%	N/A	72.2% (13/18)	87.3% (124/ 142)	86.9% (146 /168)	84.6% (159/ 188)
% and # retained Loan Repayment awardees still accepting Medicare/Medicaid/CHIP 3 years' post-service obligation[3]	≥84.6%	≥85%	N/A	84.6% (11/13)	87.9% (109/ 124)	87% (127/ 146)	88% (140/ 159)
% and # of Provider Recruitment Grant awardees successfully recruiting a physician from out of state[4]	60%	60%	50% (5/10)	61.5% (8/13)	52.9% (10/17)	47.6% (10/21)	46% (12/26)

N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Amount awarded (# new loan repayment awards)[1]	$452,300 (8)	$500,000 (10)	$504,297 (13)	$670,000 (11)	$678,000 (12)	$510,000 (7)	$160,000 (4)	$558,000 (8)	$120,000 (4)
Amount awarded (# new provider recruitment awards)[4]	0	$200,000 (3)	$200,000 (4)	$200,000 (4)	$238,520 (5)	$200,000 (4)	0	$238,520 (5)	0
# new J-1 Visa Waiver physicians[6]	10	4	10	4	10	N/A*	4	N/A*	10
# recruitment referrals/ candidates sourced[5]	368	46	0	378	686	0	378	441	245
# candidates placed[5]	12	6	0	4	9	1	3	3	6
EFFICIENCIES									
Average Provider Recruitment Grant Reimbursement [4]	$50,425	$39,286	$42,342	$42,342	$47,020	N/A*	N/A*	N/A*	N/A*
Average cost per referral/ candidate sourced (contract cost to date/#)[5]	$318 ($117,000/ 368)	$2,418 ($111,240/ 46)	0	$62.81 ($23,740/ 378)	$39.25 ($26,928.43/ 686)	N/A*	$62.81 ($23,740/ 378)	$42.45 ($18,721.13/ 441)	$33.50 ($8,207.30 / 245)
Average cost per placement (contract cost to date/#)[5]	$9,750 ($117,000/ 12)	$18,540 ($111,240/ 6)	0	$8,000 ($32,000/ 4)	$7,111 ($64,000/ 9)	$8,000 ($8,000/ 1)	$8,000 ($24,000/ 3)	$8,000 ($24,000/ 3)	$6,666.67 ($40,000/ 6)
N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

1. Awards for both the Wyoming Healthcare Professional Loan Repayment Program (WHPLRP) and the Wyoming Provider Recruitment Grant Program (PRGP) are prioritized based on areas determined to be underserved and of greatest need for healthcare professionals. Further prioritization goes to those providers who graduated from a Wyoming college and those who have been practicing in Wyoming the least amount of time.

   Awards for the Wyoming State Loan Repayment Program (WY-SLRP) are available to primary care physicians, physician assistants, nurse practitioners, and certified nurse midwives practicing full-time at approved National Health Service Corps sites located in a primary care Health Professional Shortage Area with a degree of shortage score under 14. Those in areas with a score between 10 and 14 have priority over those with scores under 10. Additional priority is given to providers who graduated from a Wyoming college and those who have been practicing in Wyoming the least amount of time. SFY 2015 data for loan repayment awards was updated to include WY-SLRP award data and the SFY 2017 Target for the percent of loan repayment applicants receiving an award was increased significantly to reflect only WY-SLRP applications and awards due to the elimination of funding for WHPLRP for 2017-2018.

2. Since 2006, 294 loan repayment awards have been issued through both WHPLRP and WY-SLRP. As of the 4th quarter of SFY2016, 264 have either successfully completed or are currently completing their service obligation and requirements. To date, 30 awardees have withdrawn from program participation prior to the first payment or have defaulted on their service obligation or other requirements. National Health Service Corps (NHSC) data for Wyoming indicates a completion rate of 98% for NHSC Loan Repayment participants between 2003 and 2013.

3. Annual retention studies for loan repayment (WHPLRP only) began in SFY2013. WY-SLRP awardee retention surveys will begin in SFY 2021. The goal of the survey is to determine the rate of prior awardees still practicing in Wyoming three years after the end of their service obligation. As of the 4th quarter of SFY2016; 188 prior awardees have been surveyed. 84.6% of survey respondents are still practicing in Wyoming and 88% of those still practicing still accept Medicare, Medicaid, and/or Kid Care CHIP insurance (approximately 10% work in a practice that does not bill for services). National Health Service Corps (NHSC) loan repayment retention rates from 2012 are 82% retained up to one year, and 55% retained after 10 years. NHSC considers a clinician retained if they were still practicing in a federally designated health professional shortage area, regardless of region, state, or if it was the original community.

4. Since 2008, 26 Provider Recruitment awards have been issued to recruiting entities. The awardees have one year to recruit a provider from out of state that meets all program requirements. Twelve have been successful at recruiting and the SFY2016 awardees have until Fall 2016 or Spring 2017 (SFY2017) to recruit. Beginning with SFY2014 awards, the maximum award was reduced to $50,000 to reflect the average expenditure and allow for additional awards with limited funding.

5. A contract for recruitment services was not in place during SFY2014. Wyoming Health Resources Network, Inc. (WHRN) was selected via RFP and a contract was in place for SFY2015. The contract pays on a per placement basis (up to $8,000 for a physician, up to $4,000 for mid-level providers) with an emphasis on the highest need specialties and areas statewide. According 3RNet (Rural Recruitment and Retention Network), the average cost to recruit a primary care physician using a national search firm is over $30,000. Additionally, vacancy advertising and promotion, education, and technical assistance services are paid on a reimbursement basis only. Outcomes and efficiencies prior to SFY2015 have been modified to fit within the structure of the SFY2015 contract.

6. Each state is allotted 30 J-1 Visa waivers per federal fiscal year (FFY). Numbers reported are for the FFY (10/01 to 09/30). J-1 physicians are foreign physicians in the US for post-graduate medical education that are required to return to their home country for two years before applying for a permanent work visa in the US. Waivers of the two-year home residency requirement are granted to eligible physicians willing to practice full-time in an underserved area for a period of three years.

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Public Health Nursing Healthy Baby Home Visitation Program

Program Description

The Public Health Nursing (PHN) Healthy Baby Home Visitation Program ("Healthy Baby Program") is a standardized home visitation service provided by trained nurses to families prenatally and/or with children at birth to two years of age.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost*	$2,356,050	$2,137,250	$2,337,473
People Served**	2,974	^	3,105
Cost per Person#	$792	^	$753
Non-600 Series***	5.3%	6.3%	6.3%

*Program cost is for a state fiscal year
**People served is for a calendar year
Cost per person is calculated using the state fiscal year costs and the previous calendar year's client count
^ Total clients served in CY2014 is not available due to new data system release on August 7, 2014
***600 series is defined as direct service contracts

Program Cost Notes

- Healthy Baby Home Visitation uses blended funds including State General Funds and Federal Funds from Temporary Assistance for Needy Families (TANF).
- State matching funds are required for the Title V Maternal and Child Health (MCH) Services Block Grant ($3 for every $4 Title V); state match must remain at 1989 levels ($2.3M) or higher.

Program Staffing

- 0.4 FTE (additional staff are reported under the Public Health Nursing Program)
- 0 AWEC
- 0 Other

Program Metrics

- Goals include decreasing maternal tobacco use, increasing breastfeeding duration to 6 months, increasing healthy birth outcomes, and decreasing infant mortality.
- The Program uses two home visitation models: Nurse Family Partnership (NFP) and Best Beginnings (BB). These programs have been shown to improve maternal and child health outcomes. Eleven (11) counties deliver the Nurse Family Partnership (NFP) model.

Events that have Shaped this Program

- Title V funding requires a needs assessment every five years; the most recent assessment began in 2013 and informed the 2016-2020 MCH priorities. These priorities are included in the Memorandum of Understanding between each county and the Public Health Division and help to guide county-level maternal and child health service delivery.
- On August 7, 2014, the Best Beginnings Data System was updated to align with the new curriculum and to provide more reliable data.
- In both 2013 and 2015, training on the Partners for a Healthy Baby home visiting curriculum was provided to public health nurses who deliver the Best Beginnings model of home visitation.
- In 2013, a fee for reimbursement structure was incorporated into contracts with counties for the delivery of MCH and home visiting services.
- In 2000, State legislation (Wyo. Stat. Ann. §§ 35-27-101 through -104) provided Temporary Assistance for Needy Families (TANF) funding for PHN home visiting services.
- In 1996, NFP, an evidence-based home visiting model for first-time mothers, was implemented in Wyoming, in addition to the already existing BB home visiting model.
- In 1990, MCH began providing grants to counties for maternal & child health services.

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Public Health Nursing Healthy Baby Home Visitation Program

PROGRAM CORE PURPOSE

The Public Health Nursing (PHN) Healthy Baby Home Visitation Program provides perinatal home visiting services for women to improve pregnancy outcomes and infant health outcomes.

OUTCOMES

Performance Metric	CY 2016 Target	CY 2017 Target	CY 2013	CY 2014	CY 2015	CY 2016
% and # of WY resident births contacted[1]	75%	75%	59.3% 4,520/ 7,617	55.7%[2] 1,691/ 3,035	71.3% 5,465/ 7,669	-
% and # of WY resident Medicaid births contacted[1]	95%	95%	81.7% 2,137/ 2,616	66.6%[2] 639/ 960	76.5% 1,828/ 2,389	-
% of women enrolled in Nurse Family Partnership (NFP) who quit smoking during pregnancy[3] (national average)	25%	25%	22.5% (15.9%)	22.0% (16.0%)	22.0% (16.0%)	23.0%* (16.0%)
% of infants enrolled in NFP born premature (<37 weeks gestation)[3] (national average)	9.5%	9.5%	9.8% (9.5%)	9.7% (9.6%)	9.8% (9.6%)	9.9%* (9.7%)
% of women enrolled in NFP who initiated breastfeeding[3] (national average)	90%	90%	87.3% (80.4%)	87.4% (81.4%)	87.6% (82.3%)	87.8%* (83.2%)

(-) indicates data not yet available
* Year to-date as of 9/30/2016

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
# of NFP clients[4]	296	282	253	239	110*	192	169	110*	-
# of Best Beginning (BB) clients[5]	3,029	2,692	572[5]	2,866	1,449**	1,402	1,464	1,073	376*
# of NFP clients graduated from the program[7]	39	45	33	31	18**	16	15	12	6
Cost to Healthy Baby program per NFP client[8]	$2,574	$2,924	$2,956	$3,450	_	N/A*	N/A*	N/A*	N/A*
Cost to Healthy Baby program per BB client[8]	$467	$569	_[9]	$534	_	N/A*	N/A*	N/A*	N/A*

* As of 3/31/2016
** Year to-date as of 9/30/2016
(-) Indicates data not yet available
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Wyo. Stat. Ann. §§ 35-27-101 through -104 requires voluntary perinatal home visiting services for all at-risk women. Public Health Nursing (PHN) and the Maternal Child Health (MCH) Unit partner to implement the Healthy Baby Home Visitation Program.
- Healthy Baby Home Visitation is delivered by Public Health Nurses using one of two models. Nurse Family Partnership (NFP), an evidence-based home visiting model, has been offered in Wyoming since 1996. NFP is available for women pregnant for the first time and they must enroll before the 28th week of pregnancy. As of July 1, 2016, eleven (11) counties will implement the NFP model, down from thirteen (13) counties implementing in SFY 2016.
    - In December of 2015, the Maternal and Child Health Unit, Maternal and Child Health Epidemiology Program, and Public Health Nursing began an evaluation of NFP in Wyoming. The evaluation will be completed by the end of 2016.
- Best Beginnings (BB), the second delivery model, is based on the research-based *Partners for a Healthy Baby* curriculum and was developed to meet the needs of those women who do not qualify for NFP, reside in a county that does not offer NFP, or choose not to participate in NFP.
    - In August 2014, the Best Beginnings Data System was updated to align with the new curriculum and to provide more reliable data.
    - In September 2015, a second *Partners for a Healthy Baby* curriculum training was held and a total of 36 nurses attended.

Footnotes:

[1] For performance metrics #1 and #2, the targets are defined in statute. It is important to note that many counties offer additional resources for pregnant women and/or families with infants beyond the Healthy Baby Home Visitation Program. The contacts made by programs or agencies outside of Healthy Baby Home Visitation Program are not included in the data presented for performance metrics #1 and #2. Currently, there is no systematic way to report or measure the number of women being contacted and/or served by other programs.

[2] Data time period from August 9, 2014 – December 31, 2014 for a total of 144 calendar days. On August 7, 2015, the new data system was released.

[3] Data reported from Nurse Family Partnership Efforts to Outcomes (ETO) data system. Time period from program initiation through end of most recent quarter (i.e. Quarter 4, CY 2014).

[4] Quarterly figures include duplicates as clients are enrolled longer than a quarter.

[5] A BB client is defined as a client who is not enrolled in NFP and who received at least one BB home visit.

[6] Data time period for CY2014 from August 9, 2014 – December 31, 2014 for a total of 144 calendar days.

[7] NFP clients graduate from the program when their child is 2 years old.

[8] County and PHN costs (nurse supervision, travel, etc.) are not included within the Healthy Baby program cost.

[9] Cost to Healthy Baby program per Best Beginnings client is not available for CY2014 due to a full year of Best Beginnings data not being available.

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Hospital Preparedness Program

Program Description

The Hospital Preparedness Program (HPP) enhances the capacities and capabilities of healthcare entities and communities in the management of public health and/or medical emergencies through exercising and improving all-hazards preparedness plans, improving surge capacity, and enhancing health system readiness.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$1,004,994	$925,070	$817,246
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	44%	47%	47%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 100% Federal Funding
- Cooperative Agreement with the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services' Assistant Secretary for Preparedness and Response for July 1, 2015 – June 30, 2016
- 10% match required from State General Fund positions, hospital, and unit personnel
- Funding reduced by 1% between 2015 and 2016

Program Staffing

- 1.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Provide funding to five regional healthcare coalitions
- Facilitate the refinement of regional healthcare coalitions
- Contract with the Wyoming Hospital Association to provide grant awards for medical surge workshops

Events that have Shaped this Program

- Federal funding for this program became available after the events of September 11, 2001.
- In January 2012, the Assistant Secretary of Preparedness and Response (ASPR) released *The Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* which provided eight capabilities for the Hospital Preparedness Program to assist local, state, healthcare coalition. Emergency Support Function #8 (Public Health and Medical Services) partners identify gaps in preparedness, determine specific priorities, and develop plans for building and sustaining healthcare specific capabilities.
- In May 2015, HPP received additional funding through the Ebola Preparedness and Response Activities grant ($774,708) to build and sustain a more robust healthcare preparedness system for infectious diseases over the five-year project period.

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Hospital Preparedness Program

PROGRAM CORE PURPOSE

Develop and maintain healthcare coalitions and their member agencies' emergency preparedness planning, mitigation, and recovery capabilities for any type of emergency.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of essential member agencies participating in a HCC[1]	75%	75%	N/A	66% (21/32)	52% (80/154)	58% (84/144)	62% (84/136)
% and # of other potential member agencies participating in a HCC[2]	25%	25%	N/A	1% (2/160)	1% (2/155)	4% (6/162)	6% (10/159)
% and # of hospital member agencies achieving full NIMS compliance[3]	75%[4]	75%	N/A	N/A	54% (13/24)	63% (17/27)	26% (6/23)

N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Number of ABLS trainings[5]	7	6	4	4	7	N/A*	N/A*	N/A*	N/A*
Number of HFR trainings[6]	19	15	6	8	11	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per student for ABLS training	$588 ($77,000/ 131)	$564 ($66,000/ 117)	$530 ($44,000/ 83)	$620 ($44,000/ 71)	$324 ($46,585/ 144)	N/A*	N/A*	N/A*	N/A*
Cost per student for HFR training	$335 ($95,000/ 284)	$434 ($75,000/ 173)	$441 ($30,000/ 68)	$427 ($38,000/ 89)	$450 ($49,000/ 109)	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

1. Essential member agencies of a healthcare coalition are defined as hospitals, emergency medical services agencies, emergency management agencies and public health departments. This measure aligns with Healthy People 2020 Objectives PREP-18.1 & 18.2.

2. Other participating agencies are defined as other healthcare entities that participate within a healthcare coalition. This includes, long-term care facilities, home health, hospice, behavioral health agencies, specialty clinics as well as other similar agencies. This measure aligns with Healthy People 2020 Objectives PREP-18.1 & 18.2.

3. National Incident Management System (NIMS) compliance is defined as meeting all eleven objectives identified in the NIMS Implementation for Healthcare Organizations Guidance provided by the U.S. Department of Health and Human Services. NIMS objectives include items such as managing all incidents, exercises, and recurring/special events consistently with Incident Command System (ICS) organizational structures, application of common and consistent terminology, and the implementation of ICS training to appropriate personnel (ICS 100, 200, 700, and 800). Hospitals not participating in an HCC are not reflected in this measure. Previously, compliance was defined as meeting six of the eleven objectives. If this same definition was used for the current reporting period, this measure would be 80%.

