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Matthew H. Mead
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MEMORANDUM

Date: January 19, 2018
To: Joint Labor, Health, and Social Services Committee
From: Thomas O. Forslund, Director
Wyoming Department of Health *107*
Subject: SFY 2017 HealthStat Final Reports
Ref: F-2018-143

The Wyoming Department of Health (WDH) is pleased to submit its SFY 207 Final HealthStat Reports, which summarize the performance of 61 WDH programs. These reports are one part of the WDH performance management system, HealthStat, which also includes regular, integrated meetings with senior management and program staff to review program data, set goals, and develop strategies to improve the performance of WDH programs. The WDH continues to utilize HealthStat to improve performance and ensure good stewardship of state funds to promote, protect, and enhance the health of all Wyoming residents in an efficient and effective manner.

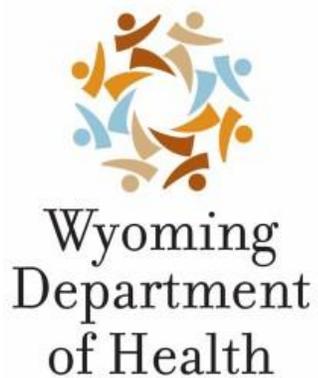
The following programs have been managed internally for some time, however this is their first appearance in the year-end reports.

- Health Care Finance Division
 - Health Management
 - Community Choices Waiver (replaces the Long-Term Care and Assisted Living Facility Waivers)
 - Patient Centered Medical Home
 - Native American Healthcare
 - Program of All-Inclusive Care for the Elderly
- Behavioral Health Division
 - Early Intervention and Education Program Part B and Part C metrics have been reported separately for the first time.

Please contact me at tom.forslund@wyo.gov or (307) 777-7656 if additional information is needed.

TOF/CC/jg

c: Governor Matthew H. Mead



HealthStat 2017 Final Reports

December 15, 2017

HealthStat 2017: A Foreward

HealthStat is a performance management initiative that began in 2011. HealthStat is now entering its seventh 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 Healthcare Financing

Information contained in this section includes:

- Medicaid Overview
 - Medicaid Members
 - Financial Stewardship
 - Provider Network
 - Health Management
- Programs
 - KidCare CHIP
 - Community Choices Waiver
 - Native American Healthcare
 - Program of All-Inclusive Care for the Elderly (PACE)
 - Patient Centered Medical Home (PCMH)
 - Medication Donation Program
- Benefits
 - Nursing Facilities
 - Behavioral Health
 - Pharmacy
 - Psychiatric Residential Treatment Facilities (PRTF)
 - Dental

- Administrative Functions
 - Eligibility Customer Service & Call Center
 - Eligibility Long Term Care Unit
 - Electronic Health Record Incentive Program
 - Third Party Liability



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 2015	SFY 2016	SFY 2017
Total Claims Cost (millions)**	\$519.5 M	\$554.6M	\$555.4M
Average Monthly Enrollment	74,628	66,696	63,247
Cost per Person (PMPM)	\$585	\$687	\$689*

*Value with a 3-month claim lag.

** By claim paid date. Only includes Medicaid expenses paid through the MMIS; therefore, expenses for administration, Medicare buy-in premiums, Medicaid Part- D premiums, and provider taxes are excluded. Does not include non-Medicaid programs included in the DHCF budget paid through MMIS including PDAP and other non-DHCF programs paid through the MMIS such as Children’s Special Health.

Program Cost Notes

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

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, 4 AWEC in AIMS/WINGS Unit
- 6 FT in Medicaid Fiscal
- 7 FT in Medicaid Home Care Unit
- 4 FT, 1 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 (PMPM) cost and per recipient cost.
- Operational efficiencies such as administration cost, time to process claims, electronic versus paper processes, and error rates.
- Health care outcomes, emergency room usage, admission rates and readmission rates.

Events that have Shaped this Program

- Mandatory Affordable Care Act (ACA) changes to rules, processes, & the mandatory Medicaid expansion.
- Potential ACA changes such as the optional Medicaid expansion requiring significant research.
- Wyoming legislative studies and efforts including the Medicaid Option 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 & Call Center, Health Information Exchange (HIE), Total Health Record (THR), the Personal Health Record, MMIS ACA compliance, and the MMIS replacement project.



Wyoming Medicaid – Members

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Estimated % and # of Uninsured Wyoming Children under Age 19, Under 138% of Federal Poverty Level (FPL) (2015 regional average** – 9.7%)	<5%	<5%	13.2% 4,242 (CY 2012)	10.4% 3,221 (CY 2013)	10.6% 3,332 (CY 2014)	12.9% 3,825 (CY 2015)	N/A
Estimated % and # of Uninsured Wyoming Adults Age 18 to 64, Under 138% of FPL* (2015 regional average** – 28.1%)	N/A	N/A	39.2% 24,043 (CY 2012)	37.9% 22,437 (CY 2013)	33.1% 19,340 (CY 2014)	31.4% 17,008 (CY 2015)	N/A
Estimated % and # of Uninsured Wyoming Children under Age 19, All Incomes* (2015 regional average** – 6.4%)	N/A	N/A	9.2% 12,846 (CY 2012)	7.1% 10,049 (CY 2013)	6.7% 9,503 (CY 2014)	8% 11,399 (CY 2015)	N/A
Estimated % and # of Uninsured Wyoming Adults Age 18 to 64, All Incomes* (2015 regional average** – 13.8%)	<16% by 2018 (WDH Strategic Plan)	<16% by 2018 (WDH Strategic Plan)	20.4% 72,616 (CY 2012)	19.3% 68,779 (CY 2013)	17.1% 60,856 (CY 2014)	15.5% 54,927 (CY 2015)	N/A
Average Months of Member Enrollment per year (overall)	10	10	9.30	9.53	9.85	9.18	9.22

* US Census Small Area Health Insurance Estimates. <http://www.census.gov/did/www/sahie/data/interactive>

** Region is defined here 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 available due to creation of new metric or re-definition of metric methodology

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Enrolled Members (unique count, total SFY)	89,684	88,642	91,062	88,775	84,785	N/A*	N/A*	N/A*	N/A*
% of State Population Enrolled in Medicaid*	15.4% (583,131)	15.2% (584,304)	15.5% (586,107)	15.2% (585,501)	14.4% (586,900)	N/A*	N/A*	N/A*	N/A*
Member Months	833,648	844,694	896,103	815,075	781,641	N/A*	N/A*	N/A*	N/A*
Average Monthly Enrollment	69,479	70,389	74,628	66,696	63,247	N/A*	N/A*	N/A*	N/A*
Recipients (unique count of members who used at least one service)	73,775	72,660	74,062	73,067	71,720	N/A*	N/A*	N/A*	N/A*
* 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). SFY 2017 state population is the forecasted data from the Wyoming Economic Analysis Division of the Department of Administration & Information. (-) 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. 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%.
- 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 (HCBS) 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.

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 2017 Target ¹	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Per Member Per Month (PMPM)		\$618	\$618	\$618	\$609	\$585	\$687	\$689
Children PMPM	Children**	\$192	\$192	\$184	\$189	\$190	\$213	\$214
	Foster Care Children	\$509	\$509	\$600	\$647	\$604	\$566	\$575
	Newborns	\$607	\$607	\$699	\$636	\$657	\$674	\$655
Non-Disabled Adults PMPM	Family-Care Adults**	\$406	\$406	\$465	\$459	\$437	\$452	\$432
	Former Foster Care	\$335	\$335	N/A	\$61	\$464	\$372	\$307
	Pregnant Women***	\$932	\$932	\$1,069	\$928	\$762	\$1,036	\$969
Aged Individuals PMPM	Community Choices****	\$1,547	\$1,547	\$1,674	\$1,645	\$1,654	\$1,719	\$1,631
	Nursing Home	\$3,912	\$3,912	\$3,805	\$3,738	\$3,763	\$4,347	\$4,285
	PACE	\$2,196	\$2,196	\$2,516	\$2,504	\$2,483	\$2,440	\$2,388
Disabled Individuals PMPM	Acquired Brain Injury	\$3,434	\$3,434	\$4,144	\$4,151	\$4,165	\$3,816	\$3,722
	Adults with ID/DD	\$4,879	\$4,879	\$5,645	\$5,488	\$5,243	\$5,421	\$5,029
	Children with ID/DD	\$2,312	\$2,312	\$2,465	\$2,400	\$2,490	\$2,569	\$2,339
	Suppl. Security Income SSI	\$703	\$703	\$685	\$733	\$730	\$781	\$762

¹ SFY 2017 targets were adjusted after the SFY 2016 reports were submitted due to observed changes in population composition, including decreased enrollment, increased Nursing Facility reimbursement rates, and increased waiver rates, that increased the PMPM. SFY 2017 and 2018 targets were set at a 10% reduction from the SFY 2016 actual PMPM.

* Kid Care Chip premium for SFY 2017 is \$246.30 (Plan A) and 2017 Marketplace premium is \$282.51 (lowest price gold plan with \$1,000 deductible and \$6,350 max out of pocket)

**2017 Marketplace premium is for a 40-yr old, non-smoker \$560.13 (lowest price gold plan with \$1,000 deductible and \$6,350 max out of pocket)

*** Excludes Presumptive Eligibility

**** Prior to SFY 2017 these individuals were enrolled in the Assisted Living Facility and Long Term Care Waivers. Data has been re-run for these years with the new title.

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)	73,775	72,660	74,062	73,067	71,720	N/A*	N/A*	N/A*	N/A*
Enrollment	89,684	88,642	91,062	88,775	84,785	N/A*	N/A*	N/A*	N/A*
Member Months	829,143	843,001	897,281	815,075	781,641	N/A*	N/A*	N/A*	N/A*
Claims Expenditures(M)*	\$512.7	\$513.0	\$524.5	\$559.6	\$538.7	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per Recipient	\$6,950	\$7,060	\$7,082	\$7,659	\$7,511	N/A*	N/A*	N/A*	N/A*
Cost per Enrolled Member	\$5,717	\$5,787	\$5,760	\$6,304	\$6,354	N/A*	N/A*	N/A*	N/A*
* All expenditures in outputs are in millions. N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

- The Per Member Per Month (PMPM) calculates the average cost of a member per month. $PMPM = (\text{Claims Expenditures} / \text{Member Months})$. 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 incentives. 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 from 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 2018. 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, as well.
- Per capita spending on healthcare in Wyoming was \$8,320 in 2014. This equates to \$586.66 per month per Wyoming resident. The United States per capita figure was \$8,045 in 2014. More recent data was not available.
 - Online: <http://kff.org/other/state-indicator/health-spending-per-capita/>
 - An annualized per capita spending for Medicaid members would be \$8,268 in SFY 2017 based on the SFY 2017 Medicaid member average PMPM.
- Potential valid benchmark for the child population would be:
 - The Wyoming Kid Care Chip program. Kid Care Plan A does not have copays and had a premium cost of \$246.30 in SFY 2017.
 - The least expensive 80% actuarial value Marketplace plan (BlueSelect Gold Basic with Kid's Dental) for a Wyoming child (ages 0-18) was \$282.51 per month in 2017 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 is a 2017 Marketplace plan for Wyoming. In Laramie County, the least expensive 80% actuarial value plan (BlueSelect Gold Basic) had a \$560.13 monthly premium for a 40-year old non-smoker with a \$1,000 deductible and \$6,350 maximum out of pocket.
 - Online: <https://www.healthcare.gov/see-plans/#/plan/results>
- Targets for SFY 2017 and SFY 2018 for PMPM were reduced by 10% to reflect statewide budget reductions.



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

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of licensed & practicing physicians enrolled	99%+	99%+	99-100% (est.)	99-100% (est.)	99-100% (est.)	99% + (est.)	99%+ (est.)
# of physicians enrolled (in-state / out-of-state)			1,658 in 6,016 out	1,671 in 6,552 out	1,800 in 7,664 out	1,891 in 7,472 out	1,786 in 7,133 out
% of in-state nursing facilities enrolled	100%	100%	100%	100%	100%	100%	100%
# nursing facilities enrolled (in-state / out-of-state)*			37 in 13 out	39 in 15 out	55 in 21 out	55 in 19 out	57 in 20 out
% of in-state hospitals enrolled**	100%	100%	100%	100%	100%	100%	96.8%
# hospitals enrolled (in-state / out-of-state)			28 in 333 out	29 in 331 out	30 in 279 out	31 in 270 out	31 in 270 out
% of in-state pharmacies enrolled	>95%	>95%	NA	86% (est.)	95%*** (est.)	98.5%	100%
# pharmacies enrolled (in-state / out-of-state)			124 in 82 out	127 in 90 out	131 in 97 out	131 in 93 out	134 in 98 out
% of in-state licensed & practicing dentists enrolled	>85%	>85%	NA	76%	78%	79%	79%
# of dental providers enrolled (in-state / out-of-state)			287 in 131 out	300 in 137 out	324 in 131 out	327 in 142 out	346 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 2017, 30 participating, 1 not participating. Aspen Mountain Medical Center in Rock Springs is the sole non-participant.

***Metric updated to reflect % enrollment of pharmacies licensed and able to enroll with Medicaid

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
Physician rates as a % of the regional average	134%	121%	111%	111%	-	N/A	N/A	N/A	N/A
Nursing facilities % cost coverage with the upper payment limit (UPL)*	89%	87%	83%	91%	91%	N/A	N/A	N/A	N/A
Hospital % cost coverage with the qualified rate adjustment (QRA)** (inpatient & outpatient) ***	85% 71%	83% 67%	85% 68%	90% 66%	-	N/A	N/A	N/A	N/A
Dental rates as a % of the estimated provider cost****	107%	96%	88%	90%	-	N/A	N/A	N/A	N/A
% of hospital inpatient days paid by Medicaid	15.28%	15.89%	13.41%	13.77%	-	N/A	N/A	N/A	N/A
EFFICIENCIES									
# of days between date of service and final payment	32.1	31.3	32	33.3	38	32.4	34.3	38.7	37.4
% of all claims denied	10.5%	9.7%	10.6%	12.9%	13.7%	12.4%	13.4%	13.9%	13.6%
(-) Indicates data not yet available N/A indicates data not available on a quarterly basis * 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 2016 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.
- 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 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, Medicaid payment cannot exceed a reasonable estimate of what Medicare would have paid.
- SF89, 2014 – Legislation passed allowing specified licensed mental health professionals to enroll with Medicaid as pay-to provider exclusive of supervisory oversight and to directly bill Medicaid. This change began July 1, 2014. During the 2015 General Session, SEA 21 added in provisionally licensed mental health professionals as a qualified provider type for Medicaid as well, beginning July 1, 2015.
- Ambulatory Surgery Center (ASC) payment methodology – was updated in SFY2015 (July 2014). The change converted the current payment structure over to mirror the outpatient prospective payment system (OPPS) currently in place for outpatient hospitals within Medicaid and Medicare.
- 2015 General Legislative Session approved an increase in nursing facility 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 (full cost coverage).
- The 2015 General Legislative Session added chiropractic services to the Medicaid State Plan. The 2016 Budget Session added independently practicing licensed dietitians to the Medicaid State Plan.
- Subpart E of the Affordable Care Act (ACA) mandates Medicaid enrollment for all ordering (includes prescribing) and rendering providers. This required lower level practitioners who had not previously been Medicaid-enrolled to enroll before March 24, 2015. The ACA also required all providers to re-enroll, ensuring appropriate provider screening as detailed in 42 CFR Subpart E.
- 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) implementation of the electronic claims mandate on July 1, 2015, and 4) mandatory inclusion of the ordering, referring, prescribing, and attending provider on all claim types in preparation for July 1, 2016 when all ordering, referring, prescribing, and attending providers MUST be enrolled with Medicaid.
- Starting July 1, 2016, Wyoming Medicaid was required to reduce its General Fund by \$54,438,246 for the 17/18 biennium, causing reductions in provider rates, coverage, and client eligibility. On November 1, 2016, Medicaid implemented a 3.3% reduction to provider fee schedule rates, including outpatient hospitals and ambulatory surgical centers. Provider participation has been closely monitored through implementation of these policy and rate changes.



Health Management

PROGRAM CORE PURPOSE

The Health Management Program strives to improve the health outcomes of Medicaid clients through population health management.

OUTCOMES							
Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Non-Emergent Emergency Room Visits per 1,000 member months (all emergency room visits)	0.59 (50.32)	0.70 (50.58)	N/A	0.48 (49.95)	0.52 (50.21)	0.60 (50.83)	0.71 (51.09)
Inpatient Readmissions within 30 days per 1,000 member months (all inpatient admissions)	0.69 (11.78)	0.66 (11.22)	N/A	0.70 (12.11)	0.71 (11.33)	0.70 (11.90)	0.67 (11.33)
HEDIS Measure: Use of appropriate medications for people with asthma (ages 5-50 years)	CY 2016 96.0%	CY 2017 96.0%	N/A	CY 2013 91.1%	CY 2014 88.9%	CY 2015 95.0%	CY 2016 *
HEDIS Measure: Comprehensive Diabetes Care – % of members 18 – 75 years of age with diabetes (type 1 and type 2) who had testing for: Hemoglobin A1c (HbA2c) LDL-C	CY 2016 74.0% 51.3%	CY 2017 74.0% 51.3%	N/A	CY 2013 63.1% 45.9%	CY 2014 66.3% 42.4%	CY 2015 71.5% 48.3%	CY 2016 * *
Non - HEDIS Measure: Early & Periodic Screening, Diagnostic & Treatment (EPSDT) Annual Participation Rate (under the age of 21)	CY 2016 45.0%	CY 2017 52.5%	N/A	CY 2013 45.1%	CY 2014 44.0%	CY 2015 42.5%	CY 2016 47.5%
(-) Indicates data not yet available * Data not available due to vendor change in the middle of reporting year N/A indicates data not available due to creation of new metric or re-definition of metric methodology							

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of emergency room visits	N/A	39,229	42,223	38,996	37,542	19,086	19,910	18,199	19,343
# of non-emergent emergency room visits	N/A	406	463	495	556	202	293	224	332
# of inpatient admissions	N/A	10,212	10,168	9,703	8,869	4,753	4,950	4,432	4,437
# of inpatient readmissions at 30 days	N/A	593	638	567	524	265	302	254	270
Non - HEDIS Measure EPSDT - Members who had screening / did not have screening	N/A	CY 2013 19,519 43,247	CY 2014 19,068 43,691	CY 2015 18,679 43,934	CY 2016 18,811 39,640	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
% of Nurse Advice Line Callers (true triage calls) Referred to Non-ER Alternatives (Total Calls)	N/A	61% (408)	67% (668)	72% (873)	-	70% (372)	75% (501)	-	-
Primary care physician (PCP) Follow-up within 30 days after ER visit (HM Members)	N/A	N/A	57%	55%	51%	54%	56%	52%	51%
Average program cost per Medicaid Member / (monthly average member count)	N/A	\$68.19 (70,389)	\$63.42 (74,628)	\$71.43 (66,696)	\$68.02 (63,247)	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

- A new contract was recently procured with OptumHealth Care Solutions beginning 7/1/16 and ending 6/30/20. The contract includes access into the vendor's reporting system through Tableau software.
- Targeted health management conditions include:
 - Asthma;
 - Diabetes;
 - Coronary artery disease;
 - Congestive heart failure;
 - High risk maternity;
 - Obesity;
 - Hepatitis C;
 - Smoking;
 - HIV/AIDS; and,
 - Chronic Obstructive Pulmonary Disease (COPD).
- Development of the WySUP Program to provide additional services to members with very high healthcare costs.
- Targeted Case Management is provided to clients with chronic disease states or other targeted conditions, such as obesity or smoking, for outreach and prevention initiatives. Specific clients are identified through claims analysis and other appropriate criteria and referral sources. While the Department has defined certain conditions (including diabetes, asthma, cardiovascular, COPD, high-risk pregnancy), the Department reserves the right to add or consider additional conditions. The Contractor may suggest other diseases than those identified by the Department if those efforts will help meet the overall HM performance measures in Table 10 of the Statement of Work.
- In addition to the general population outreach services, clients in the HM category with severe and/or chronic illness will receive intensive individualized case management which may involve the use of interactive technology to monitor client status and track adherence to treatment based on stratification and other criteria. Its intent is to slow the progression of chronic disease and to help contain healthcare expenditures for program participants.
- Complex Case Management is for individuals who are at risk of demonstrating poor health outcomes, experiencing fragmented healthcare delivery, have high-cost utilization of services, or whose pattern of health services access may indicate an inappropriate utilization of healthcare resources that would benefit from case management services.
- The fee structure for Case Management was changed from a PMPM rate to a rate based on the number of clients engaged. The definition of 'engaged' has also been refined. An 'engaged' member has had an initial qualifying assessment, an open or completed problem in the reporting month, an 'HM Care Path Review' (for targeted cases) or 'HM Care Plan Review' (for complex cases) or an 'HM Initial Assessment' outreach note in the reporting month, and a continuity of care document in the reporting month.



Kid-Care CHIP

Program Description

The Wyoming Children’s Health Insurance Program (CHIP) is a public/private partnership between the WY 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 a household with income up to 200% of the Federal Poverty Level. CHIP is jointly financed by the Federal and State governments with 88% federal match and 12% from the state general fund.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$10,576,592	\$10,612,056	\$10,534,071
People Served*	2,898	3,540	3,455
Cost per Person	\$3,649	\$2,997	\$3,048
Non-600 Series**	7.7%	6.4%	5.8%

* Average Monthly Enrollment,

**600 series is defined as direct service contracts.

Program Cost Notes

- PMPM increased 3.98% from 2015/16 to 2016/17.
- Prescription drug charges increased by 29% from 2016 to 2017.
- Institutional charges increased by 9% from 2016 to 2017.
- Utilization rate increased by 4% from 2016 to 2017.

Program Staffing

- 3 FTE (Program Manager, Benefit & Eligibility Analyst, Outreach Specialist)
- 0 AWEC
- 0 Other

Program Metrics

- Metrics such as benefit limitations, types of services provided, institutional charges, professional charges, prescription drugs, utilization rate and membership age breakdown are provided monthly/quarterly by the CHIP benefit and claims administrator, i.e. 65% of CHIP enrolled population is between 6 and 15 years of age, only 19% between birth and 5.
- WES metrics provide enrollment, renewal, application and closure data.
- Monitoring of such metrics allows assessment of the overall health of CHIP population, effectiveness of benefit package, guide for appropriate messaging, detection of WES abnormalities, identification of under/over utilization and corrective action planning.

Events that have Shaped this Program

- By a joint decision of the WY Legislature and WDH, in 2001 CHIP transitioned to a public/private partnership with a private insurer, BCBS, benefit & claims administration.
- 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 resulting in 1,252 CHIP children transitioning to Medicaid.
- Beginning October 1, 2017 CHIP federal match rate increased to 88%.
- Since its beginning, CHIP has been reauthorized three times and the program is currently funded through September 30, 2017 and authorized through September 30, 2019. States are currently awaiting notification of funding by the federal government. The program has implemented planning for potential program end if funding is not renewed.