4. The Pandemic and All Hazards Preparedness Reauthorization Act (PAHPRA) benchmark for NIMS requires that at least 75% of hospitals involved in healthcare coalitions are addressing the 11 NIMS implementation activities for hospitals.

5. Advanced Burn Life Support (ABLS) training increases medical surge capabilities in delivering care to burn patients. The certification is valid for four (4) years.

6. Hospital First Receiver (HFR) training addresses multiple capabilities such as healthcare system preparedness, emergency operations coordination, and medical surge and provides an exercise component for hospital staff to demonstrate competencies from the training.

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Immunization Program

Program Description

The Immunization Program operates the federal Vaccines for Children (VFC) Program, the state Wyoming Vaccinates Important People (WyVIP) Program, as well as two adult vaccine programs, all of which provide vaccines to participating providers at no cost. The Immunization Program also operates the Wyoming Immunization Registry (WyIR), as well as providing education and clinical resources, monitoring vaccine storage and handling, determining immunization coverage rates, and processing vaccination exemption requests related to school attendance.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$6,183,939	$4,409,809.05	$5,365,174.60
People Served	110,241	123,570	117,811
Cost per Person	$56.09	$35.68	$45.54
Non-600 Series*	22%	39%	33%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 68% funding from the Centers for Disease Control and Prevention (CDC) and 32% State General Funds
- Number of people served, as recorded in the Wyoming Immunization Registry (WyIR)

Program Staffing

- 8 FTE: 1 state-funded, 7 federally-funded
- 1 AWEC: federally funded
- 1 Other: Federal Assignee

Program Metrics

- Approximately 127 public and private healthcare providers receive state and federally-purchased vaccines through the Immunization Program.
- More than 165,730 doses of vaccines were distributed to participating providers by the Immunization Program during SFY 2016.
- Over 7 million immunizations for more than 682,345 individuals have been entered into the WyIR, as of August 8, 2016.

Events that have Shaped this Program

- Program is governed by Wyo. Stat. Ann. § 14-4-116, 21-4-309, and 35-4-101.
- The Wyoming Childhood Immunization Act was passed in 2006, authorizing state funding for vaccines to be administered to children who do not qualify for the VFC Program. This identified Wyoming as a Universal Purchase State. Wyo. Stat. Ann. § 35-4-139.
- In 2011, four vaccines were eliminated from the state formulary due to funding. This changed Wyoming's status to a Universal Select Purchase State.
- Meaningful Use activities have greatly increased the demand for provider access to the WyIR.
- In 2013, Wyo. Stat. Ann. §33-24-157 was passed that requires Wyoming pharmacies to enter immunizations into the WyIR.

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Immunization Program

PROGRAM CORE PURPOSE

The Immunization Program's core purpose is to facilitate the distribution of vaccines, provide resources, and educate providers to ensure that Wyoming residents are protected against vaccine-preventable diseases.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Missed opportunity rate[1]	≤10%	≤8%	14%	15%	16%	19%	2%
HPV series initiation rate[2]	35%	38%	12%	11%	12%	26%	32%
HPV series completion rate[2]	20%	25%	13%	12%	14%	17%	18%
Childhood vaccination coverage rate[2,3]	62%	65%	59%	61%	60%	63%	60%
% of wasted[4] vaccine doses	≤3%	≤3%	N/A	4.5%	5%	4.6%	3.1%

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of HPV vaccine[5] doses administered	2,636	4,171	3,768	3,919	4,780	2,791	1,128	3,296	1,484
# of Immunization Exemptions	393	368	383	556	530	191	365	190	340
# of facilities submitting electronically[6]	5	9	47	53	95	N/A	N/A	60	35
%of Compliance Visits with a score of 100% for storage and handling	N/A	N/A	N/A	N/A	77%	N/A	N/A	82%	72.5%
EFFICIENCIES									
Average # of expired vaccine doses per provider	N/A	52	129	44	26	31	13	18	8
Average # of wasted vaccine doses per provider	67	55	66	63	42	43	20	28	14

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

[1]Missed opportunities are when a child receives a vaccine and was eligible to receive another vaccine but did not.

[2]Wyoming Rates are calculated according to information reported to the Wyoming Immunization Registry (WyIR), not the National Immunization Survey (NIS). The sample size using the WyIR is larger than what is used by NIS, making it a more reliable data source.

[3]Childhood coverage level includes 4 Diptheria, Tetanus, Pertussis (DTaP), 3 Polio, 1 Measles, Mumps, Rubella (MMR), 3 Haemophilus influenza type B (Hi)b, 3 Hepatitis B, 1 Varicella, and 4 Pneumococcal vaccines for ages birth to 24 months.

[4]The CDC threshold for acceptable vaccine waste is 5%.

[5] Doses distributed minus doses wasted equals doses administered.

[6]The number of facilities sending immunization data electronically reflects the volume of data entering the WyIR and the quantity of patient information that can be queried by connected providers.

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Infectious Disease Epidemiology Program

Program Description

The program conducts infectious disease surveillance and epidemiologic follow-up and investigation of cases, clusters, and outbreaks for the purposes of monitoring occurrences, trends, and risk factors for diseases that pose a threat to public health and to mitigate the risk to public health, as indicated. W.S. § 35-1-223,240; 35-4-103; 35-7-123.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$703,011	$728,589	$776,992
People Served	576,412	584,153	586,107
Cost per Person	$1.10	$1.20	$1.32
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- FY 16 federal funding through the Centers for Disease Control (CDC) Epidemiology and Laboratory Capacity Grant and the CDC Chronic Wasting Disease Contract is $655,384
- FY16 State funding is $121,608

Program Staffing

- 5 FTE (4 federally funded, 1 state general funded)
- 0 AWEC
- 0 Other

Program Metrics

- Wyoming pediatric influenza mortality incidence is statistically equivalent to the national incidence (0.0/100,000 vs. 0.02/100,000).
- Wyoming incidence of pertussis, measles, and mumps is statistically equivalent to the national incidence (5.8/100,000 vs. 6.03/100,000).
- Wyoming incidence of salmonellosis, shigellosis, and *E. coli* is above the national incidence (29.4/100,000 vs. 23.9/100,000).

Events that have Shaped this Program

- The recent emergence of Zika Virus infections has necessitated an immediate need for surveillance of the disease in Wyoming. The program tracks all cases of the disease in the state and works with healthcare providers and the Wyoming Public Health Laboratory to properly assess the need for patient testing.
- The emergence of Ebola, Hantavirus, West Nile virus, MERS Co-V, H1N1 flu, etc. continue to shape the program and place a high emphasis on reacting quickly and effectively to detect and respond to emerging diseases that pose a threat to Wyoming residents.

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Infectious Disease Epidemiology Program

PROGRAM CORE PURPOSE

Conduct infectious disease surveillance and epidemiologic investigation of cases, clusters, and outbreaks for the purposes of monitoring occurrences, trends, and risk factors for diseases that pose a threat to public health and to mitigate the risk to public health, as indicated.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
Average #of days to complete case investigations	3	3	2.4	2.9	2.7	2.3	2.6*
# of enteric disease outbreaks detected and investigated by program through case surveillance and reporting and # of other outbreaks investigated	>5 (>8/1M population)	>5 (>8/1M population)	23 enteric 12 other	21 enteric 5 other	16 enteric 10 other	16 enteric 17 other	8 enteric 11 other
Wyoming pediatric (<18 years old) influenza mortality incidence (# per 100,000 population) (national rate)	At or below U.S. incidence	At or below U.S. incidence	0.0 (0.01)	0.0 (0.02)	0.0 (0.05)	0.17 (0.05)	0.0 (0.02)
Wyoming incidence (# per 100,000 population) of pertussis, measles, and mumps (vaccine-preventable diseases)* (national rate)	At or below U.S. incidence	At or below U.S. incidence	11.10 (12.95)	12.01 (7.86)	10.6 (9.54)	5.8 (6.03)	-
Wyoming incidence (# per 100,000 population) of *Salmonella*, *Shigella*, and *E. coli* (enteric diseases)* (national rate)	At or below U.S. incidence	At or below U.S. incidence	15.44 (21.1)	14.75 (19.5)	35.43 (21.8)	29.40 (23.9)	-

*Data thru 9/30/16
(-) indicates data not yet available

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of initial case reports detected through surveillance	1,638	4,245	2,806	5,396	2,924	2,145	3,251	982	1,942
# of influenza surveillance reports created	40	40	40	40	40	20	20	20	20
% and # of outbreak reports completed within four weeks of completion of investigations	N/A	N/A	100% (10/10)	100% (4/4)	100% (5/5)	3	1	3	2
EFFICIENCIES									
Cost per case investigated	$499	$149	$243	$135	$265	N/A*	N/A*	N/A*	N/A*

N/A indicates data not available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- The recent emergence of Zika Virus infections has necessitated an immediate need for surveillance of the disease in Wyoming. The program tracks all cases of the disease in the State and works with healthcare providers and the Wyoming Public Health Laboratory to properly assess the need for patient testing. The program has also initiated a Zika Pregnancy Registry to ensure proper follow-up and tracking of any babies born to Zika Virus-infected mothers. This information is then sent to the Centers for Disease Control (CDC) for the National Registry.
- The program investigated a large outbreak of gastroenteritis associated with rancid tortilla chips at a correctional facility in October and November of 2015. The outbreak investigation utilized unique laboratory techniques and was published in the Centers for Disease Control and Prevention Morbidity and Mortality Weekly (MMWR) Report in October, 2016, available at http://www.cdc.gov/mmwr/volumes/65/wr/mm6542a4.htm .
- The state incidence of enteric diseases continues to be above the national incidence rate. The program has looked at risk factor data for Wyoming cases. Many of the cases have direct contact with farm and ranch animals, which are known sources of enteric pathogens. It is believed that the risk factor of contact with animals will continue to be a significant source of infection for enteric diseases in Wyoming.
- The dramatic drop in incidence of vaccine-preventable diseases both in Wyoming and the U.S. is due to decreased reports of pertussis. Wyoming had fewer cases of pertussis reported in 2015 (29 cases) compared to 2014 (62 cases) and 2013 (75 cases).

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Wyoming Injury Prevention Program

Program Description

The Wyoming Injury Prevention Program fosters partnerships, disseminates injury data, educates Wyoming residents and decision makers, supports statewide injury prevention efforts, and assists community partners with program implementation.

Program Expenditures and People Served

	2014*	2015	2016
Total Program Cost	N/A	$131,040	$112,308
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series**	N/A	100%	100%

*Program began in 2015, no data to report for 2014

** 600 series is defined as direct service contracts.

Program Cost Notes

- The Wyoming Injury Prevention Program is funded through the Centers for Disease Control (CDC) Preventive Health and Health Services Block Grant and the National Highway Traffic Safety Administration (NHTSA) Highway Safety 402 Grant.
- The Injury Prevention Coordinator and half-time Injury Epidemiologist positions are funded through a collaborative effort from seven different funding sources.

Program Staffing

- 1.0 FTE
- 0.5 AWEC (was vacant 75% of CY 2016)
- 0 Other

Program Metrics

- From 2009 – 2013, the three leading causes of unintentional injury-related deaths in Wyoming were motor-vehicle crashes, poisonings, and falls per data from the Web-based Injury Statistics Query And Reporting System (WISQARS)
- From 2009 – 2013, the Wyoming unintentional injury-related death rate was approximately 18 times higher than the homicide rate and 2.5 times higher than the suicide rate. (WISQARS)
- From 2009 – 2013 the three leading causes of unintentional injury-related hospitalizations in Wyoming were falls, motor-vehicle crashes, and other transportation (snow mobiles, ATVs, etc.).
- From 2009 – 2013, the Wyoming unintentional injury-related hospitalization rate was approximately 18 times higher than the homicide rate and 2.5 times than the self-inflicted rate.
- In 2012, the annual charges for unintentional fall-related hospitalizations totaled $45.6 million.
- In 2012, the median hospital charge for an unintentional fall-related hospitalization was $25,000

Events that have Shaped this Program

- The Wyoming Injury Prevention Program (WIPP) was created in June 2014.
- The Public Health Division (PHD) identified unintentional injury prevention as a priority in the PHD strategic plan.
- In 2015, the WIPP conducted statewide meetings to introduce the program and to identify prevention partners.
- The WIPP has developed and fostered partnerships with statewide, county-level, and local prevention organizations.

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Wyoming Injury Prevention Program

PROGRAM CORE PURPOSE

Reduce unintentional injury-related fall hospitalizations and support statewide prevention efforts of unintentional motor vehicle crashes and traumatic brain injuries (TBIs).

OUTCOMES

Performance Metric	FFY 2016 Target	FFY 2017 Target	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016
% of Tai Chi: Moving for Better Balance (TCMFBB) participants with an improved Timed Up & Go (TUG) test score[1]	80%	85%	N/A	N/A	N/A	N/A	84%
% and # of TCMFBB participants completing the course	75%	75%	N/A	N/A	N/A	N/A	59% (32/53)
# of Wyoming counties with TCMFBB instructors	10	10	N/A	N/A	N/A	N/A	8
Rate of non-fatal unintentional injury-related fall hospitalizations per 100,000 population[2] (national rate)	N/A	132	124.5[3] (194.2)[4]	125.2[3] (181.8)[4]	134.7[3] (-)	(-)	(-)

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of WY residents who have completed the TCMFBB course	N/A	N/A	N/A	N/A	32	N/A	N/A	N/A	32
# of helmets purchased for distribution	N/A	N/A	N/A	N/A	369	N/A	N/A	N/A	369
# of trainings/technical assistance encounters	N/A	N/A	N/A	N/A	14	N/A	N/A	8	6
EFFICIENCIES									
Cost per individual for TCMFBB (course participants and instructors)	N/A	N/A	N/A	N/A	$41.75 ($1,837 /44)	N/A	N/A	$41.75 ($1,837 /44)	N/A

N/A indicates data not yet available due to the creation of a new metric

STORY BEHIND THE PERFORMANCE

[1]Tai Chi: Moving for Better Balance (TCMFBB) is an evidence-based fall prevention program. Participants learned eight Tai Chi forms that have been modified to improve balance and to reduce falls. This is 12-week course that meets two times per week. Each class session is up to forty-five minutes in duration. The The Timed Up & Go (TUG) test assesses the functional mobility of participants. TUG times of greater than 12 seconds are associated with higher fall risk.

[2]This performance measure is a national performance measure used by the Centers for Disease Control and Prevention (CDC) and is a consensus recommendation for injury surveillance in state health departments as outlined by the State and Territorial Injury Prevention Directors Association (Safe States Alliance) and the Society for the Advancement of Violence and Injury Research.

[3]Wyoming Hospital Discharge Data & Bureau of Census for Population Estimates are calendar year estimates.

[4]Healthcare Cost and Utilization Project (HCUP) is a group of healthcare databases. HCUP rates are based on statewide data collected from various organizations from across the United States and analyzed by the Agency for Healthcare Research and Quality (AHRQ). The numbers are from the National Inpatient Sample, which is a sample of over several million hospital stays each year and are calendar year estimates.

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Integrated Cancer Services

Program Description

The Integrated Cancer Services Program provides screenings, education, advocacy, and tools to Wyoming residents. The program works under the Wyoming Cancer Control Act, Wyo. Stat. §§ 35-25-203-205. The program operates the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP) & the Wyoming Colorectal Screening Program (WCCSP), which provide cancer screening and diagnostic services (i.e., mammograms, Pap tests, colonoscopies, and biopsies) for low-income, uninsured and underinsured (WCCSP only); and the Wyoming Comprehensive Cancer Control Program (WCCCP), which assists with advocacy and education efforts across the state.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$2,064,667	^$2,948,325	^3,461,627
People Served	1,812	^1,867	^1,733
Cost per Person	$1,002	^$1,579	^$1,997
Non-600 Series*	38%	^43%	^62%

* 600 series is defined as direct service contracts. ^ These figures are not comparable with previous years due to inclusion of Comprehensive Cancer Program funding.

Program Cost Notes

- WBCCEDP is funded by federal dollars from the Centers for Disease Control and Prevention (CDC), state general funds, tobacco settlement funds, and private grants.
- WCCSP is funded through state general and tobacco settlement funds.
- WCCCP is funded by federal dollars from the CDC and tobacco settlement funds.

Program Staffing

- 10 FTE
- 1 AWEC
- 0 Other

Program Metrics

- The WBCCEDP has been in existence since 1997; over 8,200 women have received clinical services, and 342 breast cancers, 37 cervical cancers, and 620 high-grade cervical pre- cancers have been detected.
- WCCSP has existed since 2007; 3,561 Wyoming residents have received colonoscopies; 46.6% had polyps removed, 26.1% had pre-cancerous polyps, and 72 had colon cancers.
- 2011/12 began the colorectal 10-year/re-screen policy. Since 2011, 502 clients have been re-screened; 57% have had polyps removed; 32.5% had pre-cancerous polyps; and 2.2% had colon cancers.
- Healthcare providers have donated more than $6,000,000 in clinical services over the past 5 years.
- An integrated application was developed, which allows patients to enroll in both programs.