Kid-Care CHIP

PROGRAM CORE PURPOSE

Kid Care CHIP (Children’s Health Insurance Program) makes available to eligible WY 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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# of children enrolled (monthly average)	3,575	3,350	5,831	4,464	2,989	3,540	3,455
% and # of Wyoming medical providers in network	94%	94%	93% (1,276)	94% (1,222)	94% (1,128)	93% (1,014)	92% (900)
% and # of Wyoming dental providers in network	80%	80%	80% (200)	80% (203)	76% (210)	79% (215)	83% (273)
% and # of children with at least 1 primary care provider appointment	54%	54%	50.5% (4,450)	45% (3,476)	42% (2,153)	40% (2,311)	41% (2,371)
% and # of children receiving services	medical	74%	74% (6,534)	69% (5,327)	67% (3,490)	67% (3,892)	68% (3,972)
	dental	52%	52% (4,316)	53% (3,634)	52% (3,984)	49% (2,833)	51% (2,921)

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of Core Set of Children's Health Quality Measures Reported*	5 N/A 7 yes 8 no	5 N/A 11 yes 4 no	6 N/A 15 yes 3 no	6 N/A 17 yes 1 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) Doctor communicating well	N/A	N/A	87.85% 93.32% 95.41% 94.87%	92.05% 90.75% 94.22% 98.50%	92.13% 94.20% 96.61% 93.81%	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Enrollment Loss Prevention Through Additional Review of Clients Losing Eligibility (# of Supplemental Reviews)	N/A	N/A	N/A	N/A	508	N/A	N/A	71	437
Text Message Reminders to Encourage Clients To Renew on Time (# of individuals that Renewed on Time / # Sent Text Message Reminders)	N/A	N/A	N/A	N/A	61% (181/ 299)	N/A	N/A	N/A	61% (181/ 299)
* Count of N/A indicates the number of measures not applicable for Wyoming (-) 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 ** 466 completed surveys received of 1,650 surveys for a response rate of 28.35%									

STORY BEHIND THE PERFORMANCE

Reducing the number of uninsured children:

- 1,998 children are uninsured in the CHIP age/income category; under 19 years of age with family income of 138% FPL to 200% FPL (2015).*
- Previously, approximately 1,781 children in the age/income category were uninsured (2014).**
- 5,823 children under 19 years of age with family income below 200% FPL are uninsured (2015).*
- Previously, approximately 5,113 children in this age/income category were uninsured (2014)**

Enrollment and CHIP family demographics:

- Sixty-five percent (65%) of CHIP enrollees are between 6 – 15 years of age.***
- Approximately nineteen per cent (19%) of CHIP enrollees are between birth & five years of age.***
- Nearly seventy-nine percent (79%) of CHIP families are enrolled in CHIP Plan C for families with income between 151% - 200% FPL. ****

Services utilized by CHIP children:

- There were twenty three children with catastrophic claims (\$50,000+) in SFY 2017. Catastrophic claims were equally female vs. male, an average age of 15, and the most prevalent and most expensive diagnoses were mental health related.
- Fifty nine percent (59%) of CHIP enrollees utilized a benefit service, including pharmacy and dental. Overall, the program experienced an increase in institutional, professional service, and prescriptions with fewer children compared to 2016.
- Twenty-three per cent (23%) of CHIP enrollees had a wellness visit.

*Data from the U.S. Census 2015 Small Area Health Insurance Estimates (SAHIE)

** Data from the U.S. Census 2014 Small Area Health Insurance Estimates (SAHIE)

***Data from the CHIP membership report from Blue Cross Blue Shield

****CHIP reconciliation report.



Community Choices HCBS Waiver Program

Program Description

The Community Choices (Home and Community Based Services) Waiver Program provides in-home services and assisted living services to Medicaid recipients 19 years of age and older that are aged, blind, or disabled and require services equivalent to a nursing home level of care.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost¹	\$32,699,875	\$37,211,944	\$37,370,359
People Served	2,214	2,322	2,457
Cost per Person	\$15,395	\$16,026	\$15,210
Non-600 Series*	2%	2%	2%

¹ Expenditures are by claim first service date * 600 series is defined as direct service contracts.
* 600 series is defined as direct service contracts

Program Cost Notes

- 50% General Fund and 50% Federal Funds.
- The SFY17-18 biennium budget for Community Choices waiver services was \$61,467,304.
 - \$55,565,829 in home services (LTC)
 - \$5,901,475 (ALF).
- Waiver recipients are eligible for Medicaid medical services included in the budget

Program Staffing

- 3 FTE allocated from 6 full-time employees
- 0 AWEC
- 0 Other

Program Metrics

- 9 individuals were waiting to transition to services as of 6/30/17.
- 632 participants chose the self-directed service delivery option in SFY 2017.
- 134 providers were enrolled to provide services for the Community Choices Waiver in SFY 2017.

Events that have Shaped this Program

- The Long Term Care Waiver Program was last renewed with CMS for a five year period to begin July 1, 2016. Upon this renewal we changed the name to Community Choices Waiver and included the Assisted Living Services within the waiver.
- The ALF Waiver Program was phased out in SFY 2017 with an end date of June 30, 2017.



Community Choices 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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of Medicaid Nursing Home eligible enrollees who are enrolled in the Community Choices Waiver	57%	55%	46%	48%	51%	55%	56%
% of returned participant satisfaction surveys that showed positive satisfaction and experience	80%	80%	88%	85%	82%	91%*	N/A
Waiver PMPM as a % of the Nursing Home PMPM	<60%	<50%	44%	44%	44%	40%	38%
ER Utilization Rate (# of visits per 1,000 member months)	25.0	25.0	21.7	20.1	26.3	25.3	26.5
Inpatient Admit Rate (# of admissions per 1,000 member months)	8.0	8.0	10.7	8.5	8.0	7.2	8.3

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of unique recipients	1,926	1,953	2,214	2,322	2,457	N/A*	N/A*	N/A*	N/A*
# of ER visits	393	370	521	547	606	N/A*	N/A*	N/A*	N/A*
# of Hospital Inpatient Admissions	194	157	158	156	191	N/A*	N/A*	N/A*	N/A*
# of providers at end of SFY	120	117	138	144	135	N/A*	N/A*	N/A*	N/A*
# of participant satisfaction surveys mailed	2,216	1,948	102	375	0	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average PMPM (waiver services only)	\$859	\$859	\$850	\$936	\$893	N/A*	N/A*	N/A*	N/A*
Average PMPM (waiver and medical)	\$1,674	\$1,654	\$1,654	\$1,719	\$1,631	N/A*	N/A*	N/A*	N/A*
% of mailed satisfaction surveys returned by applicants	43%	56%	73%	55%	N/A	N/A*	N/A*	N/A*	N/A*

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

STORY BEHIND THE PERFORMANCE

- In July of 2016, the Community Choices waiver program began a new five year cycle. The name was changed to Community Choices, and ALF services were added.
- The phase out of the ALF waiver program was completed on June 30, 2017.
- In July 2014, wait lists for these programs were removed, as directed by Senate File 60. Individuals currently are on the wait list are not ready to start the program by their own choice.



Native American Health Care Programs

Program Description

The Wind River Reservation is comprised of the Eastern Shoshone Tribe and the Northern Arapaho Tribe. Six facilities make up the healthcare programs on the reservation. Medical expenditures are paid by Medicaid on behalf of the Native American population to Indian Health Services/638-contracted tribal facilities and to non-tribal providers through special efforts. An 1115 Waiver may be pursued in the future.

Program Expenditures and People Served

	2015	2016	2017
\$ paid to IHS/638 facilities	\$10,602,489	\$9,961,562	\$11,134,878
\$ paid to Non-Tribal facilities	\$33,507,054	\$32,567,847	\$33,530,715
Average Monthly Enrollment	5,749	5,079	5,204
Cost per person (PMPM)	\$577	\$662	\$697

Program Cost Notes

- Total cost paid to IHS/638 tribal facilities is paid at 100% federal match
- Cost paid to non-tribal facilities are paid at 50/50 state and federal match

Program Staffing

- 1.17 FTE (1.0 FTE Tribal Waiver Manager, 0.17 FTE Provider Operations Administrator)
- 0 AWEC
- 0 Other

Program Metrics

- Increase number of enrolled Native American clients
- Decrease or maintain PMPM for Native American clients
- Increase federal funding through updated CMS payment policy related to funding “received through” an IHS/tribal facility
- Reduce client emergency room visits and 30 day hospital readmissions

Events that have Shaped this Program

- In 1976, Congress passed the Indian Health Care Improvement Act (IHCA) to give authorization for IHS and 638-contracted tribal health programs to bill Medicare/Medicaid
- Wyoming’s Tribal Consultation State Plan Amendment effective September 30, 2011
- Enrolled Act 56, 2015, Section 48, Footnote 22 appropriated \$16,900,000 in federal funds and \$676,000 in other funds in support of an 1115 tribal health uncompensated care waiver
- Tribal Waiver Manager hired in July of 2015. The 1115 Demonstration tribal waiver application was submitted to CMS on December 31, 2015
- In August of 2015, Director Forslund at the WDH approved a policy to implement the Tribal Leadership Advisory Council which is facilitated by the WDH Health Care Finance Division
- In March of 2017 State Plan Amendment approved by CMS to change reimbursement methodology for IHS and 638-contracted Tribal facilities
- Pilot project for a co-located eligibility worker at Wind River Family & Community Health Care



Native American Health Care Programs

PROGRAM CORE PURPOSE

Native American health care programs provide access to healthcare services to the American Indian and Alaskan Native (AI/AN) population with the goal of improving access to primary and preventative services in order to reduce the health disparities that are prevalent in this population.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
PMPM cost for disabled AI/AN Disabled* (Non-Disabled)	\$2,226 (\$358)	\$2,226 (\$344)	\$2,169 (\$352)	\$2,064 (\$359)	\$2,074 (\$345)	\$2,286 (\$381)	\$2,433 (\$386)
Amount Paid at 100% FMAP for "Received Through"***	\$2,000,000	\$2,000,000	N/A	N/A	N/A	N/A	\$0.00
AI/AN 30-Day Inpatient Readmissions per 1,000 member months (General Population)	0.8	0.8	1.2 (0.9)	1.2 (0.7)	0.9 (0.7)	1.2 (0.7)	0.9 (0.7)
AI/AN ER utilization rates per 1,000 member months (General Population)	75.0	75.0	75.1 (45.3)	67.3 (44.6)	72.8 (44.8)	78.3 (45.2)	76.6 (45.1)
% of AI/AN ER Visits that are Non-Emergent (General Population)	0.5	0.5	4.9 (1.5)	0.9 (1.1)	0.8 (1.1)	0.6 (1.4)	0.5 (1.6)

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

* PMPM costs for General Population (non-AI/AN) for SFY 2016 were \$2,291 and \$300 for Disabled and Non-disabled, respectively

** "Received Through" are services provided at a non-IHS/638 facility to a Medicaid enrolled Native American who has been referred by one of the IHS/638 tribal facilities which allows Wyoming Medicaid to receive 100% FMAP

All targets are based on outcomes similar to general population, to be met by 2021. Implementation of 1115 Tribal Demonstration Waiver funds will increase access to services, specialists, strategies, and additional programs.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4	
OUTPUTS										
total unique AI/AN enrollees	7,170	7,097	7,202	6,973	6,937	N/A*	N/A*	N/A*	N/A*	
% of total Medicaid enrollees who are AI/AN	12.5%	12.5%	12.6%	12.7%	12.2%	N/A*	N/A*	N/A*	N/A*	
# of AI/AN enrollees by age	<21	5,160	5,112	5,059	4,777	N/A*	N/A*	N/A*	N/A*	
	21-64	1,756	1,756	1,883	1,932					1,962
	65+*	339	339	332	337					350
# of disabled AI/AN enrollees / non-disabled*	906 6,301	870 6,269	880 6,372	897 6,128	953 6,069	N/A*	N/A*	N/A*	N/A*	
% of AI/AN population enrolled in Medicaid	33%	32%	33%	32%	35%	N/A*	N/A*	N/A*	N/A*	
EFFICIENCIES										
% of encounters at IHS/638 tribal facilities / non-tribal facilities	19% 81%	19% 81%	20% 80%	17% 83%	16% 84%	N/A*	N/A*	N/A*	N/A*	
* Summing the enrollment across age ranges or disabled/non-disabled will not match the total unique enrollment, as individuals may change age brackets or eligibility program within the SFY, causing them to be counted in two categories. N/A* indicates data not available on a quarterly basis										

STORY BEHIND THE PERFORMANCE

- In 2016, the American Community Survey indicated the population of Native Americans in Wyoming was 20,025 individuals. Native Americans have the highest health disparities in the state. Their average age of death is 58.1 years (2016 data). This is a general increase in average age from 2015, largely due to decreasing infant mortality, but is still 17.3 years less than the rest of the Wyoming population, which is 73.3. Due to these extreme health disparities, the Eastern Shoshone Tribe and the Northern Arapahoe Tribe requested the State of Wyoming, Department of Health, and Medicaid submit an 1115 Demonstration waiver on their behalf. The funds from the Demonstration waiver are to be used to improve the health outcomes of Wyoming's Native American population by increasing service capacity, expanding operating hours, increasing available clinical and specialty staff, and globally improving access to care. An 1115 Demonstration Tribal waiver application was submitted to CMS in December of 2015. To date, no decision has been made by CMS on this 1115 waiver.
- There are 6 facilities that make up the Wind River Reservation health care system. Indian Health Service and Wind River Family & Community Health Care provide primary care services to individuals, including medical, dental, mental health, vision, pharmacy, etc. A third facility, the Eastern Shoshone Tribal Health Clinic, is also starting to provide primary care. There are two substance abuse centers, the White Buffalo Recovery Center and the Eastern Shoshone Recovery Center, a dialysis center, Wind River Dialysis, and a nursing home, Morning Star Care Center. Some of these facilities have branched out to provide additional services such as long term care, transportation, diabetes education, and home health.
- In March of 2017, a State Plan Amendment was approved by CMS. The State Plan Amendment changed the reimbursement methodology for Indian Health Services and 638 Tribal Facilities. The Amendment allows for encounters to be billed for each type of visit and also approved the billing of pharmacy encounters per prescription. The Wind River Dialysis Center will now bill an encounter rate for their services instead of the fee for service rate. Additionally, the IHS encounter rate for primary care and behavioral health services was increased by 10% and 13% respectively due to a survey in the Wyoming Access Review Monitoring Review plan which indicated these services are paid at a higher rate than other states in the region in the fee-for-service model. This increase in the number of encounters able to be billed and the encounter rate may account for some of the increase in the PMPM for AI/AN clients. These changes to the reimbursement methodology have the potential to increase the revenue to the facilities by \$7 to \$8 million annually.
- The State of Wyoming, Wyoming Department of Health, Division of Health Care Financing, has piloted a co-located eligibility staff person at the Wind River Family & Community Health Care facility to provide Medicaid eligibility services for AI/AN clients. This staff person started on August 14, 2017. This individual has been to Cheyenne to receive training in the Wyoming Eligibility System and policies. The individual will be providing assistance to AI/AN clients who are applying for Medicaid. The facilities also have access to a real time eligibility system which allows them to review clients to see if they are eligible for the services they have provided and to have them apply for services if appropriate.
- In February of 2016, a letter was sent by CMS providing guidance on an updated payment policy affecting federal funding for services received by Medicaid Native American clients "received through" Indian Health Service or a tribal health facility. The guidance indicated IHS/tribal facility health providers may choose to enter into a care coordination agreement with non-IHS/tribal providers to furnish certain services to their clients, and the amounts paid to the state for services requested or referred by the tribal facility practitioners in accordance with the agreement would be eligible for the enhanced federal match authorized under section 1905(b) of the ACA at 100%. The state has been working closely with IHS/638 tribal facilities and the top 10 non-HIS and non-tribal facilities in the state (by cost) to implement this new guidance. When implemented it could bring a significant amount of state general funds back into the state of Wyoming.
- An additional waiver has been drafted to include services for AI/AN clients that were discontinued due to the recent budget cuts, including adult dental services and reserve bed days for the nursing home.



Program of All-Inclusive Care for the Elderly (PACE)

Program Description

PACE is a Medicare/Medicaid program for adults age 55 and over living with disabilities. PACE provides and coordinates medical care and long term care services covered by Medicare and Medicaid. PACE providers also have the flexibility to cover additional services not covered by Medicare and Medicaid if recommended by the interdisciplinary team. PACE provides coverage of prescription drugs, doctor care, transportation, personal care, day services, check-ups, hospital visits, and nursing home stays.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost¹	\$2,261,896	\$2,942,611	\$3,496,684
People Served	97	121	141
Cost per Person	\$23,319	\$24,319	\$24,799
Non-600 Series*	3.9%	3.9%	3.9%

¹ Expenditures are by service date.

* 600 series is defined as direct service contracts.

Program Cost Notes

- 50% General Fund and 50% Federal Funds.
- All-inclusive PMPM
 - \$2,470.66 Medicaid/Medicare clients
 - \$3,798.17 Medicaid-only clients

Program Staffing

- 1 FTE allocated from 3 full-time employees
- 0 AWEC
- 0 Other

Program Metrics

- 141 unique recipients in SFY 2017 with 128 enrolled on 6/30/17
- 1 participant is private pay
- 1 provider is enrolled to provide services as of 6/30/17

Events that have Shaped this Program

- Wyoming Statute (W.S. 42-4-121) Program of All-Inclusive Care for the Elderly (PACE) was passed in the Sixtieth Legislature of the State of Wyoming 2010 Budget Session.
- By CMS Regulation and W.S. 42-4-121 the capitation rate (premium) shall be no less than ninety percent (90%) of the fee for services equivalent cost, this includes the department's cost of administration which the department has estimated would be payable for all services covered under the PACE organization contract if all of those services were to be provided on a fee-for-service basis.
- The program began February 1, 2013. The only provider is located in Cheyenne.



Program of All-Inclusive Care for the Elderly (PACE)

PROGRAM CORE PURPOSE

PACE coordinates medical and long-term care services (including home-based, day center, and medical services) for eligible individuals in order to provide quality, cost-effective care for Medicaid/Medicare recipients 55 years of age and older who require services equivalent to nursing home level of care.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of participants receiving services based on assessed and interdisciplinary team identified needs as monitored by CMS/State Audits*	100%	100%	100%	100%	100%	100%	100%**
% of participants discharging from the program and enrolling in other Medicaid programs (Community Choices waiver)	<6%	<6%	0%	3%	5%	1%	3%
% of participants discharging due to client choice to leave program	< 5%	< 5%	0%	4%	1%	0%	5%

* CMS performed annual audits SFY 2013 thru SFY 2016, with audits being every other year following.
 ** SFY 2017 audit was a random review of participants by WDH staff
 (-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of unique participants*	22	64	86	112	128	N/A*	N/A*	N/A*	N/A*
# of Medicare/Medicaid participants	21	59	80	102	124	N/A*	N/A*	N/A*	N/A*
# of Medicaid-only participants	1	5	5	8	3	N/A*	N/A*	N/A*	N/A*
# of Private Pay participants	0	0	1	2	1	N/A*	N/A*	N/A*	N/A*
# of unsatisfied participant calls	0	1	6	0	0	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
# of participants admitted to hospital	20	45	58	39	60	N/A*	N/A*	N/A*	N/A*
# of participants admitted to nursing home (Short-Term / Long-Term)	9 / 2	18 / 2	13 / 7	14 / 6	22 / 4	N/A*	N/A*	N/A*	N/A*
PACE PMPM as % of Nursing Home PMPM	66%	67%	66%	56%	56%	N/A*	N/A*	N/A*	N/A*

* Count based on PACE provider point-in-time data as of 6/30/17
 (-) 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

- This program started February 1, 2013 in Cheyenne with Cheyenne Regional Medical Center as the PACE provider and five (5) participants.
- PACE has exceeded the initial estimates of sixteen (16) participants the first year and forty (40) participants for the second year.
- The PACE provider expanded their facility/program at their current location in December, 2014 as they were nearing capacity for their facility. The provider has also started remodeling a building as a new facility in order to expand their program as they are nearing capacity for their current facility.



Patient Centered Medical Home (PCMH)

Program Description

The PCMH Program is a value-based purchasing model that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. The program promotes improved primary care processes and health outcomes so care meets national standards and avoids preventable events.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$59,256	\$500,907	\$840,927
People Served	2,615	12,221	20,076
Cost per Person (PMPM)	\$3	\$6*	\$6
Administrative Cost	\$25,000	\$100,000	\$100,000

* PMPM was increased from \$3 to \$6 starting in SFY 2016 Quarter 3.

Program Cost Notes

- PCMH is funded with 50% Federal and 50% State General Funds
- Administrative cost for the program is an estimated \$100,000 annually.

Program Staffing

- 1 FTE divided among a team of 7 individuals
- 0 AWEC
- Other: Contractor, Health Tech Solutions

Program Metrics

- 18 practices are eligible to participate in the PCMH program; however, only 11 currently do so.
- These practices have 365 days to bill a clean claim and be paid for the PMPM, which has caused a lag in accurate billing data.
- Some practice have not billed for all clients they could receive reimbursement for and some are now past the timely filing limit.
- The goal of the program is to improve the quality of care which is monitored through the reporting of core quality measures (CQMs). The average quarterly change is calculated using only data from practices who have been participating in the program for at least two years to ensure the practices have adequate time to see improvements in the measures.

Events that have Shaped this Program

- As part of Medicaid Reform, a State Plan Amendment on Primary Care Medical Homes was approved by CMS in September 2014.
- The PCMH program launched January 1, 2015 with 3 early adopter practices.
- The PMPM has gone from \$3.00 in 2015 to \$6.00 in 2016.