Events that have Shaped this Program

- In 2010, the WBCCEDP, WCCSP, and WCCCP Programs were combined to form the Integrated Cancer Program
- Wyoming's cancer screening rates are low: breast cancer 69.4% (U.S. 78.1%); cervical cancer 81.9 % for (U.S. 82.8%); colorectal cancer 61.8% (U.S. 69.3%) (data from the 2014 Behavioral Risk Factor Surveillance System (BRFSS)
- WBCCEDP funding and match ratio, designated covered services, data collection, and staffing are governed by federal, CDC requirements. For example, women diagnosed with breast, cervical, or high-grade cervical pre-cancer must be transitioned to Medicaid program for cancer treatment.
- WBCCEDP received a CDC Outstanding Program Performance Award in 2009.
- Camp Courage, in partnership with Jason's Friends, has served dozens of Wyoming families who are dealing with childhood cancer.

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Integrated Cancer Services

PROGRAM CORE PURPOSE

To provide Wyoming residents with education, outreach, and screening assistance through the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP), the Wyoming Colorectal Cancer Screening Program (WCCSP), and the Wyoming Comprehensive Cancer Control Program (WCCCP).

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Rate of colon cancers (national rate)	N/A	25.81	37.11 (40.36)	32.56 (38.93)	29.81 (37.67)	-	-
Rate of breast cancers (national rate)	N/A	125.29	108.52 (124.06)	106.10 (127.28)	122.80 (127.77)	-	-
Rate of cervical cancers (national rate)	N/A	6.28	6.62 (7.45)	6.03 (7.34)	5.69 (6.86)	-	-
% and # of program participants with colon cancer	<2.5%	<2.5%	1.4% 6/439	1.0% 4/395	3.3% 15/455	3% 9/305	1.4% 5/349
% and # of participants with breast cancer	<3.5%	<3.5%	4.61% 34/737	4.58% 29/633	5.3% 42/793	1% 6/550	1% 6/550
% and # of participants with of cervical cancer	<0.5%	<0.5%	0.5% 3/632	0.8% 4/533	0.7% 4/564	0% 0/248	0.06% 1/157

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
#of colonoscopies per year	439	391	370	342	349	192	150	148	201
# of stool tests completed	-	-	38	54	95	38	16	68	27
#of breast early detection clinical services per year	737	639	793	637	550	366	271	407	143
#of cervical early detection clinical services per year	632	533	564	248	157	148	100	85	72
EFFICIENCIES									
Cost per colonoscopy	$1,729	$1,720	$1,704	$1,812	$1,279	$1,812	$1,812	$1,279	$1,279
Cost per woman (breast and cervical clinical services)	$300	$300	$300	$367	$304.75	$367	$367	$304.75*	$304.75*
Cost per stool test completed	-	-	$218.63	$35	$6.90	-	-	$6.90*	$6.90*

(-) Indicates data not yet available
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- All numbers for testing are YTD as of June 30, 2016.
- The costs per screening are not set by these programs, but rather by the Medicaid/Medicare rates for the services delivered.
- In 2011, an amendment to W.S. § 35-25-204 allowed for individual re-screens in less than 10 years, as medically necessary on a case-by-case basis, using nationally recognized guidelines. Overall polyp removal rates and adenoma find rates increased in 2012 and onward because the data now includes rescreening colonoscopies. Rescreening colonoscopies have higher polyp & adenoma find rates (these are high-risk patients with a personal history of polyps).
- There is a projected cost avoidance of $50,000 per cancer detected, totaling over $3,000,000 to date. This projection is based on a study done in 2010 using real treatment costs avoided by the detection of early stage cancers through the WCCSP.
- The eligible population is all Wyoming residents ages 50-64 who are at or below 250% of the federal poverty level; these data are from the U.S. Census Bureau, Population Estimates, 2010.
- WBCCEDP has the highest CDC data rating possible with a 0% error rate and full compliance with 11 core performance indicators.
- An initial stool test pilot rolled out in 2013/4 with Sublette County. The most recent iteration was a statewide effort, in partnership with the State Public Health Lab.

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Office of Health Equity

Program Description

The Office of Health Equity (OHE) serves as the central point for the exchange of information, expertise, and assistance to improve the health status of Wyoming's populations most affected by health disparities.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$143,521	$137,420	$137,420
People Served	201	1,120*	1,666*
Cost per Person**	$714	$123	$82
Non-600 Series***	89%	99%	99%

*This number includes all people trained: WDH and partners. Training options greatly increased this year to include more than the traditional cultural competency class.
** This includes only 900 series expenditures
*** 600 series is defined as direct service contracts.

Program Cost Notes

- 2014-2016: 100% State funded
- 2010-2013 funded by the Federal State Partnership Grant (grant not awarded in 2014 forward)

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The Office of Health Equity priorities for 2015-2016, which are echoed in the Public Health Division's strategic map and the Public Health Accreditation Board (PHAB) standards, are: 1) Education on health equity for Public Health Division (PHD) staff and 2) Education and implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.
- In 2016, a language service contract was implemented, effective July 1, 2016. The contract supports a PHD Language Access Plan which was one of the many activities organized under the Health Equity Workgroup (HEW).

Events that have Shaped this Program

- 2010: National Partnership for Action to End Health Disparities/National Stakeholder Strategy for Achieving Health Equity and Affordable Care Act mandates further direct program
- 2010: Healthy People 2020 released, with "Achieve Health equity, eliminate disparities and improve the health of all groups" as an overarching goal.
- 2013: CLAS Standards enhanced
- 2010-2013: State Partnership Grant Funded
- 2013: PHD Strategic Map listed "Promote Health Equity and Health Literacy" as a foundational element
- 2014: PHAB standards have "health equity" and "cultural competence" elements throughout; standard 7.2 dedicated to access improvement via reducing disparities and improving cultural competence
- 2014: Health Equity Workgroup formed

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Office of Health Equity

PROGRAM CORE PURPOSE

Promotes health equity and the Culturally and Linguistically Appropriate Services (CLAS) standards via training, evaluation, and participation in Wyoming Department of Health programs and partnerships across the state.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
% and # of WDH staff with current training in health equity[1]	10%	10%	3% (40/1450)	3% (46/1450)	4% (62/1450)	17% (214/1240)	5% (70/1240)
% and # of PHD staff with current training in health equity[2]	15%	20%	N/A	N/A	N/A	88% (204/231)	16% (38/231)
% and # of PHD programs evaluated[3]	50%	60%	N/A	N/A	N/A	7% 2/26	62% 16/26
N/A indicates data not available due to the creation of a new metric							

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of health equity trainings offered	10	6	8	44	41	30	14	13	28
# of people trained[4]	287	204	201	1,120	1,666	693	427	698	968
# of WDH programs evaluated	0	0	0	2	16	2	0	16	0
EFFICIENCIES									
cost per training attendee[5]	$50	$36	$58	$138	$2.97	$138	$0.41	$2.33	$3.61

STORY BEHIND THE PERFORMANCE

[1] To ensure WDH/PHD staff have an understanding of existing disparities and resulting health outcomes in WY, WDH staff are encouraged to participate in health equity and cultural competency training annually. This number reflects a running cumulative total of those trained in the last five years as a starting point in years 2012-2015. In 2016 the number reflects non-duplicates who attended training within SFY 2016.

[2] PHD staff were offered more varied training options this year to include webinars, the Unnatural Causes video series, and cultural competency. The Health Equity Workgroup (HEW) is developing a standard curriculum to be included in WDH new employee orientation. This number reflects a running cumulative total of those trained in the last five years as a starting point in year 2015. In 2016 the number reflects non-duplicates who attended training within SFY 2016.

[3] In 2015, the HEW work group piloted a survey designed to gauge PHD adherence to CLAS standards and progress on the National Partnership for Action strategic priorities (National Stakeholder Strategy for Achieving Health Equity) with programs that volunteered. The pilot survey results suggested some language changes to the survey, to create a list of in-house resources, and assistance tailored to program needs.

[4] People trained reflects external partners as well as internal staff. This includes not just classes offered, but webinars, some of which extended nation-wide.

[5] This reflects only 900 series expenditures. All trainings were offered by the OHE in 2016; none were contracted out.

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Public Health Oral Health Program

Program Description

The Public Health Oral Health Program promotes optimum oral health for Wyoming residents through prevention, education, and access to care. Funding is provided for children and seniors to access dental treatment. Prevention and oral health education programs, along with dental screenings, are offered for children, pregnant women, and seniors through Community Oral Health Coordinators. The Public Health Oral Health Program also coordinates and runs the Wyoming Cleft Palate Clinic.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$893,146	$739,659	$796,316
People Served	24,437	25,240	25,793
Cost per Person	$36.54	$29.31	$30.87
Non-600 Series*	48%	52%	62%

* 600 series is defined as direct service contracts.

Program Cost Notes

- A state dentist, program manager, and temporary administrative assistant were hired, resulting in an increase in SFY16 expenditures.
- An orthodontist was added to the Cleft Palate, Team increasing expenditures

Program Staffing

- 1.5 FTE
- 5 AWEC (community oral health coordinators (COHCs))
- 1 Other (Temporary Employee)

Program Metrics

- The Senior Dental Program, funded by state general fund, provides reimbursement up to $800 per year to providers for dental services to eligible seniors.
- Community Oral Health Coordinators (COHCs) provided screenings, education, and fluoride treatments primarily for young children but also served adolescents, pregnant women, and older adults.
- Cleft lip/palate clinics were offered twice a year in Casper to provide treatment planning by a team of professionals.

Events that have Shaped this Program

- A part-time state dentist was hired in January of 2015.
- A full-time program manager was in March of 2015.
- The Senior Dental Program transitioned to the Aging Division in January 2016.
- The Public Health Oral Health Program was eliminated as of June 30, 2016, due to budget reductions.

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Public Health Oral Health Program

PROGRAM CORE PURPOSE

The purpose of the Public Health Oral Health Program is to provide oral health education, preventive services, screenings, and access to treatment for eligible children and seniors.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of eligible sites receiving screenings in counties served by COHCs[1,2,3]	95%	Program Eliminated	63% (71/113)	50% (75/149)	48% (71/149)	50% (83/165)	47.9% (79/165)
% and # of eligible sites receiving fluoride in counties served by COHCs[3]	35%	Program Eliminated	33%[3] (37/113)	32% (47/149)	28% (42/149)	25% (41/165)	30.9% (51/165)
% and # of children seen at the cleft palate clinic (of those scheduled to be seen)	90%	Program Eliminated	85% (72/85)	84% (51/61)	89% (51/57)	93% (41/44)	93% (53/57)
% and # of seniors who applied whose treatment was paid for by the program [4]	ND[5]	Program Eliminated	84% (684/815)	87% (722/814)	74% (624/842)	88% (1,043/1,185)	64%[5] (429/667)

ND- Not determined

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of participants served by COHCs[3]	22,212	23,868	23,679	23,354	23,020	N/A*	N/A*	N/A*	N/A*
# of children (ages 0-18) receiving fluoride applications in eligible counties[3]	3,687	5,312	5,413	4,797	5,716	N/A*	N/A*	N/A*	N/A*
# of educational sessions offered by COHCs[3,6]	N/A	223	719	802	218[8]	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of children receiving consultation at the cleft palate clinic[7]	72	51	51	41	57	20	21	29	28
# of eligible seniors receiving treatment	684	722	624	1,043	429	487	556	429	-[5]
EFFICIENCIES									
Cost per child receiving cleft lip and cleft palate clinic services	$217.67 ($15,672/ 72)	$354.51 ($18,080/ 51)	$252.54 ($12,880/ 51)	$381.54 ($15,643/ 41)	$284.91 ($16,240/ 57)	$469.80 ($9,396/ 20)	$297.49 ($6,247/ 21)	$233.83 ($6,781/ 29)	$337.83 ($9,459/ 28)
N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

In January of 2015, a State Dentist was hired, and in March of 2015 a new Oral Health Program Manager was hired.

[1] "Eligible sites" are defined as elementary schools with 40% or higher of enrolled students who are eligible for the National School Lunch Program. These sites are served by the Community Oral Health Coordinators (COHCs).

[2] Counties served by the COHCs include Albany, Carbon, Fremont, Goshen, Johnson, Platte, Sheridan, Sublette, Teton, and Uinta.

[3] Due to data reporting limitations, this figure does not include data from all counties.

[4] Eligibility is determined annually beginning January 1.

[5] The Senior Dental Health Program transitioned to the Aging Division in January of 2016.

[6] Research indicates that in the short term, education and information positively impact oral health knowledge and plaque/gingival indices. SFY14 and SFY15 data included individual oral hygiene instruction. SFY16 educational sessions are defined as utilizing the Washington Tooth Tutor Oral Health curriculum taught in a group setting.

[7] Number of children served was readjusted. Numbers originally reported in previous program performance documents reflected number of children scheduled to receive services. Beginning with SFY2013, the numbers reported are actual children seen in the clinic.

[8] This count does not include education provided to individuals during screening, which was previously included.

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Public Health Emergency Preparedness (PHEP)

Program Description

The Public Health Emergency Preparedness Unit enhances preparedness and integrates state and local public health responses to pandemics, natural disasters, terrorism, and other public health emergencies with federal, state, local, and tribal governments, the private sector, and non-governmental organizations. Program activities are designed to develop emergency-ready public health departments.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$4,424,689	$4,004,515	$4,749,210
People Served	582,658	584,153	584,153
Cost per Person	$7.59	$6.86	$8.13
Non-600 Series*	56%	54%	53%

* 600 series are defined as direct service contracts.

Program Cost Notes

- 100% Federal Funding, Cooperative Agreement with CDC for July 1, 2015 - June 30, 2016 for FY 2016
- 10% match requirement was partially met by Public Health Nursing in-kind contributions (6.98%)
- Ebola / Zika Supplemental funding of $1,124,426 received late 2015 with spending in 2016

Program Staffing

- 11 FTE (plus 3 funded positions in the Wyoming Public Health Lab)
- 1 AWEC
- 1 Other (CDC Career Epidemiology Field Officer (CEFO))

Program Metrics

- PHEP maintains contracts that support 19 county public health nursing offices, four county health departments, and two tribal health departments with preparedness contract deliverables.
- 20 of 25 counties and tribes met all contract deliverables as of the quarter ending June 30, 2016
- PHEP operates a 24/7/365 emergency notification and disease reporting hotline for Wyoming Department of Health (WDH) with on-call epidemiologists, laboratorians, and other professionals.
- In SFY16 there were 132 calls, a significant increase from SFY15. The CDC's ability to reach WDH through a 24/7 phone line is a CDC metric. In SFY16, the WDH received two successful test calls.
- CDC has five separate requirements that states must meet annually or have funding penalized by 10-20%. WDH consistently meets the requirements.

Events that have Shaped this program

- Significant events: terrorism events of 9/11 and anthrax attacks in October 2001, natural disasters (flooding and fires), disease outbreaks such as Ebola Virus Disease and Zika virus, and pandemics (H1N1 influenza pandemic).
- CDC developed 15 public health planning capabilities that PHEP used in spring 2011 to develop a five-year strategic plan which was updated in February of 2015.
- Federal budget cuts reduced PHEP funding by approximately 23% from 2011 to 2014. Funding remains at this reduced amount. In 2015, PHEP received an additional $1,174,074 for Ebola and Zika preparedness.
- Emergency Support Functions (ESFs) group together activities most frequently used to provide support for disasters and emergencies. ESF #8, Public Health and Medical Services, provides the mechanism for coordinated assistance to supplement state, tribal, and local resources in response to a potential or actual public health and medical disaster or emergency (e.g., pandemic flu outbreak, bioterrorism attack). Support examples: assessment of public health/medical needs (including behavioral health), public health surveillance, and distribution and dispensing of Strategic National Stockpile assets.
- WDH activated the Incident Management Team for the Ebola Virus Disease preparedness activities.

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Public Health Emergency Preparedness (PHEP)

PROGRAM CORE PURPOSE

Develop and maintain public health emergency response capability within the Wyoming Department of Health and County/Tribal Public Health agencies through planning, training, exercise, evaluation, and improvement planning.

OUTCOMES							
Performance Metric	**SFY 2015 Target**	**SFY 2016 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
Time, in minutes, for Immediate After Hours Assembly of WDH Incident Management Team, in-person or virtually[1] (national average)	<60	<60	13 (27)	14 (39)	10 (-)	15 (-)	23 (-)
% and # of county and tribal public health responders completing respirator fit testing[4]	95%	95%	N/A	91.4% (287/314)	93.8% (242/258)	83.9% (256/305)	86.1% (223/259)
WDH Jurisdictional Risk Assessment (JRA) score (updated every 3 years)[2]	+5% /assessment	90%	N/A	80%	N/A	N/A	76%
Wyoming (state) score for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency[3] (national average)	100% (89% - PAHPA Benchmark for FY14)	3.0	99% (98)	100% (99%)	100% (99%)	100% (99%)	3.3 (-)
Average county score for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency [3] (# of counties participating)	90% (69% - PAHPA CRI Benchmark for FY14)	90% (69% - PAHPA CRI Benchmark for FY15)	71.7% (22)	87.5% (22)	92.5% (22)	93.3% (21)	96.9% (21)

N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Number of courses of antibiotics compared to estimated number of key personnel identified[5]	5,060/ 5,060	5,060/ 5,060	0/ 5,060	3,313/ 5,060	3,313/ 5,060	3,313/ 5,060	3,313/ 5,060	3,313/ 5,060	3,316/ 5,060
Number of CDC 24/7 no notice bidirectional contact drills for epi and lab staff	2/2	2/2	2/2	4/4	2/2	0/0	4/4	0/0	2/2
% and # of WDH Incident Management Team trained to role requirements for agency response management	64% (14/22)	63% (15/23)	72% (18/25)	77% (21/27)	87.5% (14/16)	21/27	21/27	14/16	14/16
EFFICIENCIES									
Cost Per Public Health Response Coordinator or county/tribal responder per session: Use of webinar and conference call vs. on-site	$4.30/ $390.40	$3.71/ $396.97	$3.11/ $394.80	$5.57/ $388.37	-	$6.35/ $388.37	$5.16/ $388.37	-	-
N/A indicates data not yet available due to the creation of a new metric (-) indicates data not yet available									

STORY BEHIND THE PERFORMANCE

1. Sum of the time (in minutes) for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty with no advanced notice. Targets are both Centers for Disease Control & Prevention (CDC) and Healthy People 2020 targets.

2. The public health Jurisdictional Risk Assessment (JRA) is a required activity for all public health jurisdictions nationwide to complete under the Community Preparedness capability of the CDC, Public Health Preparedness Capabilities: National Standards for State and Local Planning. Completion of a JRA is also a 2016 contract deliverable for WDH public health preparedness subawardees. In Wyoming, the JRA process requires each county, tribe, and the state public health department to score and document their unique hazards, risks, and public health capabilities, as measured against specific elements. Each jurisdiction determines a set of outputs ranking hazards, capabilities, available resources, and resource gaps with respect to their system. This information assists in building the preparedness and response infrastructure to develop hazard-resistant and resilient communities. In 2016, the state JRA scores dropped by four points, which is likely the result of different staff providing input (due to turnover) and a better understanding of our capabilities after three additional years.

3. The Technical Assistance Review (TAR) is a measurement tool utilized by the CDC's Division of Strategic National Stockpile (DSNS) to determine a project area's level of planning to receive, stage, store, distribute, and dispense DSNS provided materiel by reviewing 12 areas of preparedness at state and local levels to produce a score between 0% and 100%. The state TAR is used to assess a state's plan to receive, stage, store, and distribute SNS assets during a public health emergency. The local TAR is used to assess a local jurisdiction's capability for distribution and dispensing of medications and supplies during a public health emergency. In 2011 we began scoring all counties' preparedness to dispense medications using the TAR tool. In 2015, the Cities Readiness Initiative (CRI) jurisdictions and the state were evaluated utilizing a new tool, Medical Countermeasures Operational Readiness Review (MCM ORR) which scores jurisdictions on a scale between 0 and 4. The MCM ORR evaluates not only the plans, but also the ability to operationalize our plans as demonstrated in real world incidents or exercises.

4. The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires a respirator fit test to confirm the fit of any respirator that forms a tight seal on the responder's face before it is to be used in the workplace. Contract deliverables for counties and tribes require annual fit testing of public health staff. The purpose of fit testing is to ensure an acceptable respirator fit which results in a seal that provides respiratory protection for the responder. It also provides an opportunity to check for problems with respirator wear and to reinforce training by having responders review the proper methods for donning, wearing, and doffing the respirator.

5. PHEP maintains a cache of antibiotics to provide prophylaxis to responders and their families, which allows responders to report to work while knowing they and their families are protected. PHEP estimates we will need 5,060 courses. In 2014, our cache of antibiotics expired. We have purchased approximately 65% of the needed amount, and will purchase the additional 35% in SFY17. Prophylaxis can prevent or reduce the severity of illness in people exposed to certain bacteria or viruses. For this purpose, responders are defined as a diverse set of individuals who are critical to mitigating the potential catastrophic effects of a wide-area aerosol anthrax attack. This definition includes professional and traditional first responders (e.g., emergency medical services practitioners, firefighters, law enforcement, and HAZMAT personnel); the emergency management community; public health and medical professionals; skilled support personnel; and emergency service and critical infrastructure personnel. Responders may be from government, volunteer, or private sector organizations.

Wyoming Department of Health
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Public Health Laboratory

Program Description

The Wyoming Public Health Laboratory (WPHL) performs public health, safety, and emergency response testing. The microbiology laboratory tests for reportable diseases involved in disease outbreaks and supports public health infectious and communicable disease programs, medical facilities, EPA drinking water sites, and public health offices. The Chemical Testing Program (CTP) supports public safety by testing biological samples for the presence of drugs and alcohol, and managing the state intoximeter program. The Preparedness Laboratory, fully funded by federal grants, provides specialized testing for high priority pathogens and works to keep Wyoming laboratories prepared through timely communications and laboratory related training.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$3,093,914	$3,241,261	$3,733,937
People Served	582,658	584,153	588,284
Cost per Person	$5.31	$5.55	$6.35
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- FY16 program cost increased due to increased federal grant funding and revenues
- Funding in FY16 was 51% General Funds, 32% revenue (lab fees), and 17% federal grants
- Approximately 55% of expenditures were payroll

Program Staffing

- 28 FTE (20 state funded, 6 federal funded, 2 revenue funded)
- 0 AWEC
- 0 Other

Program Metrics

- Provide accurate and quality assured laboratory testing; complete proficiency/competency tests and monitor the results obtained by laboratory scientists in all sections to assure quality of services.
- Provide rapid laboratory testing:
  - Monitor time from specimen receipt to result reporting as an indicator of turnaround time
  - Increase the number of microbiology clients receiving real-time laboratory results
- Develop and deliver relevant trainings for WPHL clients, including the Wyoming Department of Family Services (DFS) and Department of Corrections (DOC) officers and sentinel laboratorians:; monitor the number of trainings and the number of attendees.

Events that have Shaped this Program

- The WPHL operates the microbiology program under W.S. § 35-1-240; 35-4-133,221,501; 35-7-123 and chemical testing program under W.S. § 31-6-105; 35-7-1007.
- Response to emerging diseases, outbreaks, new designer drugs, and bioterrorism events has required implementation of new instrumentation and advanced technologies to accurately and rapidly detect pathogens or drugs.
- Moving into the Combined Laboratory Facility in November, 2010 has improved WPHL biosafety, security, increased space for testing and equipment, and improved workflow efficiency.

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Public Health Laboratory

PROGRAM CORE PURPOSE

The mission of the Wyoming Public Health Laboratory (WPHL) is to support public health, public safety, and emergency response by providing Wyoming communities, agencies, and healthcare providers with timely, cost-effective, and quality-assured public health laboratory services and technical support.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of competency/proficiency tests performed accurately[1]	98%	98%	99.3% 147/148	99.3% 147/148	99.7% 194.5/195	99.1% 315/318	99.2% 395/398
Average time, in days, from specimen receipt to result reporting in Microbiology and Preparedness (Tb culture excluded) [2]	1.3	1.3	N/A	1.34	1.31	1.29	1.22
% of Microbiology clients receiving real-time laboratory results[3]	50%	75%	0	0	0	36.3%	58.5%
# of non-WPHL employees trained[4]	250	200	N/A	N/A	N/A	246	207
# of newly validated tests[5]	≥ 4	≥ 5	1	1	0	5	7

N/A indicates data not available due to the creation of a new metric

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
# of Chemistry samples tested (# confirmed)	35,024 (N/A)	33,192 (N/A)	30,460 (N/A)	33,527 (12,095)	34,726 (12,418)	16,437 (6,133)	17,090 (5,962)	18,271 (6,546)	16,455 (5,872)
# of Microbiology tests performed	40,760	31,682	36,033	37,018	39,224	18,204	18,814	19,887	19,337
# of trainings provided	N/A	N/A	N/A	13	11	7	6	5	6
# of Litigation Support Packages provided	N/A	N/A	N/A	132	154	73	59	58	96
# of times court testimony was provided	N/A	N/A	N/A	77	42	41	36	18	24
EFFICIENCIES									
Cost per test[6]	$35.87	$39.87	$42.25	$42.27	$46.41	$43.55	$41.04	$44.55	$48.40
% of expenses from revenues[7]	N/A	N/A	N/A	17.5%	32.0%	16.1%	18.9%	27.2%	37.0%
% of expenses from Federal Grants (no state match)	N/A	N/A	N/A	13.8%	16.8%	13.5%	14.2%	16.9%	16.7%

N/A indicates data not yet available due to the creation of a new metric

STORY BEHIND THE PERFORMANCE

[1]This metric accounts for the accuracy of the analytic stage of laboratory testing. The accuracy of competency and proficiency tests performed by all laboratory sections was combined into one metric. The overall target for the combined metric is 98% or better, but each lab section has different mandated target levels. To maintain funding and/or the ability to offer specific tests, preparedness must achieve 100%, and microbiology and chemistry must achieve 80% for each individual assay. Although the mandated target for Micro & Chemistry is 80%, we have set our target for these sections at 97% for an overall target of 98%.

[2]Time from specimen receipt to result reporting is the main controllable factor related to total turnaround time (TAT). Each test has a specific target TAT. In Microbiology, rapid immunoassays and molecular tests should be resulted on the same day of receipt, Quantiferon and serologic assays require 2 days, and culture based assays should be resulted in $\leq$ 5 days. Tb testing can take up to 8 weeks and was excluded from this calculation. Chemistry tests also have target TATs, however they were excluded from this calculation because of the wide range of acceptable times (ex: negative urine tests require 3 days, whereas a blood THC confirmation requires 20). Regardless, TATs are closely monitored in the Chemistry section and are reported in the lab's Program Management document.

[3]This metric was calculated differently in SFY16 than in SFY15 and the numbers for SFY15 were changed in this document. Until 2015, results from Microbiology were mailed to clients or faxed upon request in instances of delayed reporting. In SFY15 RightFax was implemented to directly fax results to clients' secure fax lines, and improve post analytic processes. In SFY15 we initially reported that 73.2% of Microbiology clients were receiving real time results. That number only included clinical Microbiology clients and not the lab's water customers. When all Microbiology clients were considered the actual number was 36.3% because the lab has many water customers and none received real time results in 2015. Most water clients do not have access to secure fax lines. In SFY16 the lab implemented a process that allowed water results to be directly emailed to water clients from the Laboratory Information Management System (LIMS). This increased the percentage of clients receiving real time results to 58.5%. If testing volume as opposed to number of clients is considered, over 95% of laboratory reports are delivered in real time. Electronic reporting (directly into a patient's medical record or clinical client's LIMS system) remains a goal for the laboratory, but we do not currently have the required infrastructure to implement such a process.

[4]People trained include sentinel laboratorians involved in packaging/shipping of infectious materials, biosafety and risk assessment, and county coroners, law enforcement, DFS and DOC officers involved with drug and alcohol testing. The lab appears to have failed to achieve its goal for SFY16 because two classes were canceled; one due to a sudden retirement of the typical teacher and one for weather related reasons. Importantly, a training video (for collection of oral fluid for drug testing) was prepared by the lab in SFY16 to make better use of staff time. The number of people that viewed the video is not captured in the presented figure because it cannot be calculated. If that number were to be included, the lab surely would have surpassed its goal. The target for SFY17 was modified because budget cuts will lead to fewer trainings and because we will utilize video based trainings when possible. For example, a SFY17 training at the WY Law Enforcement Academy was already canceled due to budget cuts in other departments.

[5]Before the laboratory can add a test to its test menu, the test must be validated. Tests added in SFY2015 include: RT-PCR for Ebola virus, Influenza B lineage determination (a grant aim), fecal occult blood testing (in conjunction with the WY Colorectal Cancer Screening Program), respiratory viral panel testing, and a more rapid West Nile virus testing platform. Tests added in SFY2016 include: Trioplex PCR for Zika, Chikungunya, and Dengue viruses, Zika MAC ELISA, blood parasite smears (required for Ebola readiness), qPCR for pertussis (switched testing platforms for cost savings), E-tests for various types of drug susceptibility testing (LRN requirement), whole genome sequencing for enteric pathogens (grant requirement) and a new oral fluid collection device for drugs of abuse testing (out of necessity as the one previously used was discontinued). Tests targeted for addition in SFY17 include: qPCR for Norovirus (switch testing platforms for cost savings), MALDI-TOF for bacterial identifications (switch testing platforms for cost savings and grant aim), qPCR for KPC and NDM-1 (grant aim), a phenotypic test for Carbapenem Resistant Enterobacteriaceae (grant aim), and a blood drug screening assay with lower cutoffs (to improve customer service).

STORY BEHIND THE PERFORMANCE, CONTINUED

[6]The large increases in cost per test that were observed between SFY12-SFY13 and SFY13-SFY14 are due to alterations in the way the number was calculated, ultimately leading to a more accurate and all-inclusive calculation. From SFY13 on, the lab's portion of a federal grant that is allocated under Unit 0540 was included in the total cost. From SFY14 on, a federal grant and a revenue account that are allocated under Unit 0534 and distributed to the lab were also included, making the cost per test calculation in SFY14 onward inclusive of all Microbiology and Chemical Testing expenses. In SFY16 the large increase in cost per test can be directly attributed to an increase in the amount of revenue and federal grant dollars received and expended.

[7]In SFY16 this measure was calculated differently and the calculation was also applied to SFY15 in this document. (This means SFY15 number are different from those previously reported). Previously, the amount of revenue generated in the period was divided by total expenses. In SF16, we wanted to show the number as the percentage of expenses paid using revenues. Therefore, the values were calculated by dividing the amount of revenue expended by total expenses. SFY14 could not be calculated in this manner, so the value was removed. While the SFY15 and SFY16 numbers vary greatly, it is not unusual for the lab to expend revenues later in the biennium as revenue takes time to earn.

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Public Health Nursing

Program Description

Public Health Nursing (PHN) is a partnership between the State and County governments for the provision of public health services in 20 counties; in three counties, these services are provided independently by county governments. Public health nurses provide the infrastructure for other public health programs in Wyoming, including public health emergency preparedness, immunizations, communicable disease, adult health (including chronic disease), maternal and child health, and long term care assessments (LT-101s).

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$7,278,485*	$7,630,742*	$8,636,577*
People Served	55,756**	54,528**	56,659**
Cost per Person	$130.54	$139.94	$152.43
Non-600 Series* **	100%	97%	85%

Program Cost Notes

- Funding is 65% State general funds and 35% county contribution required for salaries and benefits for State PHN employees working in the counties.

*Mostly salary costs, including the counties' 35%; does not include other expenses paid by counties. Includes funding for Natrona and Sweetwater county contracts in 2015 and 2016.

**Visit count of clients receiving direct services. Does not include participants in clinics or classes, and does not include population-based activities.

***600 series is defined as direct service contracts.

Program Staffing

- 89 FTE
- 2 AWEC positions
- ~185 Other County PHN positions, which includes the PHN staff from the 3 independent counties.

Program Metrics

- Public health protection and infrastructure
- During FY 2016, PHN provided services to 93,644 participants in 29,913 clinics or classes. Also, 13,202 clients received individual PHN services with a total of 56,408 visits (average of four visits per client).
- Clients and visits are statewide data for 23 counties.

Events that have Shaped this Program

- State statutes pertaining to Public Health Nursing are W.S. 35-1-240; 35-1-305, 35-1-306; 35-27-101 through 104 and W.S. 35-1-243.
- PHN has 9 FTEs in administration who provide nursing oversight, supervision, support, and consultation. The other 80 positions provide direct services in the local county public health nursing offices
- Counties are divided between four State Nursing Supervisors (SNS), all located regionally in the field. Three PHN program consultants are also located in the field. These positions are part of the nine FTEs in administration.
- PHN continues to work on assessing and strengthening PHN's infrastructure by improving the efficiency, uniformity, and accountability of the county PHN offices.

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Public Health Nursing

PROGRAM CORE PURPOSE

The Public Health Nursing (PHN) program works in collaboration with other Public Health Division programs to provide eight basic services to Wyoming residents. These include: **Direct Services**: 1) maternal and child health programs (e.g., Healthy Babies Home Visitation program and children's special health case management); 2) nursing home and Medicaid long-term waiver pre-admission eligibility screenings (LT-101); 3) chronic disease prevention, education, and management; 4) communicable disease prevention (e.g., immunizations, STI/HIV/viral hepatitis testing and counseling, HIV case management, and tuberculosis screening, testing, and follow-up). **Population-based Services**: 5) Public Health Emergency Preparedness (PHEP); 6) community health assessment and planning; 7) public information and education; and 8) health hazards in the environment.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of clients reporting no difficulty with appointment availability on State PHN client satisfaction surveys[1]	95%	95%	56.8%[1]	73.7%	94.8%	93.5%	94.25%
% of data entered timely & accurately into the PHNI data system as measured by Quality Performance Audits done in State PHN counties	94%	94%	N/A	91%	92.45%	94.8%	90%
% of State PHN counties that provide all the 8 essential PHN services	100%	100%	N/A	N/A	100%[2]	100%[2]	95%[4]
% and # of State PHN counties offering basic reproductive health services 5 days/week either through PHN offices or Title X offices[3]	95%	100%	80% (16/20)	85% (17/20)	90% (18/20)	95% (19/20)	95%[4] (19/20)
% and # of State PHN counties with trained personnel to do HIV case management (1 training annually)	95%	100%	50% (10/20)	55% (11/20)	75% (15/20)	90% (18/20)	95%[4] (19/20)

N/A indicates data not available due to the creation of a new metric

[1] Survey question asked: "I can get an appointment that fits my schedule. Answers are always, usually, sometimes, never.