Patient Centered Medical Home (PCMH)

PROGRAM CORE PURPOSE

The PCMH program promotes high value care for the citizens of Wyoming using a care delivery model in which patient treatment is coordinated through their primary care physician/practitioner. The PCMH model increases office visits while decreasing more expensive hospital utilization.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of eligible practices participating	63%	70%	N/A	N/A	21%	43%	65%
% of clients treated by multiple PCMHs	6%	9%	N/A	N/A	0.1%	4%	7%
% of PCMH-eligible clients unclaimed by the practice	15%	10%	N/A	N/A	25%	12%	37%
% of enrolled clients served by a PCMH	25%	28%	N/A	N/A	3%	14%	24%
Average percent on clinical quality measures (CQMs) for all participating clinics:							
1) Breast Cancer	33%	41%	42%	38%	44%	44%	46%
2) Childhood Immunization	31%	40%	42%	38%	42%	42%	41%
3) Diabetes Hemoglobin**	27%	31%	40%	29%	33%	38%	36%
4) Controlling High Blood Pressure	65%	70%	68%	66%	74%	73%	73%
5) Colorectal Cancer	32%	34%	42%	34%	33%	35%	32%
* Practices must have been a participating PCMH for at least two years to be included in this metric calculation to ensure adequate time to see improvements in quality.							
** This measure should decrease overtime to show improvement							
N/A indicates data not available due to creation of new metric or re-definition of metric methodology							

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of practices participating	N/A	N/A	3	5	11	4	5	8	11
# of practitioners	N/A	N/A	20	36	130	18	36	80	130
# of unique clients served by PCMHs	N/A	N/A	2,615	12,221	20,076	8,130	11,550	14,549	18,450
# of client claims & # of qualifying client claims that could be billed	N/A	N/A	11,454 2,918	80,668 9,696	123,622 45,856	26,502 3,820	54,166 5,876	69,605 6,045	54,017 39,811
total expenditures outstanding due to unclaimed clients	N/A	N/A	\$8,754	\$29,088	\$257,001	\$11,460	\$17,628	\$18,135	\$238,866
EFFICIENCIES									
# of site surveys completed	0	0	8	0	0	2	4	6	2
# of participating practices pulling continuum of care documents (CCDs) & total # of CCD views	3 N/A	5 5,901	11 13,830	4 1,784	5 4,117	7 2,076	8 2,041	8 4,117	11 9,795
# of NCQA recognized clinics & # in process	16 0	16 2	17 3	16 2	16 2	16 2	16 2	16 2	17 3
** This measure should decrease overtime to show improvement 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

- Providers must meet the following qualifications to participate in the PCMH program:
 - Must be National Committee for Quality Assurance (NCQA), Joint Commission, or URAC recognized or in-process and following the guidelines of these recognitions
 - Must submit clinical quality measures (CQMs) for each month
 - Must Pull Continuum of Care Documents each month on clients that they are seeing (prior to the visit is the goal)
- Originally 29 practices were interested in becoming recognized as a PCMH. Many practices have since dissolved, or been acquired by larger practices. Currently, an additional 7 practices could potentially join the program.
- Providers have access to the PCMH dashboard, allowing them to monitor their performance and identify areas of improvement.
- The program has aligned the 10 CQMs with those for Meaningful Use (MU) to avoid any unnecessary burden to participants' time and the cost of creating reports.
- The Per Member Per Month (PMPM) rate paid to practices was raised from \$3 to \$6 on January 1, 2016.



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 with income up to 200% of the federal poverty level, who lack adequate prescription coverage, while reducing medication waste.

Program Expenditures and People Served

	CY 2015	CY 2016	CY 2017 (Jan-June)
Total Program Cost	\$252,452	\$340,132	\$149,405
People Served¹	2,948	2,967	2,249
Cost per Person	\$86	\$114	\$66
Non-600 Series*	92%	100%	100%

* 600 series is defined as direct service contracts; each program should be prepared to defend how it chooses to report these dollars.

¹ Number of people served 2012-2014 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 Source:
Grants: 2014-9%, 2015-13%, 2016/2017-0%
- Return on Investment (Value of Rx’s dispensed*/program cost):
 - 2014- ROI \$6.09
 - 2015- ROI \$10.77
 - 2016- \$6.92
 - 2017 (Jan-June)- \$9.39

Program Staffing

- (0.75 FTE pharmacist, Fill-in pharmacist up to 0.25 FTE as needed, 1 FTE pharmacy technician)
- Other: 0.75 FTE contracted pharmacy technician & Volunteers
 - 2015- 368 hours
 - 2016- 390
 - 2017- 195

Program Metrics

- Improving Prescription Access: number of prescriptions filled / number of 30 day fills, 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 2012-2015.
- In January 2015 resources became available to purchase needed medications to fill in the gaps of donated inventory via the Cheyenne Regional Medical Center, Dispensary of Hope, and a Block Grant.



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 2016 Target	CY 2017 Target	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017 (Jan-June)
Total patients served by re-dispensed medication ¹	>1,500	>1,500	1,704	1,558	2,948	2,967	2,249
Total value of re-dispensed prescriptions ^{1,2}	\$1,500,000	\$1,500,000	\$1,264,842	\$1,765,148	\$2,718,536	\$2,353,926	\$1,402,241
Patient medication compliance rate on mailed prescriptions	>85%	>85%	59%	62%	86%	88.77%	88.6%
Return on Investment (ROI) to communities (value of Rx's dispensed ² / program cost)	> \$5.00	> \$5.00	\$4.73	\$6.09	\$10.77	\$6.92	\$9.39

(-) 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 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 health care industry.

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017 (Jan-June)	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of prescriptions filled using re-dispensed medication ¹	20,404	17,115	22,341	24,641	14,011	N/A*	N/A*	N/A*	N/A*
# prescriptions mailed & value of Rx Mailed ¹	1,255 \$165,603	2,959 \$510,022	6,215 \$1,101,064	9,583 \$1,403,106	6,339 \$1,017,001	N/A*	N/A*	N/A*	N/A*
Pounds / AWP value of medication donated	13,410 \$2,409,988	12,902 \$3,198,712	15,948 \$3,274,153	14,675 \$3,132,899	8,593 \$2,252,615	N/A*	N/A*	N/A*	N/A*
# of donation sites ²	17	25	28	28	33	N/A*	N/A*	N/A*	N/A*
Pounds of unacceptable medication properly disposed	3,161	3,167	4,101	3,614	1,870	N/A*	N/A*	N/A*	N/A*

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

EFFICIENCIES

Performance Metric	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017 (Jan-June)	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
Average program cost per prescription dispensed ³	\$13.09	\$16.93	\$11.30	\$13.80	\$10.66	N/A*	N/A*	N/A*	N/A*
Average AWP value per prescription dispensed	\$61.99	\$103.13	\$121.68	\$95.53	\$100.08	N/A*	N/A*	N/A*	N/A*
Donation usage rate (\$ dispensed/ \$ donated)	52.5%	55%	83%	75%	62%	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

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.

² 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.

³ 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.

STORY BEHIND THE PERFORMANCE

- 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 allowed us to fill a prescription even though the medication had not been donated in sufficient quantity. This was key to improving the patient medication compliance rate. This funding expired June 30, 2015 and the drugs ran out early in 2017.
- In September of 2015, Block Grant funds were used to purchase needed mental health medications. These drugs ran out in early 2017.
- July 2015, medications available via the Dispensary of Hope. First 12 month subscription fee was \$7,500. Value dispensed in the first 12 months was \$208,609 AWP (\$26.81 ROI). Second year and beyond, subscription fee will be \$12,500. 2nd year value \$783,652 AWP (\$61.69 ROI).
- 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 statewide. 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) closed.
- In July of 2017 the program started filling 90 day supply prescriptions on select formulary medications from the Dispensary of Hope and donations.



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 2017 Wyoming had 34 enrolled in-state SN's and 3 enrolled in-state NFs. There are also two Transitional Care Units in Wyoming.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost*	\$70,354,260	\$82,425,487	\$88,272,125
People Served	2,357	2,451	2,587
Cost per Person	\$29,849	\$33,629	\$34,121
Non-600 Series**	0.3%	0.6%	0.6%
Total Provider Tax Paid	\$30,438,174	\$29,379,786	\$30,551,874

*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 the rate model; WRC is paid 100% of their audited costs and Morning Star is paid a fixed IHS rate.
- Extraordinary Care Clients have severe conditions that require a special negotiated rate; there are currently 8 cases.
- The 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 in Wyoming, 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 five (5) 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 of 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 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 \$1.7 million to NH providers for FFY16, per the remaining upper payment limit (UPL) gap for each.



Medicaid: Nursing Homes

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	
% and # of Nursing Homes achieving at least 95% cost coverage reimbursement with upper payment limit (UPL)	>50%	>50%	N/A	27% (10/37)	57% (20/35)	49% (17/35)	46% (16/35)	
Average Medicaid Patient Acuity Score	>0.86	>0.89	0.92	0.90	0.87	0.86	0.89	
Cost coverage weighted average history (including provider assessments)	85-100%	85-100%	89%	87%	83%	91%	91%	
Utilization Rate per 1,000 Member Months	Emergency room	<5	<5	2.2	2.4	3.4	4.6	4.2
	Inpatient admissions	<5	<5	2.5	1.9	2.3	3.7	3.3
% of Wyoming Nursing Homes that accept Medicaid residents	100%	100%	100%	100%	100%	100%	100%	

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
% and # of Wyoming Medicaid recipients served in a NH/swing bed	3% (2,445)	3% (2,387)	3% (2,357)	3% (2,451)	3% (2,587)	1,939	2,066	2,080	2,117
Total Cost for Extraordinary Care Clients (% of Total NH Costs)	\$873,421 (1%)	\$1,436,290 (2%)	\$1,470,960 (2%)	\$1,481,129 (2%)	\$1,221,211 (1%)	\$607,226	\$873,903	\$635,351	\$585,860
Member Months of NH Program Enrollment	20,232	20,092	19,667	20,255	20,807	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per Recipient / Per Member Per Month (PMPM)*	\$30,100 \$3,805	\$30,527 \$3,738	\$29,849 \$3,763	\$33,629 \$4,347	\$34,121 \$4,285	\$20,069 N/A*	\$21,061 N/A*	\$21,055 N/A*	\$21,010 N/A*
Average Length of Stay (months)**	8.5	8.8	8.3	8.3	8	N/A*	N/A*	N/A*	N/A*
# and % of Nursing Home Bed Days Paid by Medicaid (based on FFY)	537,013 61%	547,206 61%	529,319 62%	502,155 60%	544,141 64%	N/A*	N/A*	N/A*	N/A*
* Excludes UPL payments									
**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 individuals with a mental illness or mental retardations, Congress, via the Nursing Home Reform Act of 1987 mandated that 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 insured by Medicare as the primary insurer to full maximum allowable days using Resource Utilization Group (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 community choices 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, rate, and other Medicaid issues and decision-making.



Medicaid Behavioral Health (BH) Services

Program Description

The 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

	2015	2016	2017
Total Program Cost	\$35,143,911	\$36,205,842	\$32,062,769
People Served	14,713	15,466	16,263
Cost per Person	\$2,389	\$2,341	\$1,972
Non-600 Series*	N/A	N/A	N/A

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY 17 FMAP=50%
- SFY 17 Behavioral Health services account for 5.5% 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 (\$5,178,447), which accounted for 16% of total SFY17 BH program expenditures.
 - Adjustment Disorder was the second diagnosis by expenditure (\$3,067,611, 9.5%).
 - Post-Traumatic Stress Disorder was the third diagnosis by expenditure (\$2,682,487, 8%).

Events that have Shaped this Program

- The Medicaid Behavioral Health Services program utilizes the federal authority granted by the Centers for Medicare & Medicaid Services 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 includes 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.
- January 1, 2017, Medicaid clients 21 years of age and older are subject to requirements for authorization of medical necessity when dates of service exceed a certain number of behavioral health visits.



Medicaid Behavioral Health (BH) Services

PROGRAM CORE PURPOSE

The 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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of Licensed Mental Health Professionals and Provisional Mental Health professionals that are enrolled with Medicaid to maintain adequate access to community-based care (Senate Enrolled Act 49 & 21)	65% 1,015	75% 1,170	N/A	N/A	66% 1,050/ 1,603	72% 1,153/ 1,605	70% 1,097/ 1,558
Adult Intellectual Disabilities (ID) waiver client psychological service cost per recipient	<\$5,000	<\$4,000	\$5,088	\$5,840	\$7,668	\$10,010	\$4,711
Average mental health visits per adult	20*	17	N/A	N/A	N/A	23	19
% of adults receiving <20 visits	70%	80%	N/A	N/A	N/A	69% (4,314)	70.3% (4,087)
% of adults receiving >20 visits	30%	20%				31% (1,937)	29.7% (1,723)
Total annual spent on all children with autism spectrum disorder (ASD) receiving Applied Behavior Analysis (ABA) Treatment	N/A	\$200,000	N/A	N/A	N/A	N/A	\$5,887

* Target adjusted due to implementation of a new service cap of 20 visits per year beginning January 1st, 2017
 (-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of BH recipients	13,101	13,838	14,713	15,466	16,263	N/A*	N/A*	N/A*	N/A*
% of total Medicaid enrolled clients who received a BH service	15%	16%	16.5%	17.4%	19%	N/A*	N/A*	N/A*	N/A*
% of total Medicaid expenditures for BH services	6%	6%	7%	6.5%	5.5%	N/A*	N/A*	N/A*	N/A*
Per Member Per Month for BH services	\$35.20	\$37.34	\$35.41	\$42.01	\$36.79	N/A*	N/A*	N/A*	N/A*
# of Adult ID waiver recipients who received a BH service	525	537	555	541	411	N/A*	N/A*	N/A*	N/A*
# of Children with a diagnosis of Autism Spectrum Disorder (ASD)	N/A*	N/A*	488	516	535	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
in-state BH providers	1,642	1,705	1,754	2,015	1,990	N/A*	N/A*	N/A*	N/A*
out-of-state BH providers	394	433	506	675	428	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	49%	44%	42%	34%	35%	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 SFY 2017 goal of enrolling a minimum of 65% licensed mental health professionals and provisional mental health professionals was met. The enrollment for Wyoming Medicaid Behavioral Health providers is currently at 70% or 1,097 providers. Legislation in SFY 2014 and 2015 allowed licensed mental health professionals and provisional mental health professionals to enroll with Medicaid and to bill for those services.
- Starting January, 1, 2017, the federal mandate stating that Medicaid programs must provide medically necessary diagnostic and treatment services to beneficiaries with Autism Spectrum Disorder (ASD) was implemented.
- The Medicaid Behavioral Health Manager launched an initiative in SFY 2012 to reduce inappropriate behavioral health services provided to Comprehensive/Supports Waiver recipients. There has been a significant decrease in cost per recipient receiving psychological services in SFY 2017.
- Rehabilitative services will be limited to twenty (20) visits a year, unless additional services are determined to be medically necessary and rehabilitative. The policy was effective January 1, 2017.
- Beginning November 1, 2017, Qualis Health will provide Medicaid Behavioral Health Services with review of medical necessity and rehabilitative services for clients over the age of 21 years and that have exceeded the 20 dates of service limit.



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 clients. At the same time, the program strives to maximize cost savings for the state through manufacturer drug rebates, the preferred drug list, and sound reimbursement methodology.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost (Before Rebate)	\$51,917,136	\$50,905,606	\$52,229,638
Total Program Cost (Net of Rebate)	\$28,956,198	\$19,504,067	\$24,516,145
People Served	47,696	44,333	44,291
Cost per Person	\$1,088	\$1,148	\$1,179

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.
- The first row of data reflects reimbursement to pharmacies for outpatient drug claims.
- The second row of data reflects the program cost once drug rebates are collected. This number is derived by subtracting rebate collected during the given fiscal year from the pharmacy reimbursement figure in the first row.

Program Staffing

- 3.5 FTE
- 0 AWEC
- Contractors: Pharmacy Benefits Manager (Change Healthcare) & Drug Utilization Review (University of Wyoming School of Pharmacy)

Program Metrics

- All Medicaid enrollees are eligible for pharmacy coverage. Approximately 67% of enrollees used the pharmacy benefit in SFY 2016, while approximately 52% used the pharmacy benefit in SFY 2017.
- Pharmacy expenditures were approximately 9.0% of total expenditures in SFY 2106 and 9.4% of total expenditures in SFY 2017.

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, CMS released the Final Covered Outpatient Drug Rule stipulating that states reimburse pharmacies for most drugs using a formula that combines drug acquisition cost and a professional dispensing fee. The Medicaid pharmacy program complied with the final rule by implementing a new reimbursement structure on April 1, 2017. The state plan amendment for this change is in the final stages of CMS review.
- An increase in the utilization of very costly specialty drugs and first in class blockbuster drugs, as well as increased costs of generic drugs has contributed to the increased “Cost Per Person” in past years in the pharmacy program.



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 medication dispensed to Medicaid enrollees and to encourage safe prescribing habits by Medicaid Providers.¹

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Short Term Outcomes – Cost Effective Coverage							
Savings generated by Preferred Drug List and Prior Authorization ^a	\$9,009,708	\$11,000,662*	\$7,091,467	\$7,844,047	\$8,894,753	\$9,821,265	\$10,476,821
State Maximum Allowable Cost Savings	\$12,000,000	\$13,000,000	\$16,937,324	\$14,359,484	\$15,085,685	\$17,045,765	\$16,501,851
Intermediate Outcome – Clinically Sound Treatment							
% and # of Prior Authorizations approved	50-60%	40-50%	56.7% 3,994/ 7,038	55.2% 4,693/ 8,507	47.7% 4,520/ 9,471	45.7% 4,783/ 10,472	40.8% 4,479/ 10,969
% and # of prescriptions changed due to Drug Utilization Review (DUR) edits	20-30%	15-20%	26.2% 12,236/ 46,733	19.5% 9,468/ 48,508	17.5% 8,572/ 49,055	16.7% 7,230/ 43,277	16.6% 7,236/ 43,498

* 5% increase over actual SFY 2017 figure

(-) Indicates data not yet available

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

¹The 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).

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of clients served	50,783	47,166	47,696	44,333	44,291	32,020	34,035	31,836	34,063
# of prescriptions paid	588,808	571,568	578,236	542,427	523,104	264,770	277,657	255,520	267,584
Average # of prescriptions per client per month	2.78	2.84	2.89	2.88	2.87	2.9	2.86	2.9	2.84
# of medication classes managed on the Preferred Drug List (PDL)	108	119	123	123	136	N/A*	N/A*	N/A*	N/A*
# of claims recovered on by Program Integrity	1,997 ^b	375	409	210	302	56	154	132	170
EFFICIENCIES									
Supplemental Rebate Savings (Contract cost is \$13,000 per year) [State Portion]	\$1,080,980 [\$540,490]	\$1,778,267 [\$889,134]	\$1,396,316 [\$698,158]	\$1,442,741 [\$721,371]	\$1,855,317 [\$927,659]	\$805,110	\$637,631	\$869,301	\$986,016
Total \$ recovered through Program Integrity efforts ^c	\$108,026	\$239,247	\$380,732	\$80,263	\$125,153	\$52,006	\$28,257	\$109,208	\$15,945
Program Integrity Cost Avoidance ^d	\$41,748	\$56,765	\$57,597	\$327,818	\$317,320	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

- 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 (which prohibited pharmacies from resubmitting unchanged and incorrect claims that Medicaid had already recovered).



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) and who meet medical necessity for a PRTF level of care.

Program Expenditures and People Served

	SFY2015	SFY2016	SFY2017
Total Program Cost*	\$13,898,099	\$11,758,859	\$12,391,507
People Served	348	305	299
Cost per Person	\$39,937	\$38,554	\$41,443
Non-600 Series**	N/A	N/A	N/A

* Medicaid & State General Fund costs & clients combined

** 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

- Medicaid youth are funded by 50% federal funds, 50% general funds. Non-Medicaid youth are 100% state general funded.
- Medicaid costs
 - SFY17- \$12,366,081
 - SFY16- \$11,719,350
- SGF-only costs
 - SFY 17 - \$25,426
 - SFY 16- \$39,509
 - SFY15- \$322,252

Program Staffing

- 0.25 FTE
- 0 AWEC
- Other: Contractor, WYhealth

Program Metrics

- Number of unique clients served in SFY 2017: 297 Medicaid-funded, 2 state general funds
- Number of PRTFs currently enrolled: 2 in-state, 14 out-of-state
- The average length of stay in SFY17 was 123 days

Events that have Shaped this Program

- Enrolled Act No. 57, House of Representatives, became effective July 1, 2013. This specifies that any court 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.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of PRTF placements with a previous PRTF admit	30%	50%	30% (97/319)	36% (121/336)	55% (184/334)	63% (188/300)	61% (180/297)
Average length of stay (days)	120	120	123	147	130	131	123
% and # of recipients with a length of stay exceeding 6 months	20%	20%	25% (81/319)	30% (100/336)	30% (99/334)	30% (89/300)	26% (76/297)
# of new PRTF admits	150	150	244	224	200	176	195

All data is based on Medicaid Chart A client information

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4	
OUTPUTS										
# of Onsite Compliance Reviews (OSCR) visits completed	N/A	N/A	N/A	8	6	N/A	N/A	3	3	
# of recipients	Medicaid	319	336	334	300	297	203	216	198	224
	SGF	115	22	14	5	2	N/A*	N/A*	N/A*	N/A*
# of placements	In-State	153	143	165	186	190	15	123	120	144
	Out-of-State	189	159	194	131	118	95	98	79	87
# of Medicaid covered/paid days	41,102	50,352	44,558	38,807	39,124	19,748	19,059	16,824	22,300	
# of PRTF continued stay reviews completed	2,537**	2,287**	1,826**	N/A	1,671***	938**	888**	N/A*	N/A*	
EFFICIENCIES										
% of PRTF placements In-State / Out-of-State	48% 59%	43% 47%	49% 58%	62% 44%	64% 40%	57% 47%	57% 45%	61% 40%	64% 39%	
Average cost per client	\$37,777	\$44,364	\$40,646	\$39,065	\$41,637	\$29,398	\$26,627	\$26,238	\$32,013	

N/A* indicates data not available on a quarterly basis
 * Partial year starting May 2013
 ** From CQS WYhealth Quarterly Reports based on CY
 *** From Optum WYhealth data Feb-June 2017

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 Joint 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 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 have been or will be visited by the OSCR team.
 - Average OSCR Score- Year 1 = 2.89
 - Average OSCR Score- Year 2 = 2.87
 - 5 OSCRs planned for SFY18



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

	2015	2016	2017
Total Program Cost	\$14,473,863	\$15,663,152	\$14,363,119
People Served	30,679	32,446	31,295
Cost per Person	\$472	\$485	\$451
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Dental expenditures were 3% of the total Medicaid expenditures for SFY 2017
- Budget reductions to the adult dental benefit are proposed to reduce overall dental expenditures by \$3.5M over the biennium.
- Correction of Severe Malocclusions account for \$488,047 of dental expenditures in SFY17.

Program Staffing

- 0.75 FTE: Program Manager
- 0 AWEC
- 1 Other: Orthodontic Consultant

Program Metrics

- Wyoming continues to attract new dentists with student loan repayment programs and an abundance of dental practices for sale by retiring dentists. Medicaid has enrolled more than 20 newly licensed dentists in SFY 2017 and continues to rank in the top 5 states in the nation in provider participation.*
- With the reductions to the adult dental benefit in 2016, close monitoring of emergency room visits and tooth extractions will be imperative to ensure that costs are not rising in other areas due to the elimination of the restorative and tooth replacement benefit.