[2] Eight basic PHN services were identified and defined. Prior to FY2016, some services were considered optional. FY14 and FY15 represent PHN offices who provided at least seven out of the eight services.

[3] Basic reproductive health services are defined as pregnancy tests, condoms, multivitamins (if available), and preconception or prenatal counseling. Some counties also provide family planning contraceptives.

[4] The PHN position in Niobrara County was vacant for 2016. Niobrara County did not meet this requirement.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of people tested for sexually transmitted infections (STIs)[6]	2,815	2,499	2,293	2,623	3,021	1,249	1,374	1,462	1,559
# of State PHN counties offering HIV screening, testing, and counseling	18/20	19/20	19/20	19/20	19/20[4]	19/20	19/20	18/20	19/20[4,5]
# of participants vaccinated[6]	41,799	47,250	43,375	41,236	49,210	32,250	8,986	38,506	10,704
EFFICIENCIES									
% of PHN maternal child health clients on Temporary Assistance for Needy Families (TANF; average statewide)[6]	61.3%	59.64%	58%	54.47%	50.53%	55.21%	53.72%	51.67%	50.76%
% of PHN hours spent on maternal child health services for TANF clients[6]	67.96%	65.11%	63.34%	60.22%	57.98%	60.33%	60.11%	58.46%	58.07%
% of home visits for maternal child health services to TANF clients[6]	65.5%	62.78%	60.73%	57.34%	55.69%	57.88%	56.80%	56.14%	55.83%

[5]Laramie County PHN began offering this service Q4 of 2016

[6]Includes data from independent counties entering into the public health nursing database (PHNI).

STORY BEHIND THE PERFORMANCE

- State PHN is a partnership between the State and County governments for the provision of public health services in 20 counties; in three counties, these services are provided independently by county governments.
- Public health nurses in county offices are the "boots on the ground" in Wyoming, implementing WDH programs and population services. There are 80 direct care nursing positions statewide.
- State PHN administrative staff provides infrastructure for the State PHN offices located in the counties and offers support and consultation for the independent counties. The administrative PHN staff provides nursing oversight, human resource and administrative support of local staff; works with WDH programs that use PHN to improve delivery of programs; and implement quality improvement measures to improve service delivery and assure a competent public health nursing workforce.
- Statutory requirements are in W.S. § 35-1-240; 35-1-305; 35-1-306; 35-27-101 through 104 and W.S. 35-1-243
- Performance of the independent counties is included in the overall picture of PHN outputs and efficiencies.

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Substance Abuse and Suicide Prevention Program

Program Description

The Substance Abuse and Suicide Prevention Program uses an integrated approach to the prevention of alcohol abuse, other drugs, and suicide in collaboration with tobacco prevention efforts. The Substance Abuse Prevention Services are authorized by the Substance Abuse Control Plan, W.S. 9-2-2701 as part of a comprehensive, integrated plan.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$3,198,972	$3,256,311	$3,256,311
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	29%	10%	10%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funds include State General Funds, Tobacco Settlement Funds and Federal Funds from the Substance Abuse Prevention and Treatment Block Grant and Partnerships for Success II.
- 900 Series expenditures include costs for program evaluation, training, data collection, analysis, compliance, consultation, and information dissemination.
- Amounts above do not reflect administrative costs (100-500 series).

Program Staffing

- 2.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Adult binge drinking rates
- Youth 30-day use rates
- Number of people trained in Gatekeeper and intervention skills

Events that have Shaped this Program

- Alcohol costs the State of Wyoming more than any other drug. It is estimated that elimination of alcohol abuse would save $843 million a year, based on 2010 costs. Costs were for healthcare, lost productivity, crime, and unintentional injury. Suicide costs Wyoming $175.1 million a year in lost potential earnings and response resources.
- This program has moved from individual program interventions to an evidence-based, population-focused approach modeled after the Substance Abuse and Mental Health Services Administration Strategic Prevention Framework, which focuses on population-level change, outcome-based prevention, prevention across the lifespan, and an emphasis on data-driven decision making.
- This program is integrated with the Tobacco Prevention and Control Program within communities through a single contract.
- The Program has created a sustainable and consistent prevention program working with the local community prevention professionals and/or other stakeholders within communities.

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Substance Abuse and Suicide Prevention Program

PROGRAM CORE PURPOSE
Reduce suicide, adult binge drinking, and underage alcohol use.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Adult Binge Prevalence % and # of Wyoming adult men surveyed who currently consume 5 or more drinks or adult women surveyed who currently consume 4 or more drinks on an occasion at least once in the past 30 days [1] (national average)	14%	14%	17% 633/6,026 (16.9%)	16.6% 619/3,228 (16.8%)	17.2% 561/5,966 (16%)	16% 511/5,211 (18.3%)	-
Youth Prevalence % and # of Wyoming high school students surveyed who have consumed alcohol within the past 30 days [2] (national average)	32%	28%	-	34.4% 942/2,737 (34.9%)	-	31% 667/2,153 (32.8%)	-
Adult and Youth Use % and # of fatal crashes with a blood alcohol content (BAC) of .08 or higher [3] (national average)	36%	28%	33% 41/123 (31%)	28% 24/87 (31%)	32% 48/150 (31%)	-	
Suicide # of Wyoming suicide death per 100,000 population[4] (national average)	20	20	29.6 (12.6)	22.1 (13)	20.5 (12.9)	26.2 (-)	-

(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Beverage Server Trainings	3,137	3,113	3,234	3,547	3,158	1,628	1,919	1,193	1,965
Suicide Risk Assessment Trainings Conducted [5] (# trained)	66 (1,080)	169 (4,283)	242 (8,120)	282 (13,502)	370 (11,569)	126 (4,765)	156 (8,737)	196 (8,297)	174 (3,272)
% and # of strategies implemented that are evidence-based[5]	92.5% (185/ 200)	100% (182/ 182)	93.3% (375/ 402)	100% (145/ 145)	100% (141/ 141)	N/A*	N/A*	N/A*	N/A*
# of prevention strategies implemented [5]	200	182	402	145	141	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Suicide Risk Assessments Trainings Cost per Attendee	N/A	$7.98 ($34,125/ 4,498)	$4.20 ($34,125/ 8,120)	$1.62 ($21,846/ 13,502)	$1.89 ($21,846/ 11,569)	N/A*	N/A*	N/A*	N/A*

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

1. Data Source - Behavioral Risk Factors Survey (BRFSS)
2. Data Source - Youth Risk Behavior Survey (YRBS)
3. Data Source - National Highway Traffic Safety Administration (NHTSA).
4. Data Source - Vital Statistics
5. Data Source - Prevention Intervention Planning and Reporting (PIPR)

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Tobacco Prevention & Control Program

Program Description

The Tobacco Prevention and Control Program works to achieve the directives of Wyoming Statutes §§ 9-4-1203 and 9-4-1204 by utilizing a science-based approach to develop comprehensive tobacco prevention, cessation, and treatment programs.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$5,549,339	$5,441,740	$5,234,969
People Served	NA	NA	NA
Cost per Person	NA	NA	NA
Non-600 Series*	45%	45%	45%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funding: 21% State General Funds; 10% Federal Funds, 69% State Tobacco Funds.
- 900 series expenditures include costs for: program evaluation, training, data collection, analysis, compliance, consultants, and resource management information dissemination.

Program Staffing

- 2.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- A sample of the program metrics tracked by this program include:
  - Adult smoking rates
  - Youth smoking rates
  - Smoking policies in workplaces

Events that have Shaped this Program

- Tobacco is the leading preventable cause of death and chronic disease in the United States, leading to more than 800 Wyoming deaths annually and contributing to more than $136 million in annual direct healthcare costs to the State (data from the Centers for Disease Control & Prevention's (CDC) Smoking-Attributable Mortality, Morbidity, & Economic Costs (SAMMEC) system, 2007).
- W.S. § 9-4-1203 and 9-4-1204 require the WDH to improve the health of Wyoming residents, including prevention of tobacco use through school and community-based programs that are evidence-based and collaboration with other efforts of the WDH.
- The program is modeled after the CDC's 2014 Best Practices Guidelines. An effective program contains these components: state and community interventions, health communication interventions, cessation interventions, surveillance and evaluation, and administration and management.

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Tobacco Prevention & Control Program

PROGRAM CORE PURPOSE
To reduce tobacco use in Wyoming

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of Wyoming employed adults surveyed who report that smoking is never allowed in indoor areas of their workplace	92%	92%	88.1% (860/ 957)	90.9% (1,088/ 1,204)	90.7% (1,940/ 2,146)	91% (2,047/ 2,232)	(-)
% and # of Wyoming adults surveyed who currently smoke (national average)	20%	18.5%	21.8% (947/ 6,159) (19.6%)	20.6% (973/ 6,315) (19.0%)	19.5% (875/ 6,078) (18.1%)	(-)	(-)
% of Wyoming high school students surveyed who smoked cigarettes on one or more of the past 30 days (national average)	17%	15%	*	17.4% (15.7%)	*	15.7% (11%)	*

(-) Indicates data not yet available
* Intervening years between survey dates for which data is unavailable

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Wyoming Quit Tobacco Program (WQTP) enrollment	3,792	3,918	2,552	2,571	3,768	1,207	1,364	1,190	2,578
# of Pregnant Women	*	23	36	32	27	19	13	16	11
# of PHN Referrals	*	*	20	46	44	31	15	29	15
# of media impressions (mass, digital, social)	*	29,886	15,707	7,383	32.3M	*	7,383	*	32.3M
# of policies implemented	*	18	22	17	16	N/A*	N/A*	9	7
EFFICIENCIES									
Average cost per WQTP enrollee	$316 (1.2M /3,792)	$306 (1.2M /3,918)	$357 (913,273 /2,552)	$355 (913,273 /2,571)	$242 ($913,273 /3,768)	NA*	$355 (913,273 /2,571)	NA*	$242 ($913,273/ 3,768)

* Intervening years between survey dates for which data is unavailable
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

Trends:

- The percentage of Wyoming adults who report that smoking is never allowed in indoor areas of their workplace has remained above 80% from 2006-2014.
- The percentage of Wyoming high school students who smoked cigarettes on one or more of the past 30 days has decreased from 40% in 1995 to 15.7% in 2015.

Challenges:

- Wyoming does not have a comprehensive, 100% smoke-free state statute.
- Wyoming has the 42nd lowest cigarette tax in the nation at $0.60/pack.

Value added to the WQTP:

- Counseling services were extended to youth ages 12-17 years.
- Counseling sessions per enrollee were increased from 3 to 5.
- A Pregnant - Postpartum Program that has demonstrated success was added to the Quitline services.
- A Fitlogix program has been added to also address weight concerns that enrollees may have.
- The American Indian Commercial Tobacco Program (AICTP) has been operational since August 2015 to provide culturally appropriate cessation services to American Indian populations.

Current Efforts:

- The Wyoming Infant Mortality Reduction Team selected tobacco cessation as one of three Collaborative Innovation and Improvement Network (CoIIN) focus areas. A tobacco cessation workgroup is working to implement strategies to increase referrals of women of reproductive age, including pregnant women, to the Wyoming Quitline by screening for smoking at all visits and referring to the Quitline when appropriate.
- A media campaign to promote the WQTP began in January 2016 resulting in increased enrollments for Q3 & Q4 of 2016.
- The promotion of free Chantix through the WQTP has more than doubled the number of Chantix prescriptions monthly since February of 2016.
- The significant increase in media impressions in 2016 is due to strategic marketing utilizing digital, radio, and newspaper media to promote the WQTP and the offering of free Chantix. The media was very successful in increasing utilization of the tobacco cessation services of the WQTP.
- Partnered with the Behavioral Health Division on a SAMHSA initiative for behavioral health and tobacco cessation to improve health outcomes for the behavioral health population.
- Partnered with Medicaid to develop a plan on how Medicaid and the WQTP can work together to provide the most effective and efficient tobacco cessation services to Medicaid clients and all residents of Wyoming.

Sources:

- BRFSS – Behavioral Risk Factor Surveillance System (Adults)
- YRBSS – Youth Risk Behavior Surveillance System (Youth)
- ATS – Adult Tobacco Survey
- NJH – National Jewish Health WQTP enrollment reports
- Warehouse Twenty-One – media analytics and metrics reports

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Wyoming Trauma Program

Program Description

The Wyoming Trauma Program serves all Wyoming residents by maintaining and improving the Wyoming trauma system infrastructure and the clinical care of trauma patients through education, support, and regulation. It is a mandated state program per W.S. § 35-1-801 et seq.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$170,398	$168,060	$216,838
People Served	582,658	584,153	587,910
Cost per Person	$0.25	$0.29	$0.45
Non-600 Series*	93%	92%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY2016: 82% General Fund and 18% Federal Fund
- SFY15-16 exception request provided $110,000 (biennium) SGF
- FY2016: Supported though Highway Safety Grant (registry), Hospital Preparedness (manikin supplies), PHHS Block Grant (data contractor), FLEX Grant and other General Fund

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- All 28 Wyoming acute care facilities must participate in the Trauma System. Specific emergency & medical standards are evaluated every three years to ensure quality patient care in each facility.
- Provides the mandatory Trauma Patient Registry for all acute care facilities.
- Provided support to Trauma Regions through travel reimbursement, technical support, and guidance.
- Provided technical support on 48 occasions in CY2014, 56 in 2015, and 75 YTD in 2016.
- Responded to 55 data report requests or assistance with writing reports for stakeholders in CY2014, 56 in 2015 and 35 in 2016 YTD. Requests were made by the State Health Officer, WDH programs, hospitals, and external partners.
- Provided 1 Trauma Program 101 Course and an ICD-10 for Traumatic Injury Coding Course training in 2016 to all acute care facilities.

Events that have Shaped this Program

- Traumatic injury is the leading cause of death of Wyoming resident's ages 1-44 years.
- Traumatic injury results in more years of potential life lost than any other disease, including cancer and heart disease.
- Wyoming had the 5th highest rate for injury-related death in the nation in 2013 (84.6 per 100,000 population).
- Position of Trauma Coordinators (TC) in acute care facilities suffer from low workforce retention. In July 2015, 47% of the TCs had been in their role 1 year or less and this percentage increased in July 2016 to 54%.

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Wyoming Trauma Program

PROGRAM CORE PURPOSE

Regulates all acute care facilities in accordance with Wyoming Trauma Rules & Regulations, maintains the State Trauma Patient Registry and provides training, performance improvement guidance, and supporting data to trauma system participants and Regional Trauma Advisory Councils.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
% and # of facilities that have had initial review[1]	100%	100%	64% 18/28	79% 22/28	93% 26/28	93% 26/28	100% 28/28
% and # of facilities actively contributing to the Trauma Patient Registry[2]	96%	96%	93% 26/28	93% 26/28	89% 25/28	93% 26/28	100% 28/28
% and # of active Trauma Regional Advisory Councils[3]	100%	100%	80% 4/5	80% 4/5	100% 5/5	60% 3/5	60% 3/5
% and # of facilities with full designation status (3 year status), running total[1a]	68%	68%	39% 11/28	64% 18/28	64% 18/28	54% 13/28	61% 17/28
% ED trauma patient dwell times <2 hours (% of patients with dwell time <120 minutes), calendar year[4]	22%	22%	24%	21.3%	20.9%	20.2%	-

(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of facility site reviews conducted	11	6	12	11	14	0	11	2	12
# of Trauma Regional Advisory Councils meeting quarterly (of 5 total)	4	4	5	5	3	3	2	2	3
# of educational opportunities to improve facility compliance	7	3	2	2	2	1	1	1	1
% and # of facilities represented at one or more sponsored educational opportunity per year	96% 27/28	96% 27/28	86% 25/28	96% 27/28	96% 27/28	86% 25/28	50% 14/28	75% 21/28	64% 18/28
# of trauma records in Trauma Registry	3,682	3,480	3,369	3,906	4,073*	1,839	2,067	2,233	1,840*
EFFICIENCIES									
Cost per trauma registry record[5]	$6.19 ($22,800/ 3,682)	$6.55 ($22,800/ 3,480)	$6.77 ($22,800/ 3,369)	$5.84 ($22,800/ 3,906)	$5.60 ($22,800/ 4,073)	$6.20 ($11,400/ 1,839)	$5.52 ($11,400/ 2,067)	$5.11 ($11,400 / 2,233)	$6.20 ($11,400/ 1,840)
*Calculated on a calendar year; year to-date as of 9/1/2016									

STORY BEHIND THE PERFORMANCE

- A trauma system is an organized, coordinated effort in a defined geographic area that delivers the full range of care to all injured patients and is integrated with the public health system. The true value of a trauma system is derived from the seamless transition between each phase of patient care, integrating existing resources to achieve improved patient outcomes. Success of a trauma system is largely determined by the degree to which it is supported by public policy.

- Robust trauma systems are effective. There is a demonstrated 15-20% improved survival rate for patients who are injured in an established trauma system. Care of the injured patient that is delivered at a trauma center hospital is associated with less morbidity and mortality than non-trauma center hospitals. A significant decrease of preventable deaths among the severely injured has been identified in regions with an established and functioning trauma system.

1. *Reviewed facility*: An acute care facility which has had a review by a qualified review team and been designated as "full" or "provisional" status.
1(a). Full Designation Status: Facility meets all standards and will be re-reviewed in three (3) years.
1(b). Provisional Status: Facility does not meet all standards and will be re-reviewed in one (1) year. This one (1) year gives the facility the opportunity to meet specific benchmarks and standards while continuing to bill for trauma team activations.

2. *Trauma Patient Registry:* A collection of data on patients who receive hospital care for certain types of injuries. Such data are primarily designed to ensure quality trauma care and outcomes in individual facilities and trauma systems, but have the secondary purpose of providing useful data for the surveillance of injury morbidity and mortality. The Wyoming Trauma Registry does not include all injuries sustained in the state; only the most severe injuries based on set criteria are included in this data bank.

3. *Regional Trauma Councils (RTC)*: The structure of the five (5) RTCs fosters interagency coordination, ensures local input into the decision-making process, and maintains strong, effective working relationships in the care of the seriously injured patient. This structure allows local systems to develop solutions to local problems through case study, data evaluation, and the performance improvement process.

4. *Patient dwell time:* The time interval between a trauma patient's emergency department admission to surgery, discharge, transfer, or hospital admission. In Wyoming, a rural/frontier environment, the benchmark is currently less than two (2) hours. For trauma patients, receiving definitive treatment within the first hour after injury is critical to prevent irreversible internal damage and to optimize the chance of survival.

5. The cost of the Trauma Registry decreased from $31,500 to $22,800 per year as the vendor is now able to separate out specific pricing of trauma components. Record numbers in the registry may increase as facilities enter data, with no cap.

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Women and Infant Health Program

Program Description

The Women & Infant Health Program facilitates access to care and promotes the physical and reproductive health of women (15-44 years old) and their infants (0-1 year old), including those with special health care needs. The program strives to improve outcomes related to newborn screening, breastfeeding, access to and use of effective family planning, maternal smoking, pre and early term birth, access to risk appropriate perinatal care and infant mortality.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$3.4M	$2.9M	$3.3M*
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series**	14.0%	11.8%	12.4%

* Includes Public Health Nursing Healthy Baby Home Visitation Program expenditures
** 600 series are defined as direct service contracts
N/A: People Served and Cost per Person are not calculated for population-based programming targeted to all women and infant residents.

Program Cost Notes

- Funding: State General Funds and Federal Funds from Temporary Assistance for Needy Families (TANF) and Title V Maternal Child Health (MCH) Services Block Grant)
- State matching funds are at 9189 levels or higher are required for the Title V Block Grant ($3 for every $4 of Title V funds)
- The Program works closely with Adolescent Health and Child Health programs within the Maternal and Child Health Unit, as services such as home visitation benefit all populations.
- The Program partners with Public Health Nursing (PHN) to jointly implement the Healthy Baby Home Visitation Program.

Program Staffing

- 2.9 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The Program strives to improve outcomes related to the following MCH priorities: (1) breastfeeding duration, (2) access & use of effective family planning, and (3) infant mortality.
- Key program activities include increasing support for breastfeeding in hospital and community settings, promoting access to smoking cessation resources and support for pregnant women, ensuring early access to risk appropriate, high-quality perinatal care for high risk pregnant women and infants, and improving access to timely newborn screening and follow up for all babies born in Wyoming.

Events that have Shaped this Program

- Title V funding requires a needs assessment every five years. In 2013, MCH began the Title V Needs Assessment process which led to the adoption of final 2016-2020 MCH priorities in Summer 2015. Strategic planning efforts began in Fall 2015 and are ongoing.
- Wyoming is participating in two Collaborative Improvement and Innovation Networks (CoIINs) to reduce infant mortality and to improve timeliness of newborn screening.
- MCH is partnering with Women, Infants and Children (WIC) and the Chronic Disease Prevention program to participate in ASTHO's Breastfeeding Learning Community with a focus on improving access to professional and peer support for breastfeeding and improving practices supportive of breastfeeding in birthing facilities.
- Since 2014, the Program has facilitated and led a Coordinated Effort to Reduce Preterm Birth Workgroup which focuses on reducing pre- and early term birth and improving risk appropriate perinatal care.

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Women and Infant Health Program

PROGRAM CORE PURPOSE

The Women & Infant Health Program facilitates access to care and promotes the physical and reproductive health of women (15-44 years old) and their infants (0-1 year old).

OUTCOMES

Performance Metric	CY 2016 Target	CY 2017 Target	CY 2013	CY 2014	CY 2015	CY 2016
% and # of births that occur in WY with first newborn screen completed (Newborn Screening Database/Vital Statistics Services (VSS))	99%	99%	96.9% 6,727/ 6,939	98.2% 6,868/ 6,993	97.2% 6,920/ 7,113	-
% of mothers who breastfeed their infants through 6 months of age (non-exclusive) (National Immunization Survey)[1]	59%	59%	55.6% 4,235/ 7,617	56.6% 4,355/ 7,693	58.1% 4,456/ 7,669	-
% of infants born to women who smoked during the first trimester (VSS)	15%	15%	15.8% 1,207/ 7,617	15.8% 1,216/ 7,693	15.7% 1,207/ 7,669	-
% of very low birth weight (≤3lbs, 4oz) infants born at facilities with the appropriate level of care (VSS)	80%	67%	65.9% 56/85	67.0% 69/103	58.2% 46/79	-
% of infants born preterm (<37 weeks) (VSS)	9%	9%	10.2% 779/ 7,617	10.5% 811/ 7,693	9.6% 736/ 7,669	-

(-) indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2015 Q1+Q2	SFY 2015 Q3+Q4	SFY 2016 Q1+Q2	SFY 2016 Q3+Q4
OUTPUTS									
# of women of reproductive age enrolled in the Quitline	N/A	N/A	N/A	N/A	515	N/A	N/A	209	306
# of individuals attending Certified Lactation Counselor training sponsored/supported by MCH[2]	N/A	N/A	20	6	19	6	0	5	14
# of women enrolled in Maternal High Risk (MHR)[3]	23	29	28	22	28	13	11	17	12
# of infants enrolled in Newborn Intensive Care (NBIC)[3]	52	40	37	54	62	30	24	31	31
EFFICIENCIES									
Cost per first newborn screen (# of first screens completed)[4]	N/A	N/A	$70.57 (6,868)	$74.21 (,6932)	$81.90 (6,786)	N/A*	N/A*	N/A*	N/A*
Cost per first & second newborn screens (# of first and second screens completed)[4]	N/A	N/A	$37.63 (12,879)	$39.50 (13,018)	$43.40 (12,812)	N/A*	N/A*	N/A*	N/A*

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- The Women & Infant Health Program (WIHP) provides leadership and support for the design, implementation, and evaluation of state and local policies and programs that address the health needs of women and infants; promotes healthy development within the women and infant populations, including mothers and infants with special healthcare needs; and promotes all Maternal and Child Health Unit priorities.
- Examples of MCH services directly supporting the women and infant population include the Healthy Baby Home Visitation program, Maternal High Risk (MHR) program, Newborn Intensive Care (NBIC) program, and the Newborn Screening (NBS) program, including appropriate follow-up and services for children (infants) with special health care needs (CSH).
- In 2013, MCH began the Title V Needs Assessment Process which led to the adoption of final 2016-2020 MCH priorities in the summer 2015. The priorities which directly relate to the Women and Infant Health Program include:
    - Improve Breastfeeding Duration
    - Improve Access to and Promote Use of Effective Family Planning
    - Prevent Infant Mortality

Footnotes:

[1] Data Source: CDC Breastfeeding Report Cards. Column year represents the year the report was released.

[2] MCH sponsored Certified Lactation Counselor (CLC) training in Lander, WY on May 12-16, 2014. In FY2015 and FY2016, MCH provided financial support to nurses to attend CLC trainings in Rock Springs, WY on September 8-12, 2014 and Gillette, WY on May 2-6, 2016.

[3] SFY totals are unduplicated. Duplicates may be present between quarters, as individuals can be enrolled for more than one quarter.

[4] A second screen between 7-14 days of life is highly recommended and does not incur any additional costs to the program when performed.

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Women, Infants, and Children (WIC) Program

Program Description

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides quality nutrition education and services, breastfeeding promotion and support, a monthly food prescription (package), and referrals to maternal, prenatal, and pediatric healthcare services.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$11,270,261	$10,073,503	$10,336,967
People Served	11,169	10,531	10,249
Cost per Person	$1,009.07	$956.56	$1,008.58
Non-600 Series*	15.3%	18.6%	16.1%

* 600 series is defined as direct service contracts

Program Cost Notes

- Additional direct service expenditures not included in the 600 series equal $4,691,820 for 2014-2016 combined.
- Total FY15-16 biennium budget of $23,918,519 includes 7% SGF, 72% FF, 21% infant formula rebates.
- People Served = average monthly caseload

Program Staffing

- 44.9 Total FTE (8.4 state office, 36.5 local agencies)
  - 38 state positions: 15 FT; 12 PT; 11 AWEC
  - 12 county positions: 1 FT; 11 PT
  - 9 hospital positions: 4 FT; 5 PT

Program Metrics

- From 2014-2016, an average of 10,650 pregnant, postpartum, and breastfeeding women, infants, and young children were served each month by WIC.
- In calendar year 2015, 17,555 total unduplicated participants were served by 19 local WIC agencies.
- Approximately half of all babies born in Wyoming, and the nation, are served by WIC.
- Eighty-three retail grocers are contracted in Wyoming to redeem participant food benefits.

Events that have Shaped this Program

- Recent changes in the WIC food packages help to ensure that participants can easily make nutritious choices, with an emphasis on fruits, vegetables, low-fat dairy, and whole grains.
- Wyoming was the first state to implement electronic benefit transfer (EBT) for delivery of food benefits, which is now federally mandated for all states by 2020.
- Wyoming participates with 22 other states, territories, and tribal organizations in the national Association of State Procurement Officials (NASPO) Value Point Cooperative Purchasing Organization's infant formula rebate contracts in order to save money; these funds are used to offset the cost of participant food purchases.

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Women, Infants, and Children (WIC) Program

PROGRAM CORE PURPOSE

The purpose of the WIC Program is to improve the nutrition and health status of low income pregnant and post-partum women, infants, and children (to age 5) by providing nutritious supplemental food, nutrition education, breastfeeding support, and healthcare referrals.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of survey respondents who met with a breastfeeding peer counselor and found it helpful	94%	92%	N/A	92.5% (319/345)	91.7% (309/337)	91.6% (1,024/1,118)	91.3% (1,220/1,336)
% and # of survey respondents who indicate that WIC helped them eat more vegetables and fruits	85%	82%	N/A	83.3% (716/859)	87.7% (615/701)	82% (1,790/2,184)	80% (2,121/2,652)
% and # of cash value benefits spent on fresh fruits and vegetables by WIC participants	69%	70%	63.0% ($540,091/ $857,582)	67.6% ($378,064/ $559,800) (no data July-Oct 2012)	67.5% ($461,188/ $683,174) (no data Nov 2013)	67.6% ($553,962/ $819,919)	69.4% ($570,710/ $822,021)
Of all WIC post-partum women, average % and # who are breastfeeding[1]	48%	50%	46.2% (829/1,793)	44.4% (735/1,654)	46.1% (799/1,732)	48% (780/1,626)	49.6% (814/1,644)
Of all WIC breastfeeding women, average % and # who are exclusively breastfeeding[2]	80%	81%	78.6% (652/829)	79.1% (581/735)	77.1% (616/799)	77.3% (603/780)	81.2% (661/814)

N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Average # of women served/month[3]	2,922	2,753	2,774	2,620	2,590	2,646	2,584	2,613	2,566
Average # of children (ages 1-5) served/month[3]	6,228	5,949	5,775	5,449	5,162	5,581	5,318	5,220	5,103
Average # of infants (ages 0-1) served/month[3]	2,397	2,618	2,620	2,462	2,498	2,500	2,425	2,439	2,557
Average # of nutrition education contacts/month[4]	N/A	2,281 3rd & 4th qtr. only	2,502	3,050	3,071	3,054	3,046	2,998	3,143
Average # of referrals documented/month[5]	N/A	687 3rd qtr. only	758	973	1,303	966	979	1,196	1,409
EFFICIENCIES									
Average monthly food cost/participant/month	$47.08 ($568,953/ 12,086)	$47.07 ($532,407/ 11,319)	$49.29 ($550,528/ 11,169)	$47.93 ($504,844/ 10,531)	$48.24 ($494,488/ 10,249)	$48.86 ($524,046/ 10,726)	$46.99 ($485,642/ 10,336)	$48.48 $498,002/ 10,273)	$48.02 ($490,974/ 10,226)
Average nutrition education cost/participant/month[6]	$5.12 ($61,053/ 11,924)	$5.10 ($57,362/ 11,256)	$5.72 ($63,008/ 11,016)	$5.49 ($57,178/ 10,420)	$5.51 ($56,216/ 10,197)	$4.65 ($49,207/ 10,573)	$6.52 ($66,743/ 10,236)	$4.39 ($44,902/ 10,244)	$6.66 ($67,531/ 10,141)

N/A indicates data not yet available due to the creation of a new metric

STORY BEHIND THE PERFORMANCE

[1] WIC has seen the percentage of breastfeeding women increase gradually since the implementation of the WIC breastfeeding peer counselor program in 2005 and with efforts to ensure at least one Certified Lactation Educator is available in each local WIC agency. Peer counselors are employed using 600 series contracts.

[2] Women who exclusively breastfeed tend to breastfeed longer. Breastfeeding provides numerous health benefits to both mother and baby. Mothers who breastfeed lose pregnancy weight more quickly and have a reduced risk of breast and ovarian cancer later in life. Infants who are breastfed have better immune systems and are less likely to become obese.

[3] Overall, WIC participation has been decreasing since 2009 in Wyoming and nationwide, in part due to lower birth rates, improved economic conditions, increased SNAP benefits, and limited resources available for program outreach.

[4] The average # of nutrition education contacts documented is expected to increase over time as WIC staff utilizes new data system reporting implemented in the 2nd quarter of 2013.

[5]The average # of referrals documented is expected to increase over time as WIC staff utilizes new data system reporting. Due to data system problems with updated software build in 4th quarter, only 3rd quarter is reported for 2013.

WDH | Aging Division

Information contained in this section includes:

- Aging Disability Resource Center
- Legal Services and Legal Developer Program
- Long-Term Care Ombudsman
- Title III-B Supportive Services
- Title III-C1 Congregate Nutrition Program
- Title III-C2 Home Delivered Meal Program
- Title III-E National Family Caregiver Support Program
- Wyoming Home Services

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Aging & Disability Resource Center

Program Description

The WyADRC provides information, referral, education and short-term resource coordination that will assist Wyoming citizens who are either 55+ years of age or 18+ years of age and living with a disability to develop a long-term care plan.

Program Expenditures and People Served

	2014	2015	2016 YTD
Total Program Cost	$199,990	$200,000	$40,519
People Served	619	354	184
Cost per Person	$301.80	$564.97	$220.21
Non-600 Series*	0%	0%	0%

* YTD is July 1. 2015 through March 31, 2016 (contract ended 4/1/2016).
* 600 series is defined as direct service contracts.

Program Cost Notes

- This program is 100% State funded
- The provider contributes an approximately 15% in-kind match (This is not a grant requirement)

Program Staffing

- 0 FTE
- 0 AWEC
- 0 Other

Program Metrics

A total of 3,129 unduplicated callers contacted the WyADRC in SFY 2016 resulting in 27,022 contacts.

Of these calls:

- 67% were for Information and Referral
- 21% were for short term case management
- 63% required options counseling
- 8% were for other services including benefits counseling and longer-term case management

Of these callers:

- 70% were over the age of 55 years
- 26% were over 18 years of age and living with a disability
- 4% were not able to be categorized

Events that have Shaped this Program

- The Wyoming Legislature appropriated $200,000 in annual funding to the ADRC direct services during SFY12-13.
- The provider, Southwest Wyoming Recovery Access Programs (SW-WRAP) has recently undergone a major staffing and 'other' funding change resulting in a new CEO and a severe reduction in support staff, including the Options Counselor and Intake staff.