*American Dental Association, Health Policy Institute Report on Dentists Participation in Medicaid 2017

Events that have Shaped this Program

- Support from Dental Advisory Group (DAG) members has continued to ensure that the Wyoming dental program stays consistent with industry standards on dental policies.
- The Wyoming Medicaid dental program has participated with the inception of a Wyoming Oral Health Coalition and hopes to work in collaboration with stakeholders to address the unmet needs of the dental community in Wyoming.
- During the summer of 2017, provider workshops were held throughout Wyoming to educate and train dental providers on accurate billing policies for Medicaid.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of practicing, licensed Wyoming dentists enrolled as a Medicaid provider	>85%	>85%	N/A	215/283 76%	232/295 78%	243/307 79%	251/319 79%
% and # of Medicaid children that received a dental cleaning (0-20 years)	39%	>50%	34% 20,506/ 59,822	38% 20,856/ 54,417	39% 21,578/ 55,589	42% 21,779/ 51,282	40% 21,433/ 54,049
% and # of children who received a dental cleaning then taken to the hospital/ambulatory surgical center for dental work (0-20 years)	<1000	<5%	6.3% 1,300/ 20,856	6.5% 1,344/ 20,856	6.3% 1,361/ 21,578	5.9% 1,291/ 21,779	5.8% 1,247/ 21,433
% and # of Medicaid teenagers that received a preventive visit	N/A	>50%	N/A	N/A	N/A	36% 5,949/ 16,308	38% 5,922/ 15,397
% and # of nursing home clients seen for a dental visit	23%	>20%	13% 334/ 2,523	17% 426/ 2,453	16% 398/ 2,490	21% 446/ 2,140	17% 402/ 2,433

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
% and # of unique children served (any dental service)	40% 23,969/ 59,822	45% 24,311/ 54,417	45% 24,929/ 55,589	48% 25,371/ 51,282	46% 24,944/ 54,049	N/A*	N/A*	N/A*	N/A*
# of unique adults served (any dental service)	17% 5,245/ 31,426	16% 5,395/ 33,450	16% 6,052/ 37,283	22% 7,075/ 32,171	20% 6,351/ 31,252	N/A*	N/A*	N/A*	N/A*
# of tooth extractions - Adults	1030	1201	1346	1599	1421	773	826	769	652
# of ER visit with dental diagnosis codes – Adults	N/A	N/A	N/A	485	544	167	318	277	267
% and # of orthodontic applications approved	28% 103/373	31% 95/310	32% 128/397	48% 223/461	42% 208/499	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Total Dental Expenditures	\$13.5M	\$13.7M	\$14.4M	\$15.6M	\$14.3M	N/A	N/A	\$7.95M	\$6.42M
Adult Dental Expenditures	\$3.23M	\$3.17M	\$3.77M	\$4.35M	\$3.16M	\$1,228,646	\$1,050,138	\$455,037	\$423,285
Per Member Per Month	\$15.92	\$15.93	\$16.02	\$18.80	\$17.74	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

- By enrolling new dental graduates each year Wyoming Medicaid can continue to increase provider participation (79%), currently one of the highest in the nation to ensure access to dental services for Medicaid clients. The national average for dental provider participation in Medicaid is 40-50%.
- Of the 51 newly licensed dentists in SFY 2017, 27 are in-state providers who are joining existing dental practices or opening new ones; 20 of the 27 have enrolled with Wyoming Medicaid.
- In order to address the unmet dental needs of Wyoming's teenage population, the dental program along with the Dental Advisory Group (DAG) is developing a campaign to be introduced into public health departments and high schools throughout Wyoming. This campaign will be to promote and remind teens to attend regular dental visits.
- Dental providers continue to reduce the number of children that are treated under general anesthesia in a hospital/ambulatory surgical center setting by attempting dental services in their offices using nitrous oxide and other behavior management codes that are covered by Medicaid.
- With the reductions to the adult dental benefit in 2016, close monitoring of emergency room visits and tooth extractions will be imperative to ensure that costs are not rising in other areas due to the elimination of the restorative and tooth replacement benefit.
- The Severe Malocclusion program continues to reach more children every year. Due to orthodontists screening all potential clients for malocclusion that affect function, Medicaid clients are receiving the orthodontic treatment they need at earlier ages which will result in less treatment time for the clients and less cost to the program.



Eligibility & Customer Service Call Center

Program Description

The Wyoming Department of Health Customer Service Center determines eligibility for Modified Adjusted Gross Income (MAGI) groups, including Medicaid children, low-income adult caretaker relatives, pregnant women, and KidCare CHIP, as well as Medicare Saving Programs, Supplemental Security Income (SSI), SSI related 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.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	N/A	\$5,491,115.31	\$4,870,905.81
People Served	N/A	45,004	54,783
Cost per Person	N/A	\$122.01	\$88.91
Non-600 Series*	N/A	100%	100%

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

* 600 series is defined as direct service contracts.

Program Cost Notes

- 75% Federal match on the cost of staffing the Customer Service Center as well as State staff
- Current monthly Customer Service Center Operations Cost \$369,031.67.
- Maximus can qualify for a monthly incentive payment of up to 7% of the monthly invoice amount if they meet all SLAs and exceed the SLA criteria in five high-priority areas.
- FFY 2017 includes 9 months of the Maximus Operations costs and three months of the Northrop Grumman (NG) Operations costs.
- Under the NG contract, the WDH was responsible for paying rent, as well as the cost of postage and mailing supplies, telephone lines, and temporary staff, none of which are included in the Maximus contract.

Program Staffing

- 0.75 FTE
- 40 Other (contractor, Maximus)

Program Metrics

- Average total call volume: 11,082 per month from July 1, 2016, through June 30, 2017, with July 2016 being the highest month at 13,850 calls.
- Average speed to answer in July 2016 was 12.34 minutes and had decreased to 2.1 minutes in June 2017.
- Average application processing time in June of 2017 was 13 days and has been as low as 1 day in previous months.

Events that have Shaped this Program

- Staffing under Northrop Grumman averaged 40 FTE per month when the contract ended on September 30, 2016.
- Maximus took over CSC Operations on October 1, 2016 and also averages 40 FTE per month.



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 timely, and provides excellent customer service.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Average Speed to Answer (Minutes)	<10	<10	N/A	N/A	22.54	10.90	9.8*
Client Satisfaction Survey Results (1 to 5, with 5 Being Most Satisfactory).	>4.6	>4.6	N/A	N/A	4	4.52	3.8** 4.8**
Average Processing Time for New Application (days)	<10	<10	N/A	N/A	15.5*** (July 2015)	6.5*** (June 2016)	13*** (June 2017)

N/A indicates data not available due to creation of new metric or re-definition of metric methodology.

* Customers who are unable to wait or do not wish to wait to speak with a Customer Service Representative have the option to leave a message and receive a call back within 24 hours or to use the automated call back system, which holds their place in the queue and calls customers back when it is their turn.

**Actual for SFY 2017 is 3.8, which includes transition (Northrop Grumman scores) and initial months of Maximus contract. Since April, the average score under the new contractor has risen to 4.8.

***The Federal application processing guideline is 45 days. The contract service level agreement is 30 days.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# processed of: New Applications (A) Renewals (R) Total (T)	N/A	N/A	8,883 A 10,740 R 19,623* T	22,591 A 22,413 R 45,004 T	23,281 A 31,502 R 54,783 T	11,117 A 10,998 R 22,115 T	11,474 A 11,415 R 22,889 T	12,142 A 15,256 R 27,398 T	11,139 A 16,246 R 27,385 T
Total Call Volume	N/A	N/A	108,965**	140,769	134,015	71,189	69,580	69,802	64,213
EFFICIENCIES									
Average Handle Time (minutes)	N/A	N/A	11.1	12.65	14.15	12.7	12.6	15	13.3
# of Abandoned Calls / Abandonment Rate	N/A	N/A	40,317 37%	33,785 24%	30,689 22.9%	21,357 30%	12,344 18%	23,384 33.5%	7,834 12.2%***

* Partial numbers reported in SFY 2015

** Only inbound calls were reported in SFY 2015

*** The abandonment rate has not been above 6% on average, per week, since the week of March 19,2017

STORY BEHIND THE PERFORMANCE

- The Wyoming Department of Health Customer Service Center (CSC) opened on October 1, 2013.
- 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 twenty-nine (29) DFS field offices to a centralized Medicaid eligibility processing system (the CSC) to promote consistent policy decisions.
- On July 1, 2016, Deloitte Consulting LLP and Maximus Health Services Inc. began a three month transitional 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 first six months of Maximus Operations showed a dip in service level agreement metrics as the new vendor set up operations, trained staff, and learned the expectations of the Department of Health. Since this six month period, the Customer Service Center metrics have greatly improved.
- Eligibility rules for the Medicaid and KidCare 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 95% functional as of June 30, 2016, but much of the missing functionality is what is needed to determine eligibility in a truly no-touch manner.
- Both vendors completely took over operations on October 1, 2016. The WES/CSC Contract Manager is currently closely monitoring both vendors to verify that deliverables are of high quality and all service level agreements are met or exceeded.
- Both vendors work in collaboration by attending joint Change Control Board (CCB) meetings as well as creating and sharing training documents when system changes or updates affect case processing.
- State staff participate in the training of new CSC employees by presenting information on each of the Medicaid programs as well as reviewing all training materials before they are approved for use.



Medicaid Long Term Care Eligibility Unit

Program Description

The Medicaid Long Term Care Eligibility Unit determines financial eligibility for the Community Choice Waiver, Comprehensive Waiver, Support Waiver, Acquired Brain Injury Waiver, Children’s Mental Health Waiver, PACE, Nursing Homes, Inpatient Hospitals, and Hospices. Applications and renewals are taken via telephone, online, fax, email, walk-ins, and mailed hard copies.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$1,229,594	\$1,502,949	\$1,701,398
People Served	5,966	6,376	6,578
Cost per Person	\$206.10	\$235.72	\$258.65
Non-600 Series*	100%	100%	100%

* 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 has increased from SFY 2015 to SFY 2017.
- Average monthly caseload per worker decreased from SFY 2016 to SFY 2017 due to the addition of two positions to the unit (increase from 14 to 16 FTE).
- Average application processing time for approvals is 16.70 days and for denials is 18.13 days.
- Average processing time for renewal approvals is 2.34 days and for denials is 13.42 days.

Events that have Shaped this Program

- From August 2012 through April 2013 the Department of Family Services (DFS) transferred twelve (12) positions to WDH for the creation of the Long Term Care Unit, with WDH supplying the additional positions.
- 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 streamlined 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.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Average processing time for new application approvals (days)*	<45	<45	N/A	N/A	20.98*	20.35	16.70
Average processing time for new application denials (days)*	<45	<45	N/A	N/A	22.87*	23.34	18.13
Average processing time for renewal approvals (days)	<30	<30	N/A	N/A	8.41*	4.01	2.34
Average processing time for renewal denials (days)	<30	<30	N/A	N/A	18.24*	15.68	13.42

(-) Indicates data not yet available

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

* SFY 2015 Data is from March 2015 through June 2015

** The Federal application processing guideline is 45 days

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Average # of new applications processed monthly	N/A	N/A	132*	152	168	139	165	159	178
% of new applications denied monthly	N/A	N/A	38%*	33%	23%	35%	31%	27%	19%
Average # of renewals processed monthly**	N/A	N/A	305*	325	358	302	348	342	374
% of renewals closed monthly	N/A	N/A	3%*	2%	1.47%	2%	2%	1.9%	1.04%
EFFICIENCIES									
Average number of active cases per month	N/A	5,519	5,966	6,376	6,578	6,285	6,466	6,556	6,601
Average caseload per worker	N/A	587	597	633	548	629	637	546	550

(-) 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

* SFY 2015 data for applications and renewals are from March 2015 through June 2015

** Excludes SSI cases as SSI does not require renewals.

STORY BEHIND THE PERFORMANCE

- The Long Term Care Unit started operations August 1, 2012.
- All Long Term Care cases 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 DFS EPICS systems to the WDH WES system.
- 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 function.
- The supervisors and manager track the number of cases in the unit as well as the 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 WYTrain. They also attend the WDH new employee orientation.
- 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 that need to be addressed, as identified through quality assurance processes.
- The average number of cases per month has increased from SFY 2015 to SFY 2017. Some of the increase is due to changes in waiver programs and an appropriation to reduce the wait list and an increase in individuals on 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 if they are calling outside of office hours. Calls are returned within 24 business hours if a message is left.



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, e.g. Meaningful Use (MU), with the ultimate goal of improving patient care.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$2,763,538	\$3,797,538	\$4,367,601
Total Incentive Payments	\$3,311,780	\$972,185	\$945,277
Non – 600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Incentive Payments 100% federally funded.
- Program Administration is a 90/10 federal match.
- Professionals are paid over 6 years
 - Yr. 1 - \$21,250 Yr. 2-6 - \$8,500 each year
- 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 Staffing

- 0.5 FTE
- 1 AWEC
- 8 Other (Contractors)
 - 4 HealthTech Solutions (EHR system)
 - 4 Meyers and Stauffer (MU audits)

Program Metrics

- An estimated 250 Wyoming professionals and 27 hospitals could be eligible to participate in the program.
- Currently 311 Wyoming professionals and 27 hospitals are registered for the Electronic Health Record (EHR) Incentive Program.
- The total amount of incentive payments since program inception is \$21,920,742
 - \$11,712,654 for Adopt, Implement, & Upgrade (AIU)
 - \$10,208,088 for Meaningful Use (MU)
- 3 payment recoupments from professionals have occurred due to provider inability to provide adequate attestation documentation during MU audits.

Events that have Shaped this Program

- The program launched in December of 2011 with Adopt/Implement/Upgrade. Eligibility requirements for providers include use of a certified EHR and a Medicaid volume of 30% or 20% for pediatricians in a consecutive 90 day reporting period in the previous calendar year.
- August 2012 – Launch of Stage 1 Meaningful Use. Eligibility requires the use of EHRs in a meaningful way by capturing patient data electronically.
- January 2014 – Launch Stage 2 Meaningful Use. Eligibility requires electronic reporting to the State.
- December 2016 – Last year to register for the incentive program and attest for Adopt, Implement, Upgrade (AIU).
- December 2021 – Program ends.



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 exchange of medical information in a meaningful way (MU).

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# of New Eligible Professionals Attested	15	Program enrollment has ended	38	45	24	10	32
% of Attested Providers who Received Incentive Payments (EPs)	23%	25%	42%	34%	16%	26%	20%
% of Potentially Eligible Providers Participating	11%	Program enrollment has ended	8%	9%	10%	10%	8%
# of New Public Health Registry Connections	30	10	2	7	10	50	31

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# EPs Paid / Registered	67/159	66/194	37/228	66/250	69/311	N/A*	N/A*	N/A*	N/A*
# EHs Paid / Registered	16/21	17/25	11/26	2/26	1/27	N/A*	N/A*	N/A*	N/A*
# of Potentially Eligible Providers (EP and EH)	EP: 2,036 EH: 27	EP: 2,112 EH: 27	EP: 2,284 EH: 27	EP: 2,495 EH: 27	EP: 2,545 EH: 27	N/A*	N/A*	N/A*	N/A*
# of Providers using MIE Webchart	N/A	N/A	70	90	106	N/A*	N/A*	N/A*	N/A*
# of Continuity of Care Document (CCD) Users	N/A	N/A	376	398	518	N/A*	N/A*	N/A*	N/A*
Incentives Paid (AIU and MU combined)	\$4,530,106	\$4,316,339	\$1,065,685	\$1,094,027	\$1,140,777	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
# of Audits completed	28	30	9	16	22	N/A*	N/A*	N/A*	N/A*
# of Outreach Activities Completed Surveys THR Demos Email Blasts	N/A	N/A	N/A	3 Surveys 5 Demos 23 Email Blast	10 Demos 21 Email Blasts	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

- To date, 24 eligible hospitals have been paid \$16,727,243.16, and 197 eligible professionals have been paid \$5,193,500.
- Total incentive payments paid to date: \$21,920,743.17.
- This program is funded by the American Recovery & Reinvestment Act (ARRA), 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act.
- Eligible Professionals in this program includes: 3 Certified Nurse Midwives, 27 Dentists, 37 Nurse Practitioners, 126 Physicians, 1 Physician Assistant, and 61 Pediatricians. Eligibility is determined by Medicaid patient volume and use of certified electronic health records.
- Outreach for this program includes: face to face visits, email blasts, surveys, follow up phone calls, webinars, and the website. Outreach is done in an attempt to provide assistance throughout the registration, reporting, and attestation process.



Medicaid – Third Party Liability (TPL)

Program Description

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

Program Expenditures and Total Dollars Recovered

	SFY 2015	SFY 2016	SFY 2017
Total Program Cost	\$948,796	\$1,017,279	\$1,043,066
Total TPL Dollars Recovered*	\$4,858,478	\$5,188,976	\$4,983,808
Non-600 Series**	100%	100%	100%

*Figure shown includes estate recovery, TPL recovery and credit balances, but does not include cost avoidance or J-Code Rebate.

** 600 series is defined as direct service contracts.

Program Cost Notes

- The AG's office performs legal services for TPL and estate recovery.
- Medicaid's Fiscal Agent, Conduent, performs cost avoidance, pay and chase recoveries, pursues small personal injury recovery, tort recovery for criminal restitution, products liability, worker's compensation, and preliminary research for estate recovery.
- Recoveries made by TPL are reported on the CMS-64 report. CMS requires that TPL recoveries be returned at the FMAP rate the claims originally paid under.

Program Staffing

- 0.9 FTE State Staff
- Other: Contractors/AG's Office
 - Conduent
 - 8.5 TPL Unit staff
 - 1.5 J-Code Rebate
 - AG's Office
 - 2 part-time senior/assistant AGs
 - 1 full-time paralegal

Program Metrics

- Dollar amount of cost avoidance, pay and chase recoveries, estate recoveries, third party liability recoveries, J-code rebate recoveries, and credit balance recoveries achieved.

Events that have Shaped this Program

- 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 (the look-back period). 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, established data matching requirements, stating that Medicaid claims may not be denied for claim format issues or procedural issues, and increased the duration of the look-back period, as well as making provisions for annuities, etc.
- The Deficit Reduction Act of 2005 mandated that states secure drug rebates for physician-administered drugs for single-source and multiple source drugs.
- Wyoming Statutes §§ 42-4-201 – 42-4-207 Medicaid Benefit Recovery.
- Wyoming Medicaid Rules Chapter 35 Benefit Recovery.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Total TPL excluding J-Code Rebate and cost avoidance*	>\$5,000,000	>\$5,000,000	\$6,501,269	\$5,140,669	\$4,858,478	\$5,118,976	\$4,983,808
Total TPL including J-Code Rebate and excluding Cost Avoidance**	>\$7,000,000	>\$7,000,000	\$7,943,632	\$6,769,831	\$5,931,231	\$7,120,313	\$9,892,467
Total TPL including Cost Avoidance****	>\$20,000,000	>\$20,000,000	\$23,015,282	\$19,519,229	\$19,401,074	\$22,160,999	\$22,011,542
% of Medicaid claims expenditures*** offset by total TPL*							
- excluding J-Code Rebate and Cost Avoidance	>1%	>1%	1.26%	0.99%	0.92%	0.92%	0.90%
- including J-Code Rebate and excluding Cost Avoidance	>1%	>1%	1.54 %	1.31%	1.12%	1.28%	1.78%
- including J-Code Rebate and Cost Avoidance	>3.75%	>3.75%	4.45%	3.77%	3.68%	4.00%	3.96%
Estimated return on investment for TPL*							
- excluding J-Code Rebate and Cost Avoidance	>\$6 to \$1	>\$6 to \$1			\$5.1 to \$1	\$5.0 to \$1	\$4.8 to \$1
- including J-Code Rebate and excluding Cost Avoidance	\$9 to \$1	\$9 to \$1	-	-	\$6.3 to \$1	\$7 to \$1	\$9.5 to \$1
- including J-Code Rebate and Cost Avoidance	\$22 to \$1	\$22 to \$1			\$20.4 to \$1	\$21.8 to \$1	\$21.1 to \$1

* These figures include estate recovery, third party liability recoveries, and credit balances.

**These figures include estate recovery, third party liability recoveries, credit balances, and J-Code rebates.

*** Based on paid claims history in SFY 2017 Annual Report.

**** Program Integrity- TPL has reviewed how cost avoidance dollars are calculated. Cost avoidance may not be fully realized, as providers are instructed that they do not have to bill Medicaid if the third party paid more than the Medicaid allowed amount. The dollars may also may be inflated. For example if a provider submits the same claim multiple times and it denies each time for TPL.

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017**	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Total Estate Recovery	\$2,297,295	\$2,433,666	\$2,618,230	\$2,582,490	\$3,264,146	N/A*	N/A*	N/A*	N/A*
Total Third Party Liability	\$3,864,731	\$2,433,598	\$2,046,823	\$2,474,959	\$1,682,650	N/A*	N/A*	N/A*	N/A*
Total Credit Balances	\$339,242	\$273,405	\$193,095	\$131,527	\$37,012	N/A*	N/A*	N/A*	N/A*
Total J-Code Rebate	\$1,442,364	\$1,629,162	\$1,073,083	\$1,931,337	\$4,908,659***	N/A*	N/A*	N/A*	N/A*
Total Cost Avoidance*	\$15,071,650	\$12,749,398	\$13,469,843	\$15,040,686	\$12,119,075	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
% of recovered estate recovery cases to current open and active cases	18.53%	12.4%	10.32%	13.71%	14.26%	N/A*	N/A*	N/A*	N/A*
% of recovered TPL cases to current open and active cases	59.12%	46.5%	52.99%	67.59%	56%	N/A*	N/A*	N/A*	N/A*
% of Medicaid clients with other insurance coverage identified (relates to TPL recoveries and cost avoidance potential)	7.34%	5.25%	5.61%	5.64%	5.38%	N/A*	N/A*	N/A*	N/A*
<p>N/A* indicates data not available on a quarterly basis</p> <p>* 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 these claims are not fully processed once TPL is identified) rather than the final amount Medicaid would have paid.</p> <p>**With the exception of J-Code Rebates, recoveries are through 06/30/2017.</p> <p>***J-Code Rebate recoveries ended 04/30/2017. With the new PBM contract, Change Healthcare (CHC) assumed responsibility for collecting physician-administered drug rebates as of 03/01/2017. However, drug rebate invoicing by CHC did not begin until 05/2017.</p>									

STORY BEHIND THE PERFORMANCE

- **Physician-Administered Drug Rebates/J-Code Rebate:** Wyoming Medicaid concluded an Office of Inspector General (OIG) audit of physician-administered drugs. The audit began 12/19/2014 and concluded on 02/22/2017. Through the course of this audit, risks to Medicaid's FMAP were identified, remediated, and improvements were made to the program. Transition of this program function from Conduent to Change Healthcare occurred on 03/01/2017. Improvements made include:
 - **06/01/2015:** Providers were re-educated about the requirement to bill with an NDC for all physician-administered drugs.
 - **07/01/2015:** Changes made to the claims processing system were implemented requiring providers to submit claims with NDCs for physician-administered drugs. Failure to submit an NDC for a physician-administered drug results in a claim line denial.
 - With the **08/2015** submission of drug rebate invoices to drug manufacturers, Wyoming Medicaid included claims for end stage renal disease. A minor system problem was identified and fixed to include claims from the end stage renal disease fee schedule with submission of drug rebate invoices.
 - **09/2016:** Wyoming Medicaid purchased an NDC to J-Code crosswalk file from RJ Health Systems. Wyoming Medicaid no longer had to access multiple files and manually calculate conversion factors. This file ensures rebates are invoiced appropriately.
 - **09/2016:** Wyoming Medicaid also purchased licenses to access RJ Health Systems proprietary web-based database to verify mapping of NDC to J-Code and verify correct calculation of conversion factor for drug rebate invoicing.
 - **12/2015:** Wyoming Medicaid sent two letters to providers requesting NDC information when an NDC was not furnished with the original claim submission (claim record). Once the NDC information was supplied by the provider, Wyoming Medicaid invoiced drug manufacturers to secure drug rebates.
- Program Integrity collaborated with the LTC Eligibility Unit to draft a conditional benefits agreement, allowing Medicaid applicants to conditionally qualify for Medicaid benefits subject to the sale of their home. A provision/stipulation in the agreement is that Medicaid will be paid for the benefits and services it has paid when the property sells.
- Wyoming Medicaid is working on a draft RFP to replace the current TPL system with cost avoidance as the cornerstone of this proposal. Data matching will be a core component of this procurement.
- Cost avoidance numbers do not include pharmacy claims. Pay and chase recoveries do not include recoveries from pharmacy carriers or pharmacy benefit managers (PBMs).
- PI has been working with the LTC Eligibility Unit to re-draft the model Irrevocable Income Trust document. New policies and procedures will be drafted to accompany the revised Irrevocable Income Trust document. Stricter enforcement and compliance with the terms of the trust document will be required to prevent exploitation and to improve efficiency.
- Wyoming Medicaid instituted two new policy changes effective 05/01/2017. Wyoming Medicaid providers will no longer be allowed to opt out of participation with a health insurance carrier. Also, Wyoming Medicaid providers will be required to include a contract write-off amount with their TPL payment.
- Wyoming Medicaid is exploring further enhancement of its estate recovery program by utilizing TEFRA liens, mandating that Wyoming Medicaid will be the beneficiary of burial/funeral contracts and life insurance policies, as well as recovering from bank accounts.
- Wyoming Medicaid is in the process of reviewing the TPL matrix to ensure that claims are cost avoided.
- **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.

WDH | Behavioral Health Division

Information contained in this section includes:

- Acquired Brain Injury (ABI) Waiver
- Comprehensive Waiver
- Court Supervised Treatment (CST) Programs
- Early Intervention & Education Program (EIEP), Part B
- Early Intervention & Education Program (EIEP), Part C
- Mental Health Outpatient Treatment
- Mental Health Residential Treatment
- Substance Abuse Outpatient Treatment
- Substance Abuse Residential Treatment
- Supports Waiver

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

	SFY2015	SFY2016	SFY2017
Total Medical & Waiver Cost	\$7,749,311	\$7,957,560	\$7,949,646
Total Waiver Cost	\$6,633,780	\$6,744,637	\$6,954,532
Total Medical Costs	\$1,115,531	\$1,212,923	\$995,114
Total People Served	172	163	164
Cost per Person (Waiver and Medical)	\$45,054	\$49,507	\$48,470
Non-600 Series*	5.4%	4.09%	3.0%

* 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 \$7,530 per person in SFY17.
- The ABI waiver average cost per participant was \$42,962 as of the end of SFY17.
- 15 participants received some self-directed waiver services in SFY17.
- 508 providers, certified and monitored by BHD, were available to provide services for this waiver during SFY17.

Events that have Shaped this Program

- **Conflict Free Case Management.** The 2013 law (SEA 0082) 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 HCB rules.** In March 2014, the federal government passed new rules for waiver settings and services to be "home and community based" (HCB) to ensure people in HCB services are truly integrated into their communities and not isolated or receiving services that seem institutional in nature.
- **Rate Increases.** The 2016 Legislative Session appropriated \$7.8 million for the 2017-18 biennium. This appropriation resulted in an across the board rate increase of 3.3%.
- **ABI Waiver ending.** The current ABI Waiver participants will start transitioning in February 2018 to the Comprehensive & Supports Waivers. The ABI waiver will end on March 31st, 2018.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# and % of waiver participants that are employed	36/163 (22.7%)	30/155 (19.4%)	53/184 (28.8%)	42/168 (25.0%)	37/172 (21.5%)	34/163 (20.9%)	25/155 (16.1%)
# and % of waiver participants living in a place they own or lease	77/161 (48%)	78/161 (48.4%)	78/191 (40.8%)	82/184 (44.6%)	76/172 (44.2%)	74/161 (46.0%)	75/161 (46.6%)

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of participants on the waiver	191	184	172	163	164	157	160	162	161
# of participants who are using supported employment services	19	20	14	15	11	14	11	11	11
EFFICIENCIES									
Average cost per participant (waiver and medical)	\$45,520	\$46,905	\$45,054	\$47,937	\$48,470	\$24,803	\$24,321	\$24,564	\$24,657
Average cost per participant (waiver only)	\$41,247	\$40,758	\$39,534	\$41,400	\$42,962	\$21,054	\$21,495	\$21,216	\$22,512

(-) 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

- **ABI Waiver ending.** The ABI waiver participants will go to the Comprehensive or Supports Waivers by March 31st, 2018 and the ABI waiver will end.
- **Wait list funding.** The ABI population was not added to the Supports Waiver until October of 2015.
- **New federal HCB 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 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.

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, 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 support needs and require intensive services, such as residential habilitation.

Program Expenditures and People Served

	2015	2016	2017
Total Medical & Waiver Cost	\$72,164,952	\$110,276,268	\$108,809,060
Total Waiver Cost	\$63,883,371	\$88,539,448	\$88,718,492
Total Medical Costs	\$8,281,581	\$21,736,820	\$20,090,568
Total People Served	1,832	1,927	1,890
Cost per Person (Medical & Waiver)	\$39,391	\$58,678	\$57,958
Non-600 Series*	2.4%	2.7%	1.9%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Participants receive Medicaid medical and 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

- FTE: 18.5
- AWEC: 0
- Other: 0

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of \$11,364 per person in FY17.
- The waiver average cost per participant in FY17 was \$47,513.
- 254 participants received some self-directed waiver services in FY17.
- 713 providers, certified and monitored by the BHD, were available to provide services for this Waiver in FY17.

Events that have Shaped this Program

- **New Waivers.** In March of 2013, the Wyoming Legislature passed Senate Enrolled 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 Developmental Disability (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.
- **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 \$9.7 million (50% State General Funds and 50% Federal Funds) for waiting list reduction of the Adult DD Waiver, \$5.9 million for waiting list reduction of the Child DD Waiver, and \$4.6 million for the Acquired Brain Injury Waiver for a total of \$20.2 million.
- **New federal HCB rules.** In March of 2014, the federal government passed new rules for waiver settings and services that are supposed to be "home and community based" (HCB) 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 2022, a delay from the previous deadline of March 2019, and providers must make several changes over the next few years.
- **Rate Increases.** The 2016 Legislative Session appropriated \$7.8 million for the 2017-18 biennium. This appropriation resulted in an across the board rate increase of 3.3%. The 2017 Legislative Session appropriated \$5 million for SFY 2018. This resulted in an across the board rate increase of 4.2%.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# and % of participants ages 18+ living independently or semi-independently	410/ 1,632 (25.1%)	408/ 1,623 (25.1%)	N/A	N/A	351/ 1,441 (24.4%)	375/ 1,632 (23.0%)	380/ 1,623 (23.4%)
# and % of participants ages 18+ working in competitive and community integrated settings earning at least minimum wage	308/ 1,593 (19.3%)	247/ 1,435 (17.2%)	N/A	N/A	258/ 1,469 (17.2%)	296/ 1,593 (18.6%)	206/ 1,435 (14.4%)
# of physical, mechanical, and chemical restraints used	1,633	1,200	N/A	N/A	1,166	1,647	1,201

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of participants ¹	N/A	38	1,832	1,927	1,890	1,918	1,884	1,887	1,871
# of participants ages 18+ living in residential services or with family	N/A	N/A	1,090	1,257	1,224	1,210	1,214	1,186	1,180
# of participants ages 18+ using waiver supported employment services	N/A	N/A	165	176	188	170	175	179	185
EFFICIENCIES									
Average cost per participant (waiver and medical)	N/A	N/A	\$39,391	\$58,678	\$57,958	\$29,641	\$29,770	\$28,756	\$29,153
Average cost per participant (waiver only)	N/A	N/A	\$36,380	\$45,863	\$47,513	\$23,147	\$23,345	\$22,963	\$24,773

(-) 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

- **New federal Home and Community Based (HCB) 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 rights 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 2022, a delay from the previous deadline of March 2019, to ensure 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's 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.



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 are in high need of substance use treatment services.

Program Expenditures and People Served

	SFY 2015	SFY 2016	SFY 2017
Total Program Cost	\$3,862,437**	\$3,729,593**	\$3,422,539**
People Served	635	610	596
Cost per Person	\$6,083**	\$6,114**	\$5,743**
Non-600 Series*	7%	7%	10%

* 600 series is defined as direct service contracts

**Program cost was previously reported as SFY expenditures and is now reported by service dates July 01, 2016- June 30, 2017

Program Cost Notes

- Biennium funding: \$4,718,903 State General Funds and \$2,398,072 State Tobacco Funds
- All funds reside in Fund 558, established in accordance to Wyo. Stat. Ann. § 7-13-1605
- Program contracts for SFY18 include a reduction of \$600,000 from budget cuts.
- Surcharge account as of July 18, 2017 contains \$117,131.57

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- There were 19 funded CST Programs in FY17 (11 adult, 2 juvenile, 1 DUI, 3 adult/juvenile combined, and 2 tribal wellness).
- Ancillary services include: education, medical/dental, life skills, 12-Step programs, church, etc. Importance: Ancillary services support completing treatment services, reduce recidivism, and increase the duration of sobriety.
- 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. Supervision services provide monitoring compliance or identify violation of program requirements.

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 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).

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of participants who graduate (retention rate)* Adult (A) Juvenile (J)	A: 68% J: 67%	A: 59% J: 59%	A: 62% J: 57%	A: 63% J: 52%	A: 49% J: 58%	A: 38% J: 66%	A: 2% J: 14%
% of participants having at least 120 days sobriety prior to graduation	A: 99% J: 90%	A: 100% J: 100%	A: 98% J: 94%	A: 99% J: 100%	A: 99% J: 97%	A: 98% J: 100%	A: 100% J: 92%
% of participants having re-arrest during their program participation (In-Program Recidivism Rate)	A: 5% J: 10%	A: <5% J: <10%	7%**	A: 8% J: 12%	A: 7% J: 18%	A: 5% J: 11%	A: 6% J: 24%
% of participants having re-arrest within three years after their program participation (Post-Program Recidivism)	N/A	A: <3% J: <15%	N/A	A: 10% J: 19%	A: 8% J: 20%	A: 4% J: 19%	A: 4% J: 24%

* Graduation rates are reported by cohort; in previous years they were reported by SFY. Individuals may spend several years in the program and numbers are subject to change as cohorts progress.

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

**Recidivism was not broken out by adult and juvenile population prior to FY14

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
Outputs									
Total # of unique participants Adults (A) Juveniles (J)	668*	636 A: 539 J: 97	635 A: 551 J: 84	610 A: 545 J: 65	596 A:542 J: 54	467 A: 415 J: 52	470 A: 419 J: 51	464 A: 418 J: 46	444 A: 409 J: 35
# of ancillary services per month, per participant	5*	A: 5 J: 2	A: 5 J: 2	A: 4 J: 2	A: 4 J: 2	A: 6 J: 3	A: 6 J: 3	A: 5 J: 3	A: 5 J: 3
# of supervision contacts per month, per participant	5*	A: 5 J: 6	A: 5 J: 6	A: 5 J: 10	A: 5 J: 8	A: 6 J: 13	A: 6 J: 14	A: 6 J: 11	A: 6 J: 11
# of substance abuse tests per month, per participant	4.5*	A: 5 J: 4	A: 5 J: 4	A: 4 J: 5	A: 4 J: 4	A: 6 J: 6	A: 5 J: 6	A: 6 J: 5	A: 6 J: 7
Units of service per month, per participant	19*	A: 20 J: 16	A: 19 J: 16	A: 17 J: 22	A: 17 J: 19	A: 22 J: 29	A: 24 J: 29	A:22 J: 25	A: 22 J: 26
EFFICIENCIES									
Cost per unit of service(ancillary, treatment, supervision, drug test)	\$26.79*	A: \$25.63 J: \$32.03	A: \$26.08 J: \$30.97	A: \$30.23 J: \$23.36	A:\$28.15 J: \$28.19	N/A*	N/A*	N/A*	N/A*
Annual program cost per participant ¹ (cost per participant per day)	\$6,108* (\$16.73)	\$6,150 (\$16.85)	\$6,083 (\$16.67)	\$6,114 (\$16.75)	\$5,743 (\$15.73)	N/A*	N/A*	N/A*	N/A*
* Metrics was not broken out by adult and juvenile population prior to FY14 N/A* indicates data not available on a quarterly basis ¹ Costs are reported for service dates from July 01 – June 30; previous reports reported on expenditures in an SFY and may differ slightly.									

Story Behind The Performance

- In SFY 2017 the WyCST system, which is used to collect all data for the Court Supervised Treatment Program (CST), was evaluated for accuracy and usability by CST and the Knowledge, Management, Analysis and Technology Unit (KMAT) staff. It was determined that the WyCST system is effective, and CST and KMAT staff evaluating WyCST were able to validate WyCST data. CST discovered that inconsistencies in the data came from court coordinators interpreting broad indicator definitions differently across the state and the Program will provide technical assistance to correct this issue.
- CST is currently working with the National Drug Court Institute to develop Wyoming standards that better align with national best practice standards. Until the standards are finalized, CST will continue to work with court coordinators to gain consistency in the definition interpretations.
- CST is completing a program tune-up project to align with national standards, to be able to successfully compare to other states, and to provide more consistency among Wyoming state courts. As a result, CST will update rules, standards, and data formulas to better align with national best practice standards. The tune-up also includes evaluation of WyCST data.
 - In the past, retention rates were reported as a point-in-time rate for all individuals active in the program. Based on research and input from the National Drug Court Institute, CST has broken the retention rate into cohorts, which are defined as anyone who starts a CST program between July 1 and June 30 of a given year. Individuals may remain in the program for more than one year, therefore the reported numbers will be updated each year as cohorts progress and data is more complete.
 - CST resumed site-visits in 2017 as a way to not only get to know the courts, provide technical Assistance, and identify any barriers courts may have. The most recent court reviews were completed through self-evaluations due to budget cuts.
- In 2017 the National Drug Court Institute designated Albany County Court a Mentor Court. CST is working with Albany County Court to learn what changes were implemented to be designated as a Mentor Court and determine if any of those changes could benefit other courts.
- The recidivism rate listed in this report is different from the FY 16 end of year report due to the calculation being utilized in 2016 being changed back to the previous formula for 2017. The FY 16 numbers have also been updated to reflect the original formula.
- Recidivism rates will continue to be reported with the current formula until WyCST is updated or a new system is obtained. In the future, recidivism will be reported based on charges and convictions.

Early Intervention & Education Program - Part B/619

Program Description

Part B/619 provides oversight of 14 Regional Child Development Centers that are contracted to provide preschool, special education, and related services to children from three through age five years who are identified with developmental delays and/or disabilities. Part B/619 is a federally mandated program.

Program Expenditures and Children Served in Part C and Part B/619

	2015	2016	2017
Total Program Cost	\$24,118,276	\$23,356,021	\$21,752,911
Children Served	2,730	2,695	2,612
State per child amount	\$8,812	\$8,659	\$8,319
Non-600 Series*	10%	10%	10%

* 600 series is defined as direct service contracts

** Total program cost includes Part C and Part B/619 state funds. See below for federal fund amounts.

Part B/619 Contract Amounts

- State Part B (three through five years): \$21,729,176
- Federal Part B funds three through five years: \$1,998,835

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- 14 Regional Child Development Centers with 41 locations statewide
- Annual Focused Monitoring of Part B/619 programs based on results of federal compliance indicators from State Performance Plan
- 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).
- State Performance Plan and Annual Performance Report for Part B/619.
- Resolution to Maintenance of Effort that ensures state level of fiscal support for services for children from three through age five meets all federal requirements
- 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.
- Part B/619 completed on-site monitoring of two Child Developmental Centers in 2017.

Early Intervention & Education Program – Part B/619

PROGRAM CORE PURPOSE

The Part B/619 program provides oversight to 14 Regional Child Development Centers that are contracted to provide preschool, special education, and related services to children ages three through five years who are identified with a disability that impacts their education. The program is state mandated under W. S. § 21-2-701 through 706.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
The percent of children who substantially increased their rate of growth in Social-Emotional skills	87.90%	89.50%	85.3%	88.5%	91.2%	90.9%	88.33%*
The percent of children who substantially increased their rate of growth in skills Acquiring and Using Knowledge and Skills	89.67%	91.27%	88.2%	89.9%	92.1%	92.7%	84.71%*
The percent of children who substantially increased ¹ their rate of growth in Taking Appropriate Action to Meet Needs	89.58%	91.18%	87.5%	90.4%	92.77%	91.5%	86.30%*

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

*Does not include COS scores from the three pilot regions.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of children served based on November 1 st count	2,823	2,804	2,730	2,695	2,612	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)	3,794	3,621	3,972	3,548	3,493	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted	\$8,743	\$8,643	\$8,812	\$8,814	\$8,318	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually	\$6,193	\$6,288	\$8,323	\$6,041	\$6,631	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 B/619 provides assistance to states for the education of all children with disabilities under Section 611 of the Individuals with Disabilities Education Act (IDEA) which provides federal funding to a State Education Agency to ensure children ages three through 21 receive a Free Appropriate Public Education (FAPE). Section 619 of the IDEA is specific funding to children ages three through five.
- The Department of Health, through a memorandum of understanding with Department of Education, administers the Part B/619 program.
- All children ages 3-5 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 eligible for Part B/619 services are evaluated for child outcomes at entry and exit from the program. This data is used to measure a child's progress through participation in the program.
- Part B/619, along with Part C, piloted a new process for determining child outcomes based on a standardized assessment in SFY 2017. This pilot included three of the fourteen regional centers from July 1, 2016 to June 30, 2017.
 - The piloted process produced scores that were consistent among the three pilot regions. It was determined this new reporting process would be implemented across all of the remaining regions in a roll out process over the next fiscal year.
 - Data from the three regions was not included in the targets reported on this document.
 - The Part B/619 Coordinator has notified Department of Education of the possible necessity to reset targets as the result of the change in the child outcome process.
- In 2017 the Wyoming State Legislature approved an update to W.S. §21-2-701-706 that requires a child ages three (3) through five (5) be placed on an Individualized Education Program as of December 1st in order to be included in the child count.

Early Intervention & Education Program – Part C

Program Description

The Early Intervention and Education Program (EIEP) provides oversight of fourteen (14) Regional Child Development Centers that are contracted to provide early intervention, special education, and related services to children birth through age two. The Part C program provides those services to children birth through age two. It is a state mandated program according to W.S. §21-2-701-706.

Program Expenditures and Children Served in Part C and Part B/619

	2015	2016	2017
Total Program Cost	\$10,655,940	\$11,528,512	\$11,294,042
Children Served	1,207	1,266	1,289
Cost per Person	\$8,812	\$9,607.75	\$8,743.45
Non-600 Series*	10%	10%	10%

* 600 series is defined as direct service contracts.

Part C Contract Amounts

- State Part C (birth through two years): \$11,270,300.85
- Federal Part C funds birth through two years: \$1,650,284.78
- Total Part C federal and state funding: \$12,920,585.63

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- 14 Regional Child Development Centers with 41 locations statewide.
- Annual Focused Monitoring of Part C programs based on results of federal compliance indicators from State Performance Plan.
- Child Outcomes Summary data, which indicates growth a child shows from receiving early intervention services.

Events that have Shaped this Program

- Individuals with Disabilities Education Act (IDEA), 1997 and IDEA Improvement Act, 2004
- The 2004 IDEA Improvement Act re-authorized and continues to require children, age birth through two years, to have access to early intervention services.
- 2017 on-site monitoring of five Part C regional service providers for children ages birth through two.
- State Performance Plan and Annual Performance Report for Part C.
- Resolution to Maintenance of Effort that ensures state level of fiscal support for services for children from birth through two meets all federal requirements.
- Department of Health continues to be the Lead Agency for the Part C federal grant.
- The SFY 18 targets are the same as SFY 17 because the targets were not met for SFY 17.

Early Intervention & Education Program – Part C

PROGRAM CORE PURPOSE

The Part C program provides oversight of 14 Regional Child Developmental Centers that are contracted to provide early intervention services to children from birth through age two.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of children who substantially increased their rate of growth in Social-Emotional skills	88%	88%**	67.5%	81.9%	80.3%	86.4%	78.83%*
% of children who substantially increased their rate of growth in skills Acquiring and Using Knowledge and Skills	85%	85%**	68.6%	80.7%	79.7%	83.8%	71.92%*
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Needs	88%	88%**	76.0%	81.6%	81.8%	86.8%	78.67%*

*Does not include COS scores from the three pilot regions.

**Targets are the same for SFY 2017 and SFY 2018 as the targets were not met for 2017.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of children served based on November 1 st count	1,219	1,210	1,207	1,266	1,289	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)	1,917	1,896	1,196	2,231	2,125	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted	\$8,743	\$8,643	\$8,812	\$8,814	\$8,743	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually	\$6,193	\$6,288	\$8,323	\$6,041	\$5,304	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 the Individuals with Disabilities Education Act (IDEA).
- 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.
- Wyoming's 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 Performance Plan (SPP).
- In 2017 the Wyoming State Legislature approved an update to W.S. §21-2-701-706 that requires a child from birth through age two (2) be placed on an Individualized Family Service Plan as of December 1st in order to be on the child count.
- EIEP used stakeholder involvement to develop a new process for reporting child progress.
- Part B/619, along with Part C, piloted a new process for determining child outcomes based on a standardized assessment in SFY 2017. This pilot included three of the fourteen regional centers with a duration of July 1, 2016 to June 30, 2017.
 - The piloted process produced scores that were consistent among the three pilot regions. It was determined this new reporting process would be implemented across all of the remaining regions in a roll out process over the next fiscal year.

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

	2015**	2016**	2017
Total Program Cost	\$21,687,325	\$20,733,470	\$20,400,451***
People Served	17,934	18,107	17,530
Cost per Person	\$1,209	\$1,145	\$1,163
Non-600 Series*	4.3%	4.2%	3.6%

* 600 series is defined as direct service contracts.