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Aging and Disability Resource Center

PROGRAM CORE PURPOSE

Help elderly and disabled adults find and coordinate supports and services for short and long-term care.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Total percentage of clients who took part in services after referral	75%	Program eliminated	N/A	N/A	35%	69%	64%

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2013	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Number of individuals assisted by the WyADRC	296	1,777	2,917	764	184	681	83	106	78
Total I&R Calls	N/A	N/A	N/A	160	93	77	83	68	25
Total Options Counseling Calls	N/A	N/A	N/A	616	138	448	168	82	56
Total Case Management Calls	N/A	N/A	N/A	209	42	109	100	37	5
Total Benefits Counseling Calls	N/A	N/A	N/A	60	4	39	21	4	0
EFFICIENCIES									
Average cost/consumer/year	$867	$914	$134.30	$207	$220	$116	$298	$219	$221
Average number of contacts per consumer	3	7	7	6	3	2.0	2.0	3.0	3.0

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- The WyADRC funding was cut during the 2016 legislative session.
- The Program was in the process of finding a new provider due to ongoing issues (decreasing performance and difficulty obtaining data) from the provider when the funding was cut and the program discontinued.
- The Aging Division continues to receive calls related to the ADRC from the public on a daily basis.

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Legal Services and Legal Developer Program

Program Description

The Legal Services and Legal Developer is a federally mandated program under Section 420 of the Older Americans Act of 1965, as amended in 2006. The Program provides funds to assist seniors over the age of sixty (60) who receive free civil legal services or are referred to the provider developed legal network for affordable legal services. The state provides matching state funds for maintenance of effort to allow seniors to continue to receive this legal help.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$75,366	$72.503	$69,072
People Served	253	302	179
Cost per Person	$297.89	$240.08	$385.88
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- The state funds match federal funds which are provided to the Legal Services and Legal Developer Program. The State funds, including State General Fund and provider's matching fund, are a 10-30% match to the Federal funds
-

Program Staffing

- 0.10 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In SFY 2016, 179 unduplicated seniors were afforded legal assistance in the form of direct assistance from the provider. No clients were turned away. Cases were resolved or referred for outside affordable legal assistance.
- In SFY 2016, total client hours performed by the provider equaled 833.
- In SFY 2016, the average number of hours spent per client was 4.65.
- The cost per client for SFY 2016 was $385.88. Average cost (Federal & State funds) per hour was $82.92.
- The average cost savings per client in SFY 2016, based on an average cost of $250.00/hour for private legal assistance, equaled $1,162.50 per client.
- This program helps Wyoming citizens over the age of 60 to remain in their homes and communities by allowing them to keep more of their money to spend on food, shelter, medicine, transportation, etc.
- No criminal cases are accepted through this program.
- A total of 30.75 hours of outreach and public education was provided by the Legal Services grantee in SFY 2016.

Events that have Shaped this Program

- The Legal Services and Legal Developer Program served all eligible clients with no waiting list. The average number of hours provided per client has increased from 2.25 hours per client in SFY 2015 to 4.65 hours per client in SFY 2016.
- Wyoming State Statute W.S. 35-20-102 (xvii) reads:
  "Vulnerable adult means any person eighteen (18) years of age or older who is unable to manage and take care of himself or his money, assets or property without assistance as a result of advanced age or physical or mental disability. Advanced age is defined as age 60 in statute but does not in any way assume those 60 and over are vulnerable and the same goes for those with a physical or mental disability."

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Legal Services and Legal Developer Program

PROGRAM CORE PURPOSE

The Legal Service and Legal Developer program that delivers free civil legal assistance to older individuals with the most social and/or economic needs.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of Wyoming's population who are age 60 and older who received legal services	1 %	1%	<1% (727/ 100,144)	<1% (274/ 97,182)	<1% (253/ 113,000)	<1% (302/ 105,000)	<1% (179/ 120,000)
Percentage of Wyoming's population who are age 60 and older, who are at or below 125% federal poverty level and received legal services.	1%	1%	N/A	1% (110/ 8,827)	4.15% (249/ 6,000)	1.7% (182/ 11,000)	50*
Percentage of Wyoming's population who are age 60 and older who live alone and received legal services.	1%	1%	N/A	<1% (167/ 26,282)	<1% (164/ 36,000)	<1% (232/ 34,000)	104*
Percentage of Wyoming's population who are age 60 and older, who are minority and received legal services.	1%	1%	N/A	1.3% (41/ 3,030)	1.2% (38/ 3,000)	1% (55/ 5,000)	12*

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
Total Number of Cases	N/A	274	253	302	179	189	209	90	89
Total Number of Hours spent performing legal services to individuals over the age of 60.	N/A	944.75	1,128.75	892.25	833	307.5	584.75	444.75	388.25
Average hour spent per client	N/A	3.44	5.24	2.95	4.65	1.64	2.94	4.94	4.36
Total savings to individuals who received services (based on $250/hour cost of obtaining private legal services)	N/A	$236,188	$282,188	$223,063	$208,250	$76,875	$146,187	$111,125	$97,125
EFFICIENCIES									
Average Cost per unduplicated client	N/A	$231.70	$297.89	$240.08	$385.90	$176.66	$193.64	$400.32	$371.31
Average cost per hour to the Federal funds	N/A	$71.22	$62.58	$77.22	$78.60	$106.72	$63.81	$76.96	$80.48
Average cost per hour to the State General Fund	N/A	$8.58	$1.26	$4.38	$4.33	$5.86	$3.08	$4.05	$4.64

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Until 2013, the provider was not able to provide an unduplicated count of clients. Since January 2013, Legal Service has improved the data collection method to show unduplicated client counts.
- **Most elder abuse and neglect takes place at home.** About 95 percent of older people live on their own or with their spouses, children, siblings or other relatives not in institutional settings. When elder abuse happens, family, other household members or paid caregivers are usually the abusers. Although there are extreme cases of elder abuse, often the abuse is subtle, and the distinction between normal interpersonal stress and abuse is not always easy to discern. As many as 1 in 20 older adults in the United States may be financially exploited.
- **Neglect usually takes place at home.** Neglect means failure to provide for oneself, or failure of caregivers to provide the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. Neglect usually occurs with older adults who live alone, relying on visiting family members and paid care givers to provide care. These older adults may have deteriorating physical and mental health condition; fear, dignity and pride usually prohibited them from reporting the neglect and exploitation to seek care.

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Long Term Care Ombudsman Program

Program Description

Under Title VII of the Older Americans Act of 1965, as amended, the State Unit or Area Unit on Aging is required to have programs in place for clients to be represented by an independent advocate (ombudsman) for persons living in Long Term Care (LTC) settings and to provide education and information to persons ages 60 and older, or their families, about prevention of physical, financial, mental, or verbal abuse. There is one contractor, Wyoming Senior Citizens, Incorporated, statewide for these services in Wyoming.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$270,895	$239,439	$250,526
People Served	2130	2584	2419
Cost per Person	$127	$93	$104
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- In SFY 2016:
  - 57% are federal funds
  - 37% are state funds
  - 6% are local funds. No local matching funds are required by federal law.

Program Staffing

- 1 FTE
- 0 AWEC
- 3 Other: regional ombudsman through a contractor

Program Metrics

- Evaluate caseloads (433 total in SFY 2016) and activity levels (1,986 activities, such as education, training, site visits) completed in SFY 2016), including cases closed, type of cases, cases opened, and the location of cases. All complaints or requests for assistance are reported monthly to the Community Living Section through the OmbudsManager Data System.
- 3% of cases were not resolved to the satisfaction of the client in SFY 2016 (0.8% in SFY 2015).
- All licensed nursing homes, assisted living, and boarding homes in the state are to be visited quarterly by an ombudsman. Other locations visited by the LTC Ombudsman in SFY 2016 included senior centers, hospice providers, adult day care, home health agencies, public health offices, and individuals' homes.

Events that have Shaped this Program

- Staffing: Three full-time Regional Long Term Care Ombudsmen are employed to cover the entire State of Wyoming with a caseload of approximately 600-700 complaints and/or requests for information per Ombudsman. In SFY 2016 the Ombudsman program experienced high staff turnover, averaging only 2 full time staff over the year.
- The primary causes of complaint are in the areas of discharges, abuse, neglect, and exploitation, and systems/others. More emphasis has been given to the subject of financial exploitation in the training and information on Elder Abuse Prevention to elders, facilities, and senior centers.
- An unmet need in Wyoming is the lack of availability for any geriatric psychiatric care for older residents.

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Long Term Care Ombudsman Program

PROGRAM CORE PURPOSE

The Long Term Care Ombudsman and elder abuse prevention program educates, investigates, advocates, mediates, and resolves issues on behalf of long-term care recipients in order to protect their health, safety, welfare, and rights.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% of complaints fully resolved to the satisfaction of the client (national average)*	48%	58%	N/A	42.3% (58.33%)	45.45%	47.72%	42.3%
% of complaints partially resolved to the satisfaction of the client (national average)*	N/A	25%	N/A	27.7% (14.94%)	24.92%	26.61%	18.83%
% of complaints not resolved to the satisfaction of the client (national average)*	N/A	0%	N/A	8.74% (4.77%)	0.64%	0.81%	2.92%
% of complaints referred to other agencies (national average)*	N/A	17%	N/A	16.97% (6.37%)	21.61%	17.34%	23.65%
Average # of complaints per facility (nursing homes, assisted living facilities, & behavioral health facilities)	N/A	6	N/A	N/A	9.6**	9	8.8

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric
* National averages are the most recently available (2013)
**Data collection began in Q2 of SFY 2014 for this metric; SFY 2014 average # of complaints for Qs 2, 3, and 4 only

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014***	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of visits to all LTC facilities/services by an Ombudsman	N/A	N/A	280*	413	332	172	241	184	148
% of nursing homes, assisted living facilities, & boarding homes (Total is 78) visited by an Ombudsman quarterly	N/A	N/A	87%*	58%	47%	N/A*	N/A*	N/A*	N/A*
# of cases opened by LTC Ombudsmen	N/A	N/A	411*	544	433	205	339	226	207
# of complaints received by Ombudsmen	N/A	N/A	751*	707	683	298	409	432	251
# of activities completed by Ombudsmen	N/A	N/A	1,357*	2,040	1,986	794	1,246	1,184	802
EFFICIENCIES									
Cost per person served (Cases opened + Activities / Total budget)	N/A	N/A	$127*	$93	$104	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis
***Data collection began in Q2 of SFY 2014 for these metrics; SFY 2014 data is for Qs 2, 3, and 4 only

STORY BEHIND THE PERFORMANCE

- In December of 2014, the position of State Long Term Care Ombudsman (SLTCO) was brought in-house as a State employee position. Prior to this, the position had been included in the Long Term Care Ombudsman contract with Wyoming Senior Citizens, Inc (WSCI). WSCI is still the contractor for the program, but only employs the regional long term care ombudsmen. WSCI provides personnel oversight and the SLTCO provides programmatic oversight. There has been significant turnover of regional ombudsman in the previous two years. The Wheatland LTCO office closed and a full time regional ombudsman is now located in Cheyenne.

- Turnover in ownership of two nursing homes in May of 2015 brought increased usage of the Ombudsman program, including an increased number of cases opened. An ombudsman was at each of the facilities throughout the transition and worked with all residents.

- The Federal Government enacted a new federal rule for the Long Term Care Ombudsman Program as of July 1, 2016. The functions of the LTCOP have always been stated within the Older Americans Act, but have never had promulgated regulations, resulting in significant variation in interpretation and implementation by state. The intent of the new rule is to standardize quality and efficiency nationally. The regulation addresses the following areas: content of policy and procedure, functions and responsibilities of the SLTCO, State agency responsibilities related to the LTCOP, responsibilities of hosting agencies, duties of the regional ombudsmen, and conflict of interest standards.

Title III-B Supportive Services

Program Description

The Title III-B Supportive Services Program allows community providers to coordinate services, educate staff, and promote a social environment for Wyoming's adults ages 60 and older in order to empower Wyoming's adults age 60 and older to remain physically, mentally, and socially active to prevent premature institutionalization. The four major categories of Title III-B service are:

1) ***Health:*** Increasing participation in physical activity to remain an active member of the community.
2) ***Socialization:*** Decreasing social isolation to maintain physical and mental well-being.
3) ***Support Services:*** Providing access to services and information about community resources.
4) ***Transportation:*** Increasing self-reliance and decreasing dependence on family and friends to meet transportation needs.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost (Federal and State)	$1,202,494	$1,789,470	$1,520,273
People Served (Unduplicated Count)	17,632	17,220	17,451
Cost per Person	$68.12	$103.92	$87.12
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funding is provided by the Administration on Aging (AoA) under Section 321 of the Older Americans Act (OAA)
- 85% Federal Funds, 7.4% General Funds, & 7.5% local match
- Grantees have typically contributed more than the required

Program Staffing

- 0.70FTE
- 0 AWEC
- 0 Other

Program Metrics

In SFY 2016, Title III-B had a total of 37 grantees covering 23 counties in Wyoming. These grantees served a total of 17,451 clients, or 14.5% of Wyoming's adults aged 60 and older, based on 2015 Census data. A total of 755,662 unit of services provided.

Events that have Shaped this Program

- Funded by the Administration on Aging (AoA), Section 321 of the Older Americans Act.
- From 2000 to 2010, the number of Wyoming's adults aged 60 and over increased 32.7%. By 2030, those 60 and older will comprise 32.2% of Wyoming's population, making Wyoming the fourth oldest state in the nation.
- The Title III-B Program impacts: community ownership, health care utilization, assisted technologies, unmet needs among older adults and care givers, and coordination of community resources to maximize services.
- National research demonstrates that participation in social activities an active life style enables older individuals to continue living independently and with dignity. A holistic health environment may alleviate high medical expenses and prevent early institutionalization.
- Title III-B funds a broad array of services that enable seniors to remain in their homes for as long as possible. These services include, but are not limited to:
  - ► Access: transportation, health & wellness program utilization, and information and assistance;
  - ► Preventive Health: health screenings and referrals for follow-up services as needed; and,
  - ► Community services: legal services, mental health services, and ombudsman service.

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Title III-B Supportive Services

PROGRAM CORE PURPOSE

To help Wyoming's older adults to remain physically, mentally, and socially active to prevent early institutionalization by providing comprehensive, coordinated, and cost effective services.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of unduplicated clients receiving III-B services	14.5% (17,451/ 120,000*)	17,501	20.4% (20,499/ 100,144*)	16.2% (15,829/ 97,128*)	15.6% (17,632/ 113,000*)	16.4% (17,220/ 105,000*)	14.5% (17,451/ 120,000)
Total # of clients receiving transportation services	1834	1884	N/A	1,894	2,283	2,237	2,237
# of clients receiving assisted transportation services who also have a disability	772	822	N/A	661	764	834	772
# of outreach services provided	3327	3377	N/A	1,275	1,380	1,388	1,363

(*) Projected census data
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Total number of Title III-B Services units provided	N/A	545,246	720,710	726,442	755,662	361,467	364,984	359,942	395,855
Units of transportation services provided	N/A	103,918	160,500	164,260	168,056	85,962	78,302	74,438	93,626
Units of assisted transportation services provided	N/A	40,469	62,956	68,366	61,640	34,813	33,553	32,348	29,292
Units of outreach services provided	N/A	67,059	80,858	80,858	83,693	41,561.75	42,131	43,737	39,923
EFFICIENCIES									
Cost per client (Federal & State funds)	$87.73	$89.46	$68.12	$103.92	$87.12	$57.44	$87.44	$56.37	$56.44
Cost per unit (Federal & State funds)	$2.48	$2.28	$1.67	$2.46	$2.01	$2.14	$2.83	$2.13	$1.91

N/A indicates data not yet available due to the creation of a new metric using unduplicated client counts

STORY BEHIND THE PERFORMANCE

- Based on the projected Census data for SFY 2015, Title III-B served approximately 14.5% (17,451/120,000) of Wyoming's total population aged 60 and older in SFY 2015.
- The Aging Division, Community Living Section will continue to provide technical assistance and collaborate with senior centers in the outreach function to promote participation.
- Title III-B served 3,106 clients who live below 100% federal poverty level, 6,229 clients who live alone, and 495 clients who are minorities in SFY 2016.
- For accurate data collection, the Aging Division, Community Living Section collaborated with DUPRE in the data analysis to identify area that needs improvement.
- The total numbers of clients served has shown a decrease from year to year due to data collection becoming more defined for the unduplicated client beginning in SFY 2013.

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Title III-C1 Congregate Nutrition Program

Program Description

The Title III-C1 Congregate Nutrition Program provides nutrition education, nutrition counseling, meals, and nutrition screening to eligible clients. Additional services may be offered including cooking, shopping, and positive social contacts, as well as the gateway to additional services. This program gives priority to low-income minority persons, those residing in rural areas, those with limited English proficiency, and those at greatest nutritional risk.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$1,613,596	$1,617,438	$1,642,384
People Served	18,427	18, 768	18,781
Cost per Person	$87.56	$86.18	$87.45
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 85% Federal funds
- 15% state and local match funds.
- The state currently provides 5% of the 15% required match amount.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In SFY 2015 Title III-C1 Congregate Nutrition Program had a total of 33 grantees covering 23 counties in Wyoming. These grantees served a total of 18,781 clients representing approximately 15.65% of Wyoming's total population of older adults based on 2016 Census data projections. These 18,781 clients received a total of 658,149 meals that they may not have otherwise received.