**Previous year reports did not include administrative costs

*** Includes year 1 of the Assisted Outpatient Treatment federal grant totaling \$700,000

Program Cost Notes

- 95% State General Funds (\$19,469,340)
- 5% Federal Funds (\$931,111)

Program Staffing

- 5 FTE shared with Mental Health Residential, Substance Abuse Outpatient and Substance Abuse Residential Programs
- 0 AWEC
- 0 Other

Program Metrics

- A total of 299,490 hours of mental health outpatient service were delivered in SFY17 with an average of 16.77 hours of service per client.
- Populations served: 43% adults with Serious Mental Illness (SMI); 12% youth with Severe Emotional Disturbance (SED), and 45% not SMI or SED.

Events that have Shaped this Program

- The Chris S. Lawsuit Settlement Agreement signed in 2002 stipulated the development of community based treatment and supports for adults with SMI.
- 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.
- Senate Enrolled Act (SEA) 77 in 2007 continued system enhancements.
- SEA 24 in 2008 provided for 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, 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.



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, which improve the levels of personal functioning for those consumers who need treatment.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017
Wait time for services (days) (12 of 14 providers met this target)	≤ 2 days	≤ 2 days	10	5.32	2.79	2.24	2.19
Treatment completion	72%	72%	50%	51%	65%	66%	68%
% of clients who were homeless at admission who were not homeless at discharge (5 of 14 providers met this target)	80%	**	35%	56%	50%	51%	52%
% of clients who are employed upon admission who were unemployed at discharge (4 of 14 providers met this target)	2%	**	N/A	4%	2%	4%	4%
% of clients who are unemployed upon admission who were employed at discharge (2 of 14 providers met this target)	40%	**	13%	20%	17%	27%	26%

(-) Indicates data not yet available

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

*FY16 data was not finalized until December, 2016 due to a system error.

** New metrics will replace these metrics in SFY 2018, therefore targets were not set for these metrics.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY * 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of persons served	17,131	17,477	17,934	18,107	17,851	13,071	13,427	12,582	12,704
Number of persons homeless at admission	213	217	358	185	222	N/A*	N/A*	N/A*	N/A*
Number of persons not employed at admission	1,982	1,868	2,461	1,486	2,002	N/A*	N/A*	N/A*	N/A*
Number of hours of outpatient services delivered	351,746	370,948	349,426	342,632	299,490	173,199	169,433	150,123	149,368
EFFICIENCIES									
Average cost per client	\$1,383**	\$1,251**	\$1,209	\$1,145	\$1,143	N/A*	N/A*	N/A*	N/A*
Average cost per service hour	\$64**	\$60**	\$62	\$61	\$68	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 *FY16 data was not finalized until December, 2016 due to a system error. **These calculations do not include administrative costs.									

STORY BEHIND THE PERFORMANCE

- A budget reduction of \$1,165,498 was applied to this Program in State Fiscal Year (SFY) 2017.
- The Behavioral Health Division was realigned early in SFY 2017, which altered quality management responsibilities. In addition to realignment, staffing levels were reduced in the Mental Health and Substance Abuse (MHSA Section).
 - These changes necessitated the creation of efficiencies within quality management processes in order to better monitor provider performance and contract compliance. In collaboration with another unit within the Division, the MHSA Section developed a mechanism embedded within the data collection system which automates reporting of contact deliverables and provider performance of specific target areas. Outcomes for this project are:
 - A single point of reference for all MHSA staff to view the status of contract deliverables and outcome measures;
 - The elimination of fragmentation of deliverable tracking and consistency in approaches to noncompliance, quality improvement and outcomes development; and,
 - A mechanism for providers to determine contract compliance.
- In SFY 2017 the Assisted Outpatient Treatment Grant, was added to this program area. The federal grant supports the development of infrastructure and implementation of services under W.S. § 25-10-110.1, Wyoming Directed Outpatient Commitment Statute.
- This program area was also given the responsibility of implementing Gatekeeping W.S. § 25-10-112, and implementing 2017 Session Senate Enrolled Act 87, which authorized one-time funding for gatekeeping and the development of diversion services to avoid psychiatric hospitalization.
 - These factors necessitate narrowing the focus of the MHSA Section for SFY 2018. The removal of previously identified program metrics for SFY 2018 is a result of this narrowed focus.

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. This program area includes community housing and crisis stabilization.

Program Expenditures and People Served

	2015**	2016**	2017
Total Program Cost	\$6,504,941	\$7,212,807	\$7,138,277
People Served	214	482	434
Cost per Person	\$30,397	\$14,964	\$16,447
Non-600 Series*	4.4%	4.0%	3.7%

* 600 series is defined as direct service contracts.

**Previous reports did not include administrative costs.

Program Cost Notes

- 100% State General Funds

Program Staffing

- 5 FTE shared with Substance Abuse Residential, Substance Abuse Outpatient and Mental Health Outpatient
- 0 AWEC
- 0 Other

Program Metrics

- 203 individuals resided in Community Housing (group homes and supervised living environments) in SFY 2017.
- 231 persons received Crisis Stabilization services in SFY 2017.

Events that have Shaped this Program

- The Chris S. Lawsuit Settlement Agreement in 2002 required the development of community-based treatment and supports for adults with serious mental illness (SMI).
- The Select Committee on Mental Health and Substance Abuse produced the 2006 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 intensive services.

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 treatment services for individuals with serious mental illness whose level of functioning requires 24/7 supports. This program area includes community housing and crisis stabilization

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017
Utilization rate for crisis stabilization beds	85%	85%	N/A	9.20%	30.47%	55.61%	50.72%
Utilization rate for group home beds	95%	95%	85.71%	83.26%	83.99%	92.57%	92.42%
Utilization rate for supervised living beds***	95%	95%	65.07%	96.18%	100.07%	103.99%	98.23%

(-) Indicates data not yet available
 N/A indicates data not available due to the creation of a new metric
 * FY 16 data was not finalized until December, 2016 due to a system error
 **Data was not reported correctly
 *** Some providers utilize "float" beds to increase capacity as needed, resulting in utilization rates over 100% of official capacity in some years.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of persons served – crisis stabilization	**	156	50	232	231	N/A*	N/A*	N/A*	N/A*
Number of persons served – group homes	46	77	80	118	104	N/A*	N/A*	N/A*	N/A*
Number of persons served – supervised living	50	77	84	132	99	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average cost per client for crisis stabilization	N/A	\$11,353	\$35,422	\$8,075	\$9,722	N/A*	N/A*	N/A*	N/A*
Average cost per client for group home and supervised living***	\$31,862	\$28,128	\$27,119	\$19,367	\$24,593	N/A*	N/A*	N/A*	N/A*

(-) Indicates data not yet available
 N/A indicates data not available due to the creation of a new metric
 N/A* indicates data not available on a quarterly basis
 * FY 16 data was not finalized until December, 2016 due to a system error
 **Data was not reported correctly.
 *** Funding for group homes and supervised living is bundled together.

STORY BEHIND THE PERFORMANCE

- A budget reduction of \$133,603 resulted in the loss of two (2) mental health supervised living beds in State Fiscal Year (SFY) 2017.
- The Behavioral Health Division was realigned early in SFY 2017, which altered quality management responsibilities. In addition to realignment, staffing levels were reduced in the Mental Health and Substance Abuse Services (MHSA) Section.
 - These changes necessitated the creation of efficiencies within the quality management processes in order to better monitor provider performance and contract compliance.
- In collaboration with another unit within the Division, the MHSA Section developed a mechanism embedded within the data collection system which automated reporting of contract deliverables and provider performance of specific target areas. Outcomes of this project are:
 - A single point of reference for all MHSA staff to view the status of contract deliverables and outcome measures,
 - The elimination of fragmentation of deliverables tracking and consistency in approaches to noncompliance, quality improvement and outcomes development, and,
 - A mechanism for providers to determine contract compliance.
- During the year, the MHSA Section received two (2) additional grants: The Assisted Outpatient Treatment Grant (AOT) and the Opioid State Targeted Response Grant (Opioid STR). The AOT Grant supports the development of infrastructure and implementation of services under Wyo. Stat. Ann. § 25-10-110.1, Wyoming's Directed Outpatient Commitment Statute. The Opioid STR Grant supports the development of infrastructure and service provision to address opioid use.

Substance Abuse 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 Wyo. Stat. Ann. § 9-2-102 *et. seq.* and Wyo. Stat. Ann. § 9-2-2701 *et. seq.*

Program Expenditures and People Served

	2015**	2016**	2017
Total Program Cost	\$9,933,424	\$10,514,963***	\$10,503,615****
People Served	6,672	6680	6,012
Cost per Person	\$1,488	\$1,574	\$1,747
Non-600 Series*	4.3%	4.0%	3.6%

* 600 series is defined as direct service contracts.

**Previous reports did not include administrative costs

***Includes MAT grant, year 1 with expenditures totaling \$932,998

****Includes MAT grant, year 2, with expenditures totaling \$1,178,650

Program Cost Notes

- 47% State Tobacco Funds (\$4,973,704)
- 29% State General Funds (\$3,053,322)
- 24% Federal Funds (\$2,476,589)

Program Staffing

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

Program Metrics

- A total of 165,977 hours of outpatient services were delivered by community substance use providers, with an average of 27.60 hours of service per client in SFY 2017.
- 50.44% of persons served in SFY 2017 were admitted with a primary problem of alcohol, 19.15% for marijuana/hashish, 18.64% for methamphetamine, 8.44% for opiates (including heroin) and 3.23% other drugs.

Events that have Shaped this Program

- The Substance Abuse Control Plan, authorized in 2002 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 to provide substance use treatment, as well as those serving court referred individuals.
- The Select Committee on Mental Health and Substance Abuse produced the 2006 House Enrolled Act 21, 2007 Senate Enrolled Act (SEA) 77, and 2008 SEA 24, resulting in substantial increases in funding for substance abuse treatment and promoted the concept of regionalization of intensive 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 use treatment services.

Substance Abuse 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 including employment, stable housing, and treatment completion.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017
% of clients who are employed upon admission who were unemployed at discharge (5 of 16 providers met the target)	≤2%	**	3.72%	5.35%	3.54%	3.61%	5.85%
% of clients who are unemployed upon admission who were employed at discharge (6 of 16 providers met the target)	40%	**	17.05%	26.46%	16.06%	22.33%	23.81%
% of clients who were homeless at admission who were not homeless at discharge (8 of 16 providers met the target)	80%	**	31.25%	42.96%	42.26%	43.75%	51.61%
% of clients completing treatment (12 of 16 providers met the target)	72%	75%	53%	59%	66%	66.04%	71.13%
Wait time for services (average days) (13 of 16 providers met the target)	≤ 2 days	≤ 2 days	12	5.69	2.46	1.98	2.75

(-) Indicates data not yet available

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

*FY 16 data was not finalized until December, 2016 due to a system error

**New metrics will replace these metrics in 2018, therefore targets were not set.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of persons served	6,878	6,560	6,672	6,680	6,012	4,228	4,501	3,988	3,881
Number of persons admitted	5,140	4,372	5,314	4,421	4,496	2,152	2,269	2,270	2,226
Number of persons discharged	6,037	5,236	5,923	4,846	5,012	2,316	2,530	2,580	2,432
Hours of outpatient services delivered	211,862	209,729	199,863	193,942	165,977	92,134	101,808	83,805	82,172
EFFICIENCIES									
Average cost per client	\$1,464**	\$1,509**	\$1,424	\$1,488	\$1,747	N/A*	N/A*	N/A*	N/A*
Average service cost per hour	\$48**	\$47**	\$48	\$52	\$63	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

*FY 16 data was not finalized until December, 2016 due to a system error

**These calculations do not include administrative costs

STORY BEHIND THE PERFORMANCE

- A budget reduction of \$565,682 was applied to this program in State Fiscal Year (SFY) 2017.
- The Behavioral Health Division was realigned early in SFY 2017, which altered quality management responsibilities. In addition to realignment, staffing levels were reduced in the Mental Health and Substance Abuse Services (MHSA) Section.
 - These changes necessitated the creation of efficiencies within our quality management processes in order to better monitor provider performance and contract compliance.
- In collaboration with another unit within the Division, the MHSA Section developed a mechanism embedded within our data collection system, which automated reporting of contract deliverables and provider performance of specific target areas. Outcomes of this project are:
 - A single point of reference for all MHSA staff to view the status of contract deliverables and outcome measures,
 - The elimination of fragmentation of deliverables tracking and consistency in approaches to noncompliance, quality improvement and outcomes development, and,
 - A mechanism for providers to determine contract compliance.
- This program area currently receives two (2) grants targeted at opioid use. The Medication Assisted Treatment Grant is in its third year and the Opioid State Targeted Response Grant was implemented in 2017.
- These factors necessitate narrowing focus of the MHSA Section for SFY 2018. The removal of previously identified program metrics for SFY 2018 is a result of this narrowed focus.



Substance Abuse 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

	2015	2016*	2017
Total Program Cost	\$14,055,877	\$13,428,946	\$13,206,817
People Served	1,174**	1,794**	1,051**
Cost per Person	\$11,973	\$7,485	\$12,566
Non-600 Series*	4.3%	4.2%	3.6%

* 600 series is defined as direct service contracts.

* FY 16 data was not finalized until December, 2016 due to a system error

**This includes only primary residential clients. Transitional living and social detoxification clients are not included.

Program Cost Notes

- 84% State General Funds (\$11,149,084)
- 15% Federal Funds (\$1,957,427)
- 1% Tobacco Settlement Funds (\$100,306)

Program Staffing

- 5 FTE shared with Mental Health Residential, Mental Health Outpatient and Substance Use Outpatient
- 0 AWEC
- 0 Other

Program Metrics

- A total of 65,565 days of residential treatment were delivered statewide with an average 62.38 days of service per client in SFY 2017.
- 39.98% of persons served in SFY 2017 were admitted with a primary problem of methamphetamine, 36.30% for alcohol, 14.52% for opiates (including heroin), 6.92% for marijuana/hashish, and 2.23% for other drugs.

Events that have Shaped this Program

- The Substance Abuse Control Plan, authorized in 2002 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 to provide substance use treatment, as well as those serving court referred individuals.
- The Select Committee on Mental Health and Substance Abuse produced the 2006 House Enrolled Act 21, 2007 Senate Enrolled Act (SEA) 77, and 2008 SEA 24, resulting in substantial increases in funding for substance abuse treatment, and promoted the concept of regionalization of intensive 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 use treatment services.

Substance Abuse Residential Treatment

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017
Utilization rate (3 of 9 providers met the target)	95%	95%	85%	87%	88%	90%	92%
Treatment completion (3 of 6 providers met the target)	80%	80%	60%	64%	73%	74%	76%
% of clients with an improvement in functioning of 5 points or more as measured by the Daily Living Activities-20 functional assessment and translated into a GAF score. (3 of 6 providers met the target)	90%	90%	73%	84%	91%	85%	82%

(-) Indicates data not yet available
 N/A indicates data not available due to the creation of a new metric
 *FY16 data was not finalized until December, 2016 due to a system error.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of persons served	1,165	1,117	1,174	1,794	1,051	702	685	629	615
Number of persons admitted	902	921	1,044	1,090	895	565	525	458	437
Number of persons discharged	973	930	1,033	1,108	892	557	551	459	433
Number of days of residential services provided	79,267	81,057	81,795	80,468	65,565	39,500	40,968	32,681	32,884
EFFICIENCIES									
Average cost per client	\$11,113**	\$11,574**	\$11,973	\$7,485	\$12,566	N/A*	N/A*	N/A*	N/A*
Average cost per day	\$184**	\$189**	\$172	\$167	\$201	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
 *FY16 data was not finalized until December, 2016 due to a system error.
 **These calculations do not include administrative costs.

STORY BEHIND THE PERFORMANCE

- A budget reduction of \$1,044,103 resulted in the loss of twenty-two (22) substance abuse residential treatment beds in state fiscal year (SYF) 2017.
- The Behavioral Health Division was realigned early in SFY 2017, which altered quality management responsibilities. In addition to realignment, staffing levels were reduced in the Mental Health and Substance Abuse Services (MHSA) Section. These changes necessitated the creation of efficiencies within quality management processes in order to better monitor provider performance and contract compliance.
- In collaboration with another unit within the Division, the MHSA Section developed a mechanism embedded within the data collection system which automates reporting of contract deliverables and provider performance of specific target areas. Outcomes of this project are:
 - A single point of reference for all MHSA staff to view the status of contract deliverables and outcome measures;
 - The elimination of fragmentation of deliverables tracking and consistency in approaches to noncompliance, quality improvement and outcomes development; and,
 - A mechanism for providers to determine contract compliance.
- In 2017 the MHSA Section received two additional grants: the Assisted Outpatient Treatment Grant (AOT) and the Opioid State Targeted Response Grant (Opioid STR).
 - The AOT grant supports the development of infrastructure and implementation of services under Wyo. Stat. Ann. § 25-10-110.1, Wyoming's Directed Outpatient Commitment statute.
 - The Opioid STR grant supports the development of infrastructure and service provision to address opioid use.

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 \$13,455 to eligible children and \$17,760 to eligible adults per year, plus case management. 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.

Program Expenditures and People Served

	2015	2016	2017
Total Medical & Waiver Cost	\$1,237,755	\$4,821,928	\$7,712,009
Total Waiver Cost	\$821,675	\$2,783,016	\$4,387,059
Total Medical Costs	\$416,080	\$2,038,912	\$3,324,950
Total People Served	203	425	556
Cost per Person (Medical & Waiver)	\$6,097	\$11,629	\$14,105
Non-600 Series*	15.3%	12.5%	6.8%

*600 series is defined as direct service contracts

Program Cost Notes

- Participants receive Medicaid medical services & 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

- FTE: 3.75
- AWEC: 0
- Other : 0

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of \$6,832 per person in FY17.
- The Waiver average cost per participant in FY17 was \$8,093.
- 78 participants self-directed some of their waiver services in FY17.
- 194 eligible individuals were on the waiting list for the Supports Waiver as of 06/30/2017.
- There were 623 certified providers monitored by the BHD during FY17.

Events that have Shaped this Program

- **New Waivers.** In March of 2013, the Wyoming Legislature passed Senate Enrolled 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 Developmental Disability (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 manager to have more authority and advocacy for overseeing the implementation of participants' plans of care.
- **Wait list funding.** The 2014 legislature appropriated \$9.7 million (50% State General Funds and 50% Federal Funds) for waiting list reduction of the Adult DD Waiver, \$5.9 million for waiting list reduction of the Child DD Waiver, and \$4.6 million for the Acquired Brain Injury Waiver, for a total of \$20.2 million.
- **New federal HCB rules.** In March of 2014, the federal government passed new rules for home and community-based (HCB) services, which set new standards for the types of settings and services that will be considered "home and community based" to ensure people in HCB services are truly integrated into their communities and not isolate or receiving services that seem institutional in nature. All service settings must be in compliance by March 2022, a delay from the previous deadline of March of 2019, and many providers will have significant changes to make in their programs over the next few years.
- **Rate Increases.** The 2016 Legislative Session appropriated \$7.8 million for the 2017-18 biennium. This appropriation resulted in an across the board rate increase of 3.3%. The 2017 Legislative Session appropriated \$5 million for SFY 2018. This resulted in an across the board rate increase of 4.2%.

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 \$13,455 to eligible children and \$17,760 to eligible adults per year, plus case management. 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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
average utilization of Individual Budget Amount (IBA) for child and adult Supports Waiver participants	32%	55.0%	N/A	N/A	21.8%	37.3%	46.5%
(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Total # of participants	N/A	47	203	425	556	329	414	448	546
# of participants, all ages, using community integration services.	N/A	0	2	38	44	37	38	38	43
# of participants, all ages, using supported living services.	N/A	1	3	107	133	N/A	N/A	113	128
# of participants ages 18+ using waiver supported employment services.	N/A	0	3	7	16	7	7	12	16
EFFICIENCIES									
Average cost per participant (waiver and medical)	N/A	N/A	\$6,097	\$11,629	\$14,105	\$5,501	\$7,073	\$7,720	\$7,789
Average cost per participant (waiver only)	N/A	N/A	\$4,302	\$6,542	\$8,093	\$3,320	\$4,081	\$4,508	\$4,575
(-) 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 Participants receiving respite care was removed from the 2017 performance metric									

STORY BEHIND THE PERFORMANCE

- **New federal HCB 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 2022, a delay from the previous deadline of March 2019, to ensure 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.** This Act requires agencies to support competitive and integrated employment; requires state agencies working with home and community based 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.

WDH | Public Health Division

Information contained in this section includes:

- 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
- 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
- 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
- Youth & Young Adult Health Program

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 and promote healthy development within the child population (ages 1-11 years), including children with special health care needs.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$518,322	\$402,515	\$388,973
People Served*	86,948	85,916	90,645
Cost per Person	N/A	N/A	N/A
Non-600 Series**	32%	40%	55%

*People Served is defined as the population of children in Wyoming ages 1-11 years.

** 600 series is defined as direct service contracts.

Program Cost Notes

- Child Health is federally funded (Federal Title V and Early Childhood Comprehensive Systems Grant (ECCS)) through July 2017.

Program Staffing

- 1.0 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The leading causes of unintentional injury hospitalization in Wyoming children, ages 1-11 years, were: 1. Falls, 2. Poisonings, 3. Motor Vehicle Crashes (Wyoming Hospital Discharge Data, 2009-2015).
- The Wyoming child unintentional injury mortality rate is consistently higher than the U.S. In 2015, the unintentional injury mortality rate among Wyoming children 1-11 years was 10.36 deaths per 100,000, twice the U.S. rate of 5.01 deaths per 100,000 children 1-11 years (Wyoming Vital Statistics, CDC WISQARS).

Events that have Shaped this Program

- The Maternal and Child Health Unit completes a Needs Assessment every 5 years to determine the Child Health Program Priorities. The three Child Health Program priorities for 2016-2020 are 1) Promoting Preventive and Quality Care for Children, 2) Reducing and Preventing Childhood Obesity, and 3) Preventing Injury in Children.
- From 2013-2017, the Wyoming Early Childhood Comprehensive Systems (ECCS) Grant worked to:
 - Expand developmental screening activities in early care and education sites while linking training opportunities to increase appropriate referrals among medical homes, early intervention, and child care providers;
 - Provide updated parent-completed developmental 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 medical home providers; and,
 - Provide initial funding to implement the Help Me Grow system to link families to services.