Events that have Shaped this Program

- Program policies and procedures have been updated to reinforce the policy of no carry-out meals and correct accounting for staff meals.
- Creation of a peer focus group made up of current clients will provide ideas to help increase client participation in the Program.

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Title III-C1 Congregate Nutrition Program

PROGRAM CORE PURPOSE

Reduce food insecurity and hunger while promoting socialization among Wyoming's older adults.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of WY population age 60 and older served likely to experience food insecurity	30.00% (3,300/ 11,000)	31.81% (3500/ 11,000)	43.64% (3,055/ 7,000)	54.38% (3,263/ 6,000)	54.90% (3,294/ 6,000)	29.33% (3,227/ 11,000)	30.19% (3321/ 11,000)
# of clients served likely to experience hunger	862	898	828	809	931	843	879
% and # of WY population age 60 and older served who live alone	17.20% (6,020/ 35,000)	17.07% (7000/ 41,000)	18.66% (5,972/ 32,000)	19.36% (6,003/ 31,000)	16.70% (6,013/ 36,000)	17.14% (6,000/ 35,000)	14.83% (6083/ 41,000)
% and # of WY population age 60 and older served who are of a minority population	8.50% (425/ 5,000)	16.66% (500/ 3,000)	6.85% (411/ 6,000)	14.83% (445/ 3,000)	15.26% (458/ 3,000)	8.30% (415/ 5,000)	15.6% (468/ 3,000)
% and # of the total WY population served age 60 and older	18.00% (18,900/ 105,000)	15.70% (18,850/ 120,000)	18.68% (18,707/ 100,144)	19.73% (19,183/ 97,182)	16.30% (18,427/ 113,000)	17.87% (18,768/ 105,000)	15.65% (18,781/ 120,000)

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Total number of meals served	663,957	643,819	635,943	648,135	658,149	336,895	311,240	331,892	326,257
Total units of nutrition education provided	13,075	12,466	3,312	1,991	6,518.25	1,108	883	372	6146.25
Total units of nutrition counseling provided	38.5	73	54	69.75	147	22.25	47.5	115.50	31.5
EFFICIENCIES									
Average total cost (State and Federal) per meal	$10.03	$9.77	$9.58	$8.98	$9.67	N/A*	N/A*	N/A*	N/A*
Average State reimbursement per meal	$0.29	$0.25	$0.20	$0.19	$.20	N/A*	N/A*	N/A*	N/A*
Average Federal reimbursement per meal	$3.18	$2.52	$2.32	$2.44	$2.52	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Quarterly provider phone conferences will not only update the providers on changes to the policies and procedures but will enable the program to increase client participation through idea sharing, brainstorming, and problem solving.
- Creation of a peer focus group made up of current clients will provide ideas to help increase participation.

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Title III-C2 Home Delivered Nutrition Program

Program Description

The Title III-C2 home delivered nutrition program provides nutrition education, nutrition counseling, meals, and nutrition screening to eligible clients. Additional services may be offered including cooking, shopping, and positive social contacts, including gateways to additional services. This program gives priority to individuals with low-income, minorities, those residing in rural areas, those with limited English speaking proficiency, and those at greatest nutritional risk.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$1,268,641	$1,267,220	$1,340,327
People Served	4,916	5,094	4954
Cost per Person	$258.06	$248.76	$270.55
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 85% Federal funds
- 15% state and local match funds.
- The state currently provides 5% of the 15% required local match amount.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In SFY 2016, Title III-C2 Home Delivered Meals Program had a total of 33 grantees covering 23 counties in Wyoming.
- Grantees served a total of 4,954 clients, or 4.12% of Wyoming's older adult population based on 2015 Census data. These 4,954 clients received a total of 533,619 meals that they may not have otherwise been received.

Events that have Shaped this Program

- Reinforcement of the policies that no carry-out meals are allowed and staff meals must be correctly accounted for has resulted in the need for updated policies and procedures.
- Creation of a peer focus group made up of current clients will provide ideas to help increase participation.

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Title III-C2 Home Delivered Nutrition Program

PROGRAM CORE PURPOSE

Reduce food insecurity and hunger while promoting socialization among Wyoming's older adults.

OUTCOMES

Performance Metric	SFY 2016 Target	SFY 2017 Target	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% and # of WY population aged 60 and older served likely to experience food insecurity	15.00% (1,650/ 11,000)	14.77% (1625/ 11,000)	22.60% (1,582/ 7,000)	26.05% (1,563/ 6,000)	26.11% (1,567/ 6,000)	14.29% (1,572/ 11,000)	14.52% (1598/ 11,000)
# of clients served likely to experience hunger	952	952	723	769	868	907	932
% and # of WY population aged 60 and older served who live alone	7.50% (2,625/ 35,000)	6.28% (2575/ 41,000)	8.23% (2,634/ 32,000)	8.31% (2,579/ 31,000)	6.92% (2,494/ 36,000)	7.34% (2,572/ 35,000)	6% (2462/ 41,000)
% and # of WY population aged 60 and older served who are of a minority population	3.40% (170/ 5,000)	6.16% (185/ 3,000)	2.80% (168/ 6,000)	5.06% (152/ 3,000)	5.26% (158/ 3,000)	3.30% (165/ 5,000)	5.8% (174/ 3,000)
Total % and # of WY population served age 60 and older	4.89% (5,144/ 105,000)	4.16% (5000/ 120,000)	5.37% (5,385/ 100,144)	5.15% (5,006/ 97,182)	4.35% (4,916/ 113,000)	4.85% (5,094/ 105,000)	4.12% (4954/ 120,000)

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Total number of meals served	510,183	526,333	522,254	522,142	533,619	261,517	256,454	265,425	268,194
Total units of Nutrition Education provided	15,875	11,659	5,839	1,576	8,066	630	3,629	186	7,880
Total units of Nutrition Counseling provided	50.75	76.5	156.5	138.5	170.5	78	39.25	74	96.50
EFFICIENCIES									

Average total cost per meal (Federal and State)	$11.33	$10.39	$9.72	$8.91	$11.05	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	$0.29	$0.25	$0.20	$0.19	$.20	N/A*	N/A*	N/A*	N/A*
Average Federal reimbursement per meal	$3.18	$2.52	$2.32	$.2.44	$2.52	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Quarterly provider phone conferences will not only update the providers on changes to the policies and procedures but will enable the program to increase client participation through idea sharing, brainstorming, and problem solving.
- Creation of a peer focus group made up of current clients will provide ideas to help increase participation.

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National Family Caregiver Support Program

Program Description

The National Family Caregiver Support Program provides supports to Caregivers, 18 and older, caring for a person who is 60 years old or older, or has Alzheimer's or related dementia, or is a grandparent or relative caregiver, 55 and older, of a child 17 and younger, or of an adult child between the ages of 19-59 who has a disability

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$627,347	$620,693	$572,845
People Served	624	508	411
Cost per Person	$1,066	$1,005	$1,394
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 75% Federal Funds, 25% Provider Match
- Federal funds are used to maintain this program, along with provider match (local funds and in-kind) and program income.

Program Staffing

- 1 FTE (0.5 FTE National Caregiver Support Program & 0.5 FTE SAMS database support)
- 0 AWEC
- 0 Other

Program Metrics

- 22% of Caregivers are aged 18 to 59 years. (4% decrease from SFY2015)
- 77% of Caregivers are aged 60 and older. (4% increase from SFY2015)
- 12 grantees provide services to Caregivers in 18 counties in Wyoming and 1 grantee provides information regarding resources in Wyoming Statewide.
- 2 grantees provide services to Grandparents Raising Grandchildren who are 17 years of age or younger. Services provided to Grandparents Raising Grandchildren include information, assistance (case management), counseling, support groups, trainings, respite, and supplemental services such as chores, homemaking, and personal emergency response systems.

Events that have Shaped this Program

- The Caregiver program was implemented in 2001.
- The Caregiver program also serves Grandparents, ages 55 and older, raising grandchildren, 17 years of age or younger, in 3 counties.
- Grantees have to meet a 25% match to receive the Federal funds. Potential grantees have opted to not apply for the funds because of the match rate. In years when state funds have not been available the providers have had to make the match themselves.
- In Federal fiscal years 2010 & 2014 -2016, the Program received no state funds.
- SAMS (social assistance management software) data entry may have over counted Caregivers in the past. FFY2014 started entering data correctly.

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National Family Caregiver Support Program

PROGRAM CORE PURPOSE

The National Family Caregiver Support Program provides supportive services to Wyoming Caregivers to continue their caregiving abilities to their loved ones.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
Number of unduplicated Caregivers Served	585	500	725	684	624	508	411
Number of Outreach events (estimated number of consumers outreached to)	1250	1300	3,326 (37,198)	1,210 (21,488)	1,274 (24,545)	1,742 (32,411)	928 (15,014)
Average Caregiver Evaluation Score	13/30	13/30	N/A	11/30	12/30	12/30	11/30
Average Caregiver Evaluation Score for newly enrolled Caregivers	16/30	16/30	N/A	N/A	11/30	11/30	12/30
% of clients reporting difficulty finding Caregiver Services	2%	2%	N/A	N/A	N/A	< 1%	< 1%

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of respite units provided	16,421	16.089	9,959	8,647	8,682	4,385	4,262	4,256	4,427
# of counseling, support group, and training units provided	2,059	2,147	1,889	1,586	1,187	769	817	525	663
# of supplemental service unis provided	6,343	6,445	7,727	6,685	5,736	3,316	3,327	3,036	2,700
EFFICIENCIES									
Average cost per caregiver	$1,150	$1,033	$1,005	$1,222	$1,394	$833	$775	$896	$897

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Grantee have to meet a 25% match to receive Federal funds. Potential grantees have opted to not apply for the funds because of the match rate. In years when state funds have not been available the providers have had to make the match themselves.
- In Federal fiscal years 2010 and 2014- 2016 the Caregiver Program received no State funds.
- Annual tracking of each National Family Caregiver Support Program Provider's Caregiver Evaluation score began in October 2012 and moved to semi-annual tracking in October of 2013.
- Getting Caregivers to accept the services has continued to be a challenge.
- Information Services, including radio ads, flyers, health fairs, and word of mouth, are being used to inform potential Caregivers that there are services available to assist them.
- Less than 1% of Caregivers surveyed in SFY2015 and SFY2016 said that finding services was difficult.

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Wyoming Home Services

Program Description

The Wyoming Home Services program is a state funded grant program contracted to 23 providers (one per county) to provide in-home services to persons 18 years and older in Wyoming who are at risk of placement in nursing homes, assisted living facilities, or other institutional care. Services are primarily care coordination, homemaking, and personal care.

Program Expenditures and People Served

	2014	2015	2016
Total Program Cost	$4,239,391	$4,168,574	$4,474,583
People Served	2,328	2257	2156
Cost per Person	$1,820	$1,847	$2,075
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY16 WyHS budget equaled approximately $3,333,584 GF and there is a 5% local match required to the state funds for all contractors. In SFY 16, the contractors used the state funds plus $349,407 in local match and $359,952 in client contribution.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In SFY 2016:
  - served 2,156 people in 23 counties at an average cost per client of $2,075
  - generated program revenue $359,952
  - had a waiting list ranging from 43 to 114 individuals

Events that have Shaped this Program

- More clients are on the program longer and needing more services to be able to stay in the home.
- More potential clients are on waiting lists.
- This program has had the same amount of state funds allocated to its general fund budget for State fiscal years 2008-2015.
- A one-time additional appropriation of $200,000 was made to the Program in the 2015 legislative session, resulting in an additional 1,100 units of service provided in SFY 2016 and increasing the number of units per person from 41.4 units in SFY 2015 to 43.8 units in SFY 2016.

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Wyoming Home Services

PROGRAM CORE PURPOSE

To provide in home services for Wyoming senior citizens and disabled adults eighteen (18) years of age and older who are at risk of premature institutionalization.

OUTCOMES							
Performance Metric	**SFY 2016 Target**	**SFY 2017 Target**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
# of people served	2,357	2,357	2,384	2,322	2,328	2,257	2,156
# and % of WyHS Clients with an activity of daily living (ADL) score of 2 or higher	80%	85%	1,770 (76%)	1,789 (77%)	1,812 (78%)	1,761 (78%)	1,599 (74%)
# and % of WyHS Clients with an instrumental activity of daily living (IADL) score of 2 or higher	97%	98%	2,218 (93%)	2,216 (95%)	2,257 (97%)	2,185 (97%)	1,479 (69%)
Average # of people on the waiting list	0	0	146	84	82	83	76

(-) Indicates data not yet available
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**	**2015 Q1+Q2**	**2015 Q3+Q4**	**2016 Q1+Q2**	**2016 Q3+Q4**
OUTPUTS									
# of adult protective services (APS) reports	N/A	88	113	159	137	65	92	74	63
# of service units provided	N/A	N/A	N/A	93,446	94,540	46,817	46,489	47,667	46,839
# of homemaking units provided	N/A	N/A	N/A	50,694	51,585	25,655	25,039	25,839	25,746
# of personal care units provided	N/A	N/A	N/A	14,819	14,648	7,665	7,154	7,473	7,175
EFFICIENCIES									
Average cost per person	$1,903	$1,790	$1,820	$1,832	$2,075	$1,102	$1,123	$1,160	$1,264
Average cost per unit of service	N/A	N/A	$41	$44	$47	$44	$45	$43	$48

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- The Wyoming Home Services (WyHS) program is a 100% state funded program.
- Clients pay a fee for services based upon a sliding fee scale and their ability to pay. No client is denied services based upon their inability to pay.
- The program income generated through client contributions is put directly back into the program to enhance services.
- WyHS is currently provided in every county throughout Wyoming. Each county's provider chooses the services they provide in their county based upon county need and feasibility for the provider.

Appendix A: Program Budget Strings

Programmatic funding comes out of the budget strings listed to the right of each Program. Note that a single budget string may contain budgetary funding for multiple programs. For example, 0401 Medicaid administrative costs includes several administrative and eligibility programs. Note also that some programs are funded out of multiple budget strings. For example, Medicaid dental benefits are paid for both adults (0470) and children (0461). Please refer to budget documents for more detailed budgetary information.

Division of Health Care Financing

Electronic Record Incentive Program 0404
Eligibility Customer Service & Call Center 0401
Eligibility Long Term Care Unit 0401
KidCare CHIP 0420
Long Term Care (LTC) & Assisted Living Facility (ALF) Waivers 0483
Medicaid Behavioral Health Program 0470, 0461
Medicaid Dental Program 0470, 0461
Medicaid Pharmacy Program 0470, 0461
Medicaid Third Party Liability 0401
Medication Donation Program 0401
Nursing Facilities 0463
Psychiatric Residential Treatment Facilities (PRTFs) 0461, 0462

Behavioral Health Division

Acquired Brain Injury (ABI) Waiver 0482
Comprehensive Waiver 0485
Court Supervised Treatment (CST) Programs 2503
Early Intervention and Education Program (EIEP) 2510
Mental Health Outpatient Treatment 2506
Mental Health Residential Treatment 2508
Recovery Supports – Peer Specialists 2502
Substance Abuse Outpatient Treatment 2507
Substance Abuse Residential Treatment 2509
Supports Waiver 0486
Veteran Outreach and Advocacy Program 2502

Public Health Division

Adolescent Health Program 0523
Child Health 0523
Chronic Disease Prevention 0539
Communicable Disease Prevention Program 0534
Communicable Disease Treatment Program 0534
Community Medical Access and Capacity (CMAC) Program 0510
Community Services Program 0510
Emergency Medical Services 0503
End Stage Renal Disease (ESRD) ..... .0510
Healthcare Workforce Recruitment, Retention and Development (HWRRD) 0510
Healthy Baby Home Visitation Program 0524
Hospital Preparedness Program (HPP) 0503
Immunization Program 0522
Infectious Disease Epidemiology 0540
Injury Prevention 0503
Integrated Cancer 0531
Office of Health Equity 0510
Oral Health Program 0521
Public Health Emergency Preparedness (PHEP) 0502
Public Health State Laboratory 0532
Public Health Nursing 0526
Substance Abuse and Suicide Prevention Program 0550
Tobacco Prevention and Control Program 0550
Trauma Program 0503
Women and Infant Health 0523
Women, Infants and Children (WIC) Program 0525

Aging Division

Aging Disability Resource Center 5002
Legal Services & Legal Developer Program 5002
Long-Term Care Ombudsman 5002, 5004
Title III-B Supportive Services 5002
Title III-C1 Congregate Nutrition Program 5003
Title III-C2 Home Delivered Meal Program 5003

Title III-D Disease Prevention and Health Promotion Program 5002
Title III-E National Family Caregiver Support Program 5002
Wyoming Home Services 5002