Child Health

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	FFY 2017 Target	FFY 2018 Target	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017
Screening % of failed vision screenings that result in a visual impairment diagnosis ¹	96%	100%	95% (128/135)	96% (106/110)	88% (191/217)	97% (326/335)	100% (219/219)
Screening % of eligible children (1-9 years) that received at least one component EPSDT screen in the past 12 months*	65%	65%	54.8% (11,862/ 21,663)	54.7% (11,356/ 21,082)	53.6% (11,207/ 20,890)	59.6% (11,144/ 18,693)	-
Physical Health % of children, (2-5 years) receiving WIC with a BMI at or above the 85 th percentile**	25%	22%	20.5% (1,742/ 8,484)	22.5% (1,785/ 7,918)	21.7% (1,650/ 7,595)	27.4% (1,975/ 7,212)	-
Physical Health Rates of hospitalizations due to nonfatal injuries (per 100,000) among children aged 1-11 years in Wyoming ² ***	18	15	29.0	24.3	21.9	-	-
Physical Health % of inspected Child Safety Restraints displaying one or more critical misuses ****	85%	85%	91.48%	93.85%	89.84%	91.94%	84.7% ¹

(-) Indicates data not yet available

*Medicaid 416 Report, Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) – calendar year, 2017 data available in 2018

**WIC data system – calendar year, 2017 data available in 2018

***Hospital discharge data –state fiscal year, 2016 data anticipated by end of 2017

****Safe Kids USA

¹ Federal fiscal year-to-date, 10/1/16 through 7/31/17

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of children screened for vision using photo screening machines as reported by the WY Vision Collaborative ³	4,011	4,794	2,302	2,726	1,963	1,501	1,225	1,148	815
Ages and Stages Developmental Screenings Distributed (ASQ3/SE2)	N/A	N/A	117 (61/56)	0*	88 (48/40)	0	0	81 (44/37)	7 (4/3)
Ages and Stages Developmental Screenings Completed (ASQ3+SE2) by PHN and other early childhood partners	N/A	N/A	1,360	1,994	1,527** YTD as of 6.30.17	N/A	N/A	962	565** Q3 April-June 2017
# of car seats distributed (D) & inspected (I) through Safe Kids Wyoming.	D:724 I:1,406	D:646 I:1,501	D:675 I:1,293	D:521 I:1,184	D:406 I:1023 YTD as of 6.30.17	D:249 I:521	D:272 I:663	D:284 I:662	D:122 I:361 Q3 April-June 2017
# of statewide educational injury prevention efforts focused on leading causes of injury/hospitalization of children in Wyoming	N/A	N/A	449	908	1,089 YTD as of 6.30.17	509	399	636	453 Q3 April-June 2017
EFFICIENCIES									
Cost per individual person participating in Safe Kids events per contracted \$ invested	\$4.70 (\$115,000/ 24,461)	\$1.12 (\$94,842/ 84,879)	\$1.30 (\$135,157/ 103,698)	\$1.85 (\$104,487/ 56,493)	\$2.85 (\$66,860 /23,487) YTD as of 6.30.17	\$0.76 (\$28,536/ 37,365)	\$3.98 (\$75,951/ 19,065)	\$3.11 (\$48,631 /15,626)	\$2.32 (\$18,229 /7,861) Q3 April-June 2017

"N/A" - not previously collected.

(-) Indicates data is not yet available

ASQ3/SE – Ages & Stages Developmental Questionnaire, Third Edition (ASQ3)/Ages & Stages Questionnaire: Social-Emotional 2 (ASQ:SE2)

*No ASQ kits distributed in 2016

**Quarter 3 data currently reflective of screenings completed by Public Health Nurses (PHN), Quarters 1 and 2 include PHN and Child Development Centers and other partners who received ASQ kits from Child Health Program

STORY BEHIND THE PERFORMANCE

¹ Annual vision screening for children beginning at age 6 months and through 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 reported increased number of referrals without appropriate diagnosis resulted from technical equipment issues. When the equipment vendor was notified, corrective adjustments were made to machines in Wyoming and across the country. Additional trainings in SFY 2016 helped ensure rates of referrals returned to typical levels and diagnoses increased.

Beginning in SFY 2017, vision screening protocols and training were created and are currently offered across the state in partnership with local optometrists and ophthalmologists. These efforts help ensure that screenings are implemented consistently across the state and are based on the most recent recommendations from Prevent Blindness America and the National Center for Children's Vision and Eye Health. These actions have resulted in 100% of children referred being identified and diagnosed appropriately.

² Although fatal injuries among Wyoming children occur at twice the rate of the U.S., child injury fatalities occur in small numbers and therefore injury hospitalizations are used as a more consistent measure to track program progress. Data for unintentional injury hospitalizations among children comes from the Wyoming Hospital Discharge Data. Unintentional injuries include injuries caused by falls, poisonings, motor vehicle crashes, bicycle, and other transportation injuries, fires, etc.

³ The number of children being screened for vision using photo screening machines has steadily declined since FFY2015, when the Wyoming Early Intervention Program began requiring Child Development Centers to report their screening data into the Early Hearing Detection & Intervention (EHDI) database. Since then, this number no longer reflects all children who are receiving vision screening in Wyoming, as only some Child Development Centers continue to forward their screening data to the Wyoming Vision Collaborative. Neither MCH nor the Wyoming Vision Collaborative has been granted access to the EHDI database system.

Chronic Disease Prevention Program

Program Description

The Chronic Disease Prevention Program promotes the implementation of evidence-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

	SFY 2015	SFY 2016	SFY 2017
Total Program Cost	\$295,882	\$665,509	\$943,393
People Served	582,658	585,501	585,501
Cost per Person	\$0.51	\$1.14	\$1.61
Non-600 Series*	93.3%	99%	99%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 100% federally funded grant from the Centers for Disease Control and Prevention (CDC).
- In FY 2017, the CDPP hired a new staff member (1.0 FTE), developed new interventions, and increased the reach of current program efforts to improve outcomes, resulting in increased program expenditures.
- 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 (600-series expenditures).
- The population of Wyoming (census data) is used as a metric for 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

2.4 FTE
1.0 AWEC
0 Other

Program Metrics

- The State of Wyoming currently has 19 Diabetes Self-Management Education (DSME) program sites and 3 Diabetes Prevention Programs (DPPs).
- 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 as well as provide technical assistance and support to DSME and DPP sites.
- In the past year, 537 Early Childhood Education (ECE) 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 is more focused.

Staffing played a large role in program outcomes. The program had three different program managers within two years, which limited program outcomes. However, the program also received approval to hire an AWEC employee in Q4 of FY17, which significantly increased program capacity and improved outcomes.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# of Early Childhood Education sites (ECEs) that adopt strategies to increase physical activity ¹	20	40	0	0	6	6	25
% of schools that do not sell less healthy foods and beverages ^{2,3}	50%	54%	x	37.4%	x	45.8%	-
% of people with diabetes in targeted settings who have at least one encounter with Diabetes Self-Management Education (DSME) ⁴	8.0%	5.0% ⁵	N/A	4.0%	4.4%	4.3%	-
% of people with self-reported hypertension ⁶ (national average)	30.0%	30.0%	28.7%* (31.4%)	x	29.9%* (30.9%)	x	-
% of people with self-reported diabetes ⁶ (national average)	9.0%	8.2%	8.6%* (9.8%)	8.4%* (10.1%)	8.4%* (10.0%)	8.3%* (10.5%)	-

(x) Indicates data not collected that year

(-) Indicates data not yet available

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

(*) Indicates weighted data

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of providers, clinical staff members, or community health workers trained on diabetes and hypertension self-management strategies ⁷	N/A	N/A	N/A	357	831	N/A*	N/A*	421	410
# of ECE providers that received professional development to adopt policies to increase physical activity ⁷	N/A	N/A	N/A	166	537	58	108	350	187
# of local education agencies that received professional development or technical assistance on strategies to create a healthy school nutrition environment ⁷	N/A	N/A	15	19	15	6	13	9	6
EFFICIENCIES									
Cost per provider, clinical staff member, or community health worker trained in hypertension and diabetes management	N/A	N/A	N/A	\$309.50 (\$110,492/ 357)	\$225.84 (\$187,677 / 831)	N/A*	N/A*	\$200.32 (\$84,333/ 421)	\$315.08 (\$129,181 / 410)
(-) Indicates data not yet available (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 Chronic Disease Prevention Program is funded by the State Public Health Actions (SPHA) to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health grant. This grant provides funding to reduce risk factors associated with childhood and adult obesity, diabetes, heart disease, and stroke. SPHA funds work in schools, early childhood education facilities, workplaces, and communities with a focus on systems, policy, 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 decreased hospitalizations and need for treatment for complications.

Footnotes:

¹ Data Source: WY Let's Move Childcare Checklist Dataset

² Data Source: School Health Profiles

³ Note: "Less healthy foods and beverages" are defined in the School Health Profiles as chocolate candy, other candy, salty snacks not low in fat, cookies, crackers, cakes, pastries, other baked goods, soda pop, fruit drinks, and sports drinks

⁴ Data Source: CDC DSME State Data Report

⁵ Note: Target was lowered to a more attainable target for FY2018 based off average change in previous years.

⁶ Data Source: Wyoming Behavioral Risk Factor Surveillance System

⁷ Data Source: Count of attendees at CDPP sponsored trainings and technical assistance sessions

Communicable Disease Prevention Program

Program Description

The Communicable Disease Prevention Program supports the prevention, control, and investigation of communicable diseases in Wyoming. The program provides education, testing, and targeted interventions to individuals and healthcare providers for Chlamydia, Gonorrhea, Hepatitis B and C, HIV, Syphilis, and Tuberculosis.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$2,343,159	\$1,681,960	\$1,955,573
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	21%	56%	48%

* 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 – 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 and Public Health Nursing, 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 Immunizations, Behavioral Health, Public Health Nursing, Medicaid, Department of Education, Department of Corrections, Department of Family Services, and the Wyoming Health Council.

Events that have Shaped this Program

- 2020: 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 spent to integrate across disease prevention and control programs resulting in: implementation of a standard 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 & Prevention Planning Alliance (CAPP), TB Advisory Committee)
- 2012: Establishment of National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) strategic priorities including prevention through healthcare and health equity.
- 2012/2013: Completion/adoption of the 2012-16 Comprehensive Prevention and Care Planning Document
- 2013: Re-established Personal Responsibility Education Program funds to decrease unintended teen pregnancy and STDs
- 2004: State Funding to support adult Hepatitis A and B vaccination

Communicable Disease Prevention Program

PROGRAM CORE PURPOSE

To prevent, control, and investigate communicable diseases in Wyoming.

OUTCOMES

Performance Metric	CY 2017 Target	CY 2018 Target	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
% of newly reported gonorrhea, syphilis, HIV, hepatitis B, and Hepatitis C (<36 years of age) cases that do not have a disposition of "unable to locate" ¹	95%	95%	N/A	N/A	N/A	97%	-
% of WyPREP participants correctly identifying effective methods of protection from STDs, HIV, and pregnancy in the Reducing the Risk (RTR) Knowledge Survey ²	75%**	82%**	N/A	N/A	N/A	69%** (214/308)	-
Rates of gonorrhea infections per 100,000 persons ³ (National rate)	28.0	45.0	11.5 (106)	19.9 (111)	29.7 (124)	47.8 (145.8) ⁴	-
Active TB case rate of <1 per 100,000 statewide ⁵ (National rate)	<1	<1	0 (3.0)	0.4 (2.9)	0.7 (3.0)	0.2 (2.9) ⁶	-
Rates of hepatitis C infection per 100,000 persons ⁷	80.0	80.0	81.6	99.7	82.1	84.7 ⁸	-

(-) 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 2013	CY 2014	CY 2015	CY 2016	CY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# condoms provided to high risk populations ⁹	199,740	362,987	275,448	242,733	251,273*	137,465	105,268	132,930	118,343*
# of condom dispenser sites	N/A	77	102	107	161*	89	102	126	161*
# of WyPREP participants**	N/A	N/A	90	587	264*	258	329	264*	-
EFFICIENCIES									
Cost per voucher – knowyo.org ¹⁰	\$51.25 \$115,000 /2,244	\$31.16 \$115,000 /3,691	\$33.04 \$115,000 /3,481	\$25.12 \$115,000 /4,674	\$26.98* \$115,000 /4,262	\$24.85 \$57,500 /2,314	\$24.36 \$57,500 /2,360	\$21.61 \$57,500 /2,661	\$35.92* \$57,500 /1,601
(-) Indicates data not yet available									
*Calendar Year-to-Date (January – October)									
**This measure is for State Fiscal Year as WyPREP programming is based on school year not calendar year.									

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.

¹This metric is for patients with laboratory confirmed Gonorrhea, Syphilis, HIV, Hepatitis B, and Hepatitis C (<36 years of age). Partner services are offered to all newly reported cases of Gonorrhea, Syphilis, HIV, Hepatitis B, and Hepatitis C (<36 years of age) and their elicited partners in Wyoming. Partner services include: ensuring appropriate treatment has been provided and recommending additional testing (if indicated), eliciting partners (sexual or needle-sharing), providing prevention messages related to identified risks, and locating the elicited partners to notify them of the exposure and recommend testing. The disposition of “unable to locate” is used for confirmed cases or partners of cases in which they are unable to be reached for follow-up and referral for testing. The disposition of “unable to locate” was standardized in 2015, therefore, data from previous years is not comparable.

²The Wyoming Personal Responsibility Education Program (WyPREP) provides funding for schools and community-based organizations to provide relationship 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 HIV/STDs through evidence-based curricula. Only organizations offering the Reducing the Risk (RTR) curriculum and administering the RTR Knowledge Survey are included in these numbers.

³Gonorrhea 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.

⁴The 2016 national Gonorrhea rate was 145.8/100,000.

⁵The World Health Organization standard for TB Prevention and Control is for States and Territories to have an incidence of less than one (1) case of Active TB per 100,000 people.

⁶The 2016 national TB rate was 2.9/100,000.

⁷Approximately 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 have Hepatitis C.

⁸Hepatitis C is not reportable in all states so a national rate is not available. However, CDC estimates 2.7-3.9 million people have chronic Hepatitis C infection.

⁹According to the CDC, condom distribution programs are structural interventions that have been shown to: increase condom use, condom acquisition, and condom carrying, promote delayed sexual initiation or abstinence among youth, provide cost-effective and cost-saving outcomes on future medical costs, and help reduce HIV/STD and unintended pregnancy risk among a wide range of at-risk groups.

¹⁰The health education campaign, WWW.KNOWYO.ORG, was established as a call to action for Wyoming residents to get tested for communicable diseases through no or low-cost confidential testing services available at Public Health Nursing offices, Family Planning clinics, and other healthcare partners across the state.

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

	2015	2016	2017
Total Program Cost	\$1,665,990	\$1,540,350	\$1,797,199
People Served¹	1,374	2,608	2,086
Cost per Person	\$1,213	\$591	\$862
Non-600 Series²	11.97%	16.42%	14%

¹ The increase in people served is in part due to the increased number of testing occurring and the increased incidence in HIV, STD and TB across Wyoming.

² - 600 series is defined as direct service contracts.

Program Cost Notes

- Grant Fiscal Year (GFY) 16 - Ryan White Part B/AIDS Drug Assistance Program (ADAP) Grant—HRSA, Federal
- GFY 16 - Ryan White Part C Grant—HRSA, Federal
- GFY 16 - Housing Opportunities for Persons with AIDS Grant, HUD
- CY 16 - TB Prevention & Control Grant—CDC, Federal
- FFY 16 - Substance Abuse Block Grant Dollars—SAMSHA, Federal
- FFY 16 - Preventative Health and Human Services—CDC, Federal
- SFY 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, STD, viral Hepatitis B and C, Tuberculosis-Active/Latent programs
- Clients who adhere to a medical case management care plan developed according to 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 receiving treatment or preventive treatment for STD infections
- Purchasing of insurance for enrolled HIV positive individuals

Events that have Shaped this Program

- 2020: Publication of Healthy People 2020 Objectives including 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)
- 2010: Adoption and implementation of baseline HIV/AIDS Bureau/CDC Standards of Care measures
- 2011/2012: Implementation of standard 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 to CDC & HRSA



Communicable Disease Treatment Program

PROGRAM CORE PURPOSE

To reduce disease incidence and improve the health of individuals diagnosed with communicable diseases in Wyoming.

OUTCOMES

Performance Metric	CY 2017 Target	CY 2018 Target	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
% of gonorrhea cases receiving the recommended dual therapy medication ¹	90%	90%	N/A	47% (70/150)	88% (151/171)	88% (243/277)	-
% and # of Latent TB (LTBI) clients starting treatment in TB Program completing LTBI treatment ²	80%	80%	74% 42/57	67% 69/103	77% 54/70	79% 45/57	-
% of newly identified HIV positive clients linked into primary care within 3 months of diagnosis ³	95%	95%	80% 12/15	70% 9/13	73% 11/15	80% 16/20	-
% of clients enrolled in HIV Services Program with suppressed HIV Viral load ⁴	75%	90%	73% 119/163	65% 106/164	61% 94/153	84% 184/219	-
% of new HIV infections considered a late diagnosis ⁵	50%	25%	46.7% 7/15	67% 8/12	31% 5/16	-	-

N/A indicates data not available
 (-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of HIV clients enrolled in care with a documented CD4/Viral Load	147	164	135	200	-	174	168	-	-
# of HIV clients enrolled in HIV Services Program ⁶	168	174	179	208	-	182	182	192	-
# of individuals in the TB Program enrolled for LTBI/active TB disease treatment	114	127	93	98	-	47	51	-	-
EFFICIENCIES									
Average cost of HIV client enrolled in HIV Service Program ⁷	-	\$2,594	\$3,247	\$3,799	-	\$2,279	\$1,520	-	-

(-) Indicates data not available

STORY BEHIND THE PERFORMANCE

- Healthy People 2020 goals and objectives, CDC goals and objectives, and the HIV/AIDS Bureau Standards of Care are the benchmarks for the Communicable Disease Treatment Program
- The Communicable Disease Treatment Program provides payment for medical services for approximately 185 clients currently living with HIV/AIDS in Wyoming.
- Statutory requirements are in W.S. § 35-4-101 through 113.

¹ CDC recommends using dual therapy (using two drugs) to treat Gonorrhea. Antimicrobial resistance in Gonorrhea is of increasing concern and successful treatment is important to stop the infection and prevent further transmission. This data was not previously tracked in 2012-2013 as the grant metrics associated with STD prevention funding changed significantly in 2014.

² According to the CDC, treating latent Tuberculosis infection (LTBI) to prevent progression to TB disease is a cornerstone of the U.S. strategy for TB elimination. National objectives aim to ensure at least 85% of LTBI cases complete treatment. The TB Program provides financial assistance to Wyoming residents for TB medications.

³ According to CDC HIV Surveillance Report, Volume 22, Number 2, July 2017, in 2015, 84% of HIV positive individuals nationally are linked into care within 3 months of diagnosis.

⁴ An individual with a suppressed viral load has small amounts of virus in their blood reducing the risk of transmission (<200 copies/mL). 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 Communicable Disease Treatment Program.

⁵ A patient is considered to have a late diagnosis of HIV when he or she progresses from HIV to AIDS within one year. The national average between an HIV diagnosis and an AIDS diagnosis is 6-7 years. This measure will always be one year behind given the one year time period needed to determine if a case is a late diagnosis.

⁶ Quarterly numbers are based on the total quarter number of clients enrolled in the HIV Services Program. The quarters reflect those that have maintained, added, or dropped from the program. The CY year totals are a culmination of the entire year view of those that have maintained, added, or dropped from the program.

⁷ Based on all services funded by the HIV Services Program, excluding medications. The program realizes savings in Q3+Q4 over Q1+Q2 due to insurance deductibles being met in the first half of the year.

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 2015	SFY 2016	SFY 2017
Total Program Cost	\$382,846	\$818,516*	\$876,034
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	32%	17%	14%

* \$253,000 in federal funds was paid out in SFY 2016

**600 series is defined as direct service contracts.

Program Cost Notes

- 40% SGF, 60% federal funds
- Medicare Rural Hospital Flexibility (Flex) Program Grant, 100% FF (\$464,345)
- Small Rural Hospital Improvement Program (SHIP) Grant, 100% FF (\$126,000)
- Community Assessment, 100% SGF (\$227,732)
- Primary Care Support Act (PCSA), 100% SGF (\$1.2M) total received for program to date

Program Staffing

- 1.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The Flex Grant provides Critical Access Hospitals (CAH) support for quality and financial improvement, population health, and emergency medical services (EMS). In addition, Flex supports hospital conversion to CAH status and develops innovative healthcare models.
- 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 Primary Care Support Act (PCSA) grant received seven applications in SFY2013; four awards were distributed in SFY2014. 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.
- 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.



Community Medical Access and Capacity Program

PROGRAM CORE PURPOSE

The Community Medical Access and Capacity Program provide 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 2017 Target	FFY 2018 Target	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016
% and # of CAHs meeting minimum requirement in the Medicare Beneficiary Quality Improvement Program (MBQIP) ¹	93.75% 15/16	100% 16/16	37.5% 6/16	87.5% 14/16	93.75% 15/16	93.75% 15/16	93.75% 15/16
% of CAHs reporting Emergency Department Transfer Communication measures (EDTC) ^{1,2}	93.75% 15/16	100% 16/16	N/A	N/A	62.5% 10/16	37.5% 3/16	81.25% 11/16
% of CAHs reporting HCAHPS ^{1,2}	93.75% 15/16	100% 16/16	N/A	N/A	81% 13/16	75% 12/16	81% 13/16
% of CAHs reporting Patient Safety ^{1,2}	93.75% 15/16	100% 16/16	N/A	N/A	N/A	75% 12/16	75% 12/16
% of CAHs reporting Out Patient ^{1,2}	93.75% 15/16	100% 16/16	N/A	N/A	N/A	38% 6/16	44% 7/16
% of CAHs reporting financial data to QHi ^{1,2}	62.5% 10/16	87.5% 14/16	N/A	N/A	N/A	37.5% 3/16	44% 3/16

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

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of Quality Improvement Roundtable calls (# of people present) ^{3,4}	18	16	5	6 (71)	1 (10)	3 (33)	3 (38)	1 (10)	-
# of CAHs participating in annual Learning and Planning event ^{3,4}	5	6	4	5	-	5	0	-	-
WYQIM website # of resources (# of visitors) ^{3,4}	N/A	N/A	N/A	18 (185)	18 (139)	N/A	18 (185)	18 (139)	-
# of CAHs participating in Patient Safety Culture Survey ^{3,4}	N/A	N/A	5	9	-	5	0	9	-
# of CAHs utilizing QHi benchmarking database ^{3,4}	6	6	5	7	7	7	0	7	-
# of CAHs participating in financial improvement projects ^{3,4}	N/A	N/A	6	6	7	6	0	7	-

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

- indicates data not yet available

Performance Metric	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
EFFICIENCIES									
Average cost per CAH participating in FI/OI initiatives ^{3,4}	N/A	\$21,575	\$22,167*	\$17,641*	-	N/A*	N/A*	-	-
Average cost per CAH participating in QI initiatives ^{3,4}	N/A	\$4,889	\$7,206*	\$4,725*	-	N/A*	N/A*	-	-
Cost per CAH to participate in QHi ^{3,4}	\$2,267	\$2,200	\$1,500*	\$1,500*	-	N/A*	N/A*	-	-
N/A indicates data not yet available due to the creation of a new metric.									
* Figures for FFY 2015 and FFY 2016 may differ from previous reports due to a new methodology.									
N/A* indicates data not available on a quarterly basis.									
- indicates data not yet available									

STORY BEHIND THE PERFORMANCE

1. In 2015, the Health Resources and Services Administration (HRSA) initiated a three year grant cycle for the Medicare Rural Hospital Flexibility (Flex) Program. The federal fiscal year 16 for Flex began September 1, 2016 and ended August 31, 2017. The core areas of the program are quality improvement (QI), financial and operational improvement (F/OI), population health, and emergency medical services (EMS). There are two additional areas for participation: CAH designation and innovative health care models. These are not incorporated into the Wyoming Flex Program. The Federal Office of Rural Health Policy (FORHP) developed the Medicare Beneficiary Quality Improvement Program (MBQIP) as a system to measure quality of care in CAHs. In order for a CAH to receive Flex funds, FORHP requires CAHs to have a signed Memorandum of Understanding (MOU) to share data and report at least one MBQIP measure for at least one quarter, in at least two of the four quality domains. Financial data is reported to Centers for Medicare and Medicaid Services (CMS) and provided through the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) and through Quality Health indicators (QHi).
2. The four domains of MBQIP are patient safety, patient engagement measured through the Hospital Consumer Assessment of Providers and Systems (HCAHPS), care transitions measured through the Emergency Department Transfer Communication (EDTC), and outpatient. There is a consistent increase and frequency of CAHs reporting in all four quarters in all four domains. Consistency in reporting MBQIP provides data that is reliable when determining areas for quality improvement projects. Data collected through CAHMPAS and QHi is used to determine areas for financial improvement. One WY CAH has not signed an MOU. The percentage is based on the number of CAHs reporting in all four quarters.
3. In the area of quality improvement for FY 15, Flex funded five CAHs with QHi, five CAHs with health information systems, two CAHs with HCAHPS, eight CAHs with peer review, and five CAHs with Patient Safety Culture (PSC) Survey. In FY 16 WY Flex funds were used to assist seven CAHs with QHi, four with HCAHPS, and nine CAHs with PSC. In FY 15 six CAHs received Flex reimbursement for financial improvement and in FY 16 eight CAHs were reimbursed for financial improvement initiatives. Wipfli, LLP conducted a statewide financial assessment of Wyoming's 16 CAHs in 2017.
4. CAH staff is invited to participate in bi-monthly QI Roundtable calls. The calls provide an opportunity to share best practices, lessons learned, and determine direction for future quality improvement projects. Reporting data and utilizing the resources of QHi provides an opportunity for QI and F/OI. WY Flex produces a monthly newsletter, maintains a Wyoming Quality Improvement Matters (WYQIM) website, host Wyoming Flex Team calls, conducts an annual assessment of the program, provides 1:1 technical assistance for reporting and developing QI and F/OI projects, and hosts an annual WY Flex Learning and Planning event.

Community Services Program (CSP)

Program Description

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 sub-contract with local service providers to assist low-income individuals and families with an array of anti-poverty related health and human services, thereby empowering recipients to move toward self-sufficiency.

Program Expenditures and People Served

	SFY 2015	FFY 2016	FFY 2017
Total Program Cost	\$3,271.12	\$3,017,665	\$3,428,404
People Served	23,402	31,503	22,606
Cost per Person	\$128.20	\$95.79	\$151.66
Non-600 Series*	9%	6%	11%

* 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 detail, programmatic statistics, and fiscal data to CSP.

Events that have Shaped this Program

- CSBG allocations are determined for each county through a poverty formula which considers 7 factors that include the low-income population, number of people unemployed, number of Medicaid recipients, number of people receiving Supplemental Nutrition Assistance Program (SNAP) benefits, etc.
- 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.

Community Services Program (CSP)

PROGRAM CORE PURPOSE

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 2017 Target	FFY 2018 Target	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017
% of emergency rent/mortgage assistance provided (# of individuals helped / # who requested assistance) ³	>30%	>30%	40% (1,889/ 4,774)	26% (2,002/ 7,797)	33% (1,537/ 4,647)	44% (753/ 1,708)	(-)
% of emergency medical care provided (# of individuals helped / # who requested assistance) ³	>80%	>80%	89% (1,673/ 1,876)	78% (1,341/ 1,726)	77% (1,941/ 2,531)	73% (1,880/ 2,599)	(-)
% of emergency food provided (# of individuals helped / # who requested assistance) ³	>95%	≥99%	99% (34,867/ 34,875)	99% (14,313/ 14,526)	99% (6,002/ 6,047)	94% (6,213/ 6,673)	(-)
% of Wyoming's eligible families receiving CSBG services ^{1,5}	>30%	>30%	42% (10,584/ 25,054)	28% (7,141/ 25,120)	61% (12,578/ 20,803)	53% (10,972/ 20,803)	(-)
(-) Indicates data not yet available; previous FFY data is not available until the end of the following FFY. N/A indicates data not available due to the creation of a new metric							

OUTPUTS AND EFFICIENCIES									
Performance Metric	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of low-income and/or homeless people receiving Services ⁴	N/A	N/A	N/A	31,503	22,606	12,466	19,037	N/A	N/A
# of Tripartite Boards meeting 75% or more of the CSBG Organizational Standards ^{7,8}	N/A	N/A	N/A	63% (10/16)	13% (2/16)	N/A	63% (10/16)	N/A	N/A
# of service providers conducting activities in top 3 areas of greatest need according to Needs Assessment	N/A	N/A	N/A	56% (38/68)	68% (42/61)	N/A	N/A	NA	N/A
EFFICIENCIES									
Cost per person	\$72.87 (\$4,928,258/ 67,630)	\$128.20 (\$3,882,241 /30,282)	\$131.50 (\$3,271,11 2/23,402)	\$95.79 (\$3,017,65 5/31,503)	\$151.66 (\$3,428,40 4/22,606)	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 *The Emergency Services Grant was transferred to the Department of Family Services as of January 1, 2014.									

STORY BEHIND THE PERFORMANCE

1. The Community Services Program (CSP) receives approximately \$3.3 million annually from the U.S. Department of Health and Human Services to administer the Community Services Block Grant (CSBG). Ninety percent of this funding is distributed directly to communities to assist low-income individuals and families and to empower them to move towards self-sufficiency.
2. CSBG services and activities are conducted in all 23 counties and on the Wind River Reservation to address 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 their abuser is assisted with their security deposit, three months of paid rent and utilities, food vouchers, and a medical voucher for a broken bone. Typically, case management continues for six to twelve months to assist the victim in continuing their path to becoming self-sufficient.

3. All regular CSBG activities were conducted, but a special emphasis was placed on education, employment, health, and housing.
4. The Emergency Solutions Grant (ESG), formerly Emergency Shelter Grant, received approximately \$180,000, annually, from Housing and Urban Development. This program transferred to the Department of Family Services in January 2014.
5. This outcome is calculated 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. Prior to FFY2017, all outcomes were reported on Federal Fiscal Year (FFY) and all outputs and efficiencies were reported on state fiscal year (SFY). Starting with FFY2016-17, all metrics 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.
8. The 2015 Organizational Standard Survey sent out to the eligible entities in 2015 did not require they provide documentation supporting that the standard was met, which is why there is a significant difference between 2015 data and 2017 data. In FFY 2017, the eligible entities were required to provide documentation via uploading supporting documents for review by the state office.

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 involves two key tasks: ensuring compliance within existing infrastructure and developing new components. The EMS Section 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

	2015	2016	2017
Total Program Cost	\$1,105,798	\$1,066,263	\$889,394
People Served	584,153	586,107	585,501
Cost per Person	\$1.89	\$1.82	\$1.51
Non-600 Series*	95%	100%	100%

* 600 series is defined as direct service contracts

Program Cost Notes

- 71% General Funds
- 29% Federal Funds

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: 34 EMT courses were provided in FY2017
- 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.
- Calendar year 2016 recorded approximately 47,064 requests for service statewide (911 only) (approximately five requests per hour).

Events that have Shaped this Program

- The Wyoming Emergency Medical Services Act of 1977 created EMS within the Department of Health.
- National trends and legislation, such as the National Emergency Medical Services Education Standards (2011).
- W.S. 35-1-801 creates 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.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of services reporting in WATRS ¹	95%	90%	69% (52/75)	82% (63/77)	91% (77/85)	89% (91/102)	89% (92/103)
% and # of services submitting complete data ²	90%	90%	81% (42/52)	85.7% (54/63)	84% (65/77)	76% (69/91)	87% (78/92)
% and # of chute times <10 minutes ³	>95%	>95%	97% (11,218/ 11,584)	90.4% (22,564/ 24,945)	84% (42,542/ 50,919)	91% (41,992/ 46,145)	92% (40,949/ 44,510)
% and # of responses ≤ 8:59 ⁴	60%	60%	48% (5,505/ 11,584)	52% (13,095/ 24,945)	43% (22,068/ 50,919)	52% (23,995/ 46,145)	51% (22,700/ 44,510)

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Supported EMT classes	23	27	19	31	34	7	24	9	25
WATRS records (911 only)	30,335	45,897	50,952	50,437	47,611	27,270	23,167	23,897	23,714
Completed records (911 only)	11,584	35,989	47,436	46,145	44,510	25,112	21,033	22,556	21,954
WATRS trainings	1	9	16	20	16	16	4	7	9
WATRS customer support (minutes)	5,569	9,466	11,758	24,744	16,620	6,552	18,192	8,940	7,680
EFFICIENCIES									
Cost per successful student	\$209 (\$54,153/ 259)	\$184 (\$33,525/ 182)	\$122 (\$32,988/ 270)	\$218 (\$55,755/ 255)	\$77 (\$21,100/ 273)	\$483 (\$22,205/ 46)	\$161 (\$33,550/ 209)	\$43 (\$4,800/ 111)	\$100 (\$16,300/ 162)
Class completion rate	82% (259/ 317)	69% (182/ 262)	87% (270/ 322)	87% (255/ 294)	82% (273/ 334)	96% (46/ 48)	85% (209/ 246)	89% (111/ 125)	78% (162/ 209)

STORY BEHIND THE PERFORMANCE

The OEMS is both a developmental and a 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(s) 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.” In other words, the degree of reliability to which Wyoming’s EMS is capable of responding promptly and delivering appropriate care. Many factors 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 is capable of meeting 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.

¹The 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.

²Following the 2012 HealthStat report, the OEMS assigned a validity score to specific data fields within 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.

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

	2015	2016	2017
Total Program Cost	\$699,742	\$751,497	\$1,009,806
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	26.78%	16%	14.24%

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY17: 69% SGF and 31% FF
- WHPLRP 15-16 award budget: \$1M (tobacco funds); funding eliminated for 17-18. PRGP 15-16 award budget: \$400K; reduced to \$244K for 17-18
- SFY2017 increase in expenditures a result of changes to payment schedule for SFY15-16 WHPLRP awards, IT projects funded by a supplemental award of federal funds, and timing of payments from SFY2016 WY-SLRP awards.

Program Staffing

- 0.88 FTE
- 0.35 AWEC
- 0 Other

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. Funding eliminated for SFY17-18.
- The REACH Program provides grants for hosting educational programs to expose students in grades 5-8 to healthcare careers. Three were hosted in 2017 with 40 participants.
- 2015 was WY-SLRP's first year. Fourteen awards have been issued since 2015 (five physicians, six physician assistants, and three nurse practitioners).

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, increased the maximum allied healthcare professional award under W.S. § 9-2-119 and expanded eligibility under PRGP (W.S. § 35-1-1101) to non-physicians.
- As a result of agency-wide budget reductions, funding for WHPLRP (100% tobacco settlement funds) was eliminated for SFY2017-2018 resulting in the loss of approximately 15 awards; funding for PRGP (\$400,000 SGF) was reduced to \$244,000 for SFY2017-2018 resulting in a reduction of approximately three PRGP awards.
- 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. The AWEC Data Manager was replaced with an AWEC Program Specialist in 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 physician and eight mid-level clinicians). Funding is 50% federal and 50% state matching funds.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of Loan Repayment (LRP) applicants awarded (# awarded / # applications) ¹	67%	100%	4.6% (10/219)	7.9% (13/165)	5.82% (11/189)	6.45% (12/186)	100% (5/5)
% and # of LRP awardees completing obligation (# / # total awards by cohort) ²	≥90%	≥80%	84% (21/25)	72.7% (8/11)	87.5% (7/8)	90% (9/10)	84.6% (11/13)
LRP 3-year retention rate (# retained / # respondents by cohort) ³	≥80%	≥80%	86.67% (13/15)	89.65% (78/87)	83.33% (15/18)	92.3% (12/13)	66.67% (2/3)
% and # of retained LRP awardees still accepting Medicare/Medicaid/CHIP (# accepting/ # retained) ³	≥85%	≥85%	84.62% (11/13)	98.72% (77/78)	100% (15/15)	91.67% (11/12)	100% (2/2)
% and # of Provider Recruitment Grant (PRGP) awardees successfully recruited (# recruited/ # awards by cohort) ⁴	60%	60%	75% (3/4)	50% (2/4)	0% (0/4)	60% (3/5)	20% (1/5)

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Amount awarded (# LRP awards) ¹	\$500,000 (10)	\$504,297 (13)	\$670,000 (11)	\$678,000 (12)	\$140,000 (5)	\$558,000 (8)	\$120,000 (4)	0	\$140,000 (5)
Amount awarded (# PRGP awards) ⁴	\$200,000 (3)	\$200,000 (4)	\$200,000 (4)	\$238,520 (5)	\$235,000 (5)	\$238,520 (5)	0	0	\$235,000 (5)
# of new candidates sourced ⁵	46	0	378	686	686	441	245	441	245
# of candidates placed ⁵	6	0	4	9	6	3	6	3	3
# of new J-1 Visa Waivers ⁶	4	10	4	10	5	N/A*	10	N/A*	5
EFFICIENCIES									
Average PRGP Reimbursement ⁴	\$39,286	\$42,342	\$42,342	\$47,020	\$46,808	N/A*	N/A*	N/A*	N/A*
Average cost per new candidate sourced ⁵	\$2,418 (\$111,240 /46)	0	\$62.81 (\$23,740 /378)	\$39.25 (\$26,928 /686)	\$45.43 (\$31,165 /686)	\$42.45 (\$18,721 /441)	\$33.50 (\$8,207 /245)	\$34.60 (\$15,258 /441)	\$64.93 (\$15,907 /245)
Average cost per placement ⁵	\$18,540 (\$111,240 /6)	0	\$8,000 (\$32,000 /4)	\$7,111 (\$64,000 /9)	\$5,333 (\$32,000 /6)	\$8,000 (\$24,000 /3)	\$6,667 (\$40,000 /6)	\$5,333 (\$16,000 /3)	\$5,333 (\$16,000 /3)
N/A* indicates data not available on a quarterly basis or for specific quarters indicated									

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. WHPLRP funding was eliminated for 2017-2018.

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. Priority is given based on shortage area score, as well as to providers who graduated from a Wyoming college and those who have been practicing in Wyoming the least amount of time. Data for loan repayment awards was updated to include WY-SLRP award data beginning in SFY2015 and the SFY 2018 Target for the percent of 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. Applications received dropped from 186 in SFY2016 to five in SFY2017 as WHPLRP was no longer funded and WY-SLRP limited funding and eligibility.

2. Since 2006, 299 loan repayment awards have been issued through both WHPLRP and WY-SLRP. As of the 4th quarter of SFY2017, 268 have either successfully completed or are currently completing their service obligation and requirements. To date, 31 awardees have withdrawn from program participation prior to the first payment or have defaulted on their service obligation or other requirements. Numbers reported under outcomes are for each cohort whose obligation ended during the corresponding fiscal year to show completion rate by award round versus overall as stated above. National Health Service Corps (NHSC) data for Wyoming indicates a completion rate of 98% for NHSC Loan Repayment participants between 2003 and 2013. NHSC and WY-SLRP have significantly higher default penalties than WHPLRP.
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 SFY2017, 196 prior awardees have been surveyed. Of survey respondents, 82.1% are still practicing in Wyoming and 88.2% 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). Numbers reported under outcomes are for each survey year cohort versus overall as stated above. 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, 31 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. Thirteen have been successful at recruiting and the SFY2017 awardees have through June 2018 (SFY2018) 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. Numbers reported under outcomes are for each award round cohort for the corresponding fiscal year versus overall as stated above.
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 (\$8,000/physician, \$4,000/mid-level) with an emphasis on the highest need specialties and areas statewide. According to 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. Data reported under outputs for SFY2016 and SFY2017 are the same based upon reports submitted by WHRN.
6. Each state is allotted 30 J-1 Visa waivers per federal fiscal year (FFY). 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.



Public Health Nursing Healthy Baby Home Visitation Program

Program Description

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

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost (SFY)	\$1.1M	\$1.2M	\$971,483
People Served (CY)*	^	2336	1745
Cost per Person	^	\$513	\$557
Non-600 Series**	6.3%	6.3%	7.4%

* People served may vary slightly from past reports due to a new methodology for tracking clients.
 ** 600 series is defined as direct service contracts.
 ^ Total clients served in CY2014 not available due to new data system release on August 7, 2014.

Program Cost Notes

- HBHV uses blended funds (State General Funds and Federal Funds from Temporary Assistance for Needy Families (TANF)).
- Only TANF funds are reported here as SGF funds are reported on the Women & Infant Health Snapshot and count as state matching funds required by the Maternal and Child Health (MCH) Services Title V Block Grant (\$3 for every \$4 of Title V funding). State match must remain at 1989 levels (\$2.3M) or higher.

Program Staffing

- 0 FTE*
- AWEC
- Other

*Two Public Health Nursing staff oversee the Healthy Baby Program. However, those FTEs and associated costs are reported on the Public Health Nursing Snapshot.

Program Metrics

- The HBHV Program goals include decreasing maternal tobacco use, increasing breastfeeding duration to 6 months, increasing healthy birth outcomes, and decreasing infant mortality.
- The HBHV consists of two home visitation models, Nurse Family Partnership (NFP) and Best Beginnings (BB).
- Evidence-based perinatal home visiting programs such as NFP have been shown to improve maternal and child health outcomes. As of July 1, 2017, five (5) counties deliver NFP and twenty-two (22) counties deliver BB.

Events that have Shaped this Program

- Title V funding requires a needs assessment to be completed 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 the summer of 2015. These priorities are included in the Memorandum of Understanding between each county and the Wyoming Department of Health, 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 2000, State Legislation (W.S.S. 35-27-101 to 104) provided Temporary Assistance for Needy Families (TANF) funding for PHN Home Visiting Programs.
- In 1996, the Nurse Family Partnership (NFP), an evidence-based home visiting model for first-time mothers, was implemented in Wyoming, in addition to the already existing Best Beginnings (BB) home visiting model.
- In 1990, MCH began providing grants to counties to implement maternal and child health services.

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 2017 Target	CY 2018 Target	CY 2014	CY 2015	CY 2016	CY 2017
% and # of WY resident births contacted ¹	75%	75%	55.7% ² 1691/ 3035	71.3% 5465/ 7669	62.4% 4607/ 7384	-
% and # of WY resident Medicaid births contacted ¹	95%	95%	66.6% ² 639/ 960	76.5% 1828/ 2389	74.0% 1772/ 2393	-
% of women enrolled in Nurse Family Partnership (NFP) who quit smoking during pregnancy (national %) ³	25%	25%	22.5% (15.9%)	22.0% (16.0%)	23.0% (16.0%)	23.0% (16.0%) *
% of infants enrolled in NFP born premature (<37 weeks gestation) (national %) ³	9.5%	9.5%	9.8% (9.5%)	9.7% (9.6%)	9.9% (9.6%)	10.4% (9.1%) *
% of women enrolled in NFP who initiated breastfeeding (national %) ³	90%	90%	87.3% (80.4%)	87.4% (81.4%)	87.8% (83.5%)	87.9% (83.8%) *

(-) indicates data not yet available
* indicates year-to-date through 9-30-17

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
# of NFP clients ⁴	282	253	239	159	-	152	121	132	76*
# of Best Beginning (BB) clients ⁵	2692	572 ⁵	2097	1586	1383*	1029	703	1021	362*
# of NFP clients graduated from the program ⁷	45	33	31	23	30*	12	6	7	5*
Cost ⁺ to Healthy Baby Home Visitation (HBHV) program per client ^{8,9}	-	-	\$513 (2336/ \$1.2M)	\$557 (1745/ \$971,483)	-	N/A*	N/A*	N/A*	N/A*

(-) indicates data not yet available
* indicates year-to-date through 9-30-17
N/A* indicates data not available on a quarterly basis
⁺SFY costs/CY people served (Ex. FY2015 \$/CY2014 people)

STORY BEHIND THE PERFORMANCE

Wyoming State Statute (Wyo. Stat. Ann. §§ 35-27-101 through -104) requires voluntary perinatal home visiting services for all at-risk women. The Public Health Nursing (PHN) Unit 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 enrolled before the 28th week of pregnancy. In December 2015, the MCH Epidemiology Program and Public Health Nursing began an evaluation of NFP in Wyoming. The evaluation was completed in April of 2017 and informed programmatic improvements. As of July 1, 2017 five (5) counties will implement the NFP model, down from eleven (11) counties implementing in fiscal year 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 September 2015, a Partners for a Healthy Baby curriculum training was held and a total of 36 nurses attended.

In August 2014, the Best Beginnings Data System was updated to align with the new curriculum and to provide more reliable data.

Footnotes:

¹ The definition of a contact is a two-way conversation between a client and a public health nurse either in person or on the telephone. For performance metrics #1 and #2, the targets are legislatively defined. 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 3, CY 2017).

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 PHN costs (nurse salary and benefits) are not included within the Healthy Baby program cost. Additionally, although State General Funds support the Healthy Baby Program and the provision of MCH services by PHN, these funds are reported on the Women and Infant Health Snapshot, and count as state matching funds required by the Maternal and Child Health (MCH) Services Title V Block Grant

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

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 healthcare system readiness.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$925,070	\$817,246	\$843,452
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	47%	47%	46%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 100% Federal Funding
- Cooperative Agreement with the Centers for Disease Control & Prevention/U.S. Department of Health & Human Services Assistance Secretary for Preparedness & Response (ASPR) for FY17
- 10% match requirement primarily from State General Fund positions and hospital and EMS personnel

Program Staffing

- 1.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Percentage of core healthcare agencies participating in healthcare coalitions
- Percentage of other healthcare agencies participating in healthcare coalitions
- Percentage of participating hospitals compliant with the National Incident Management System (NIMS)
- Metrics are based upon HPP Program Measures from ASPR

Events that have Shaped this Program

- Federal funding for this program became available after the events of September 11, 2001.
- In January 2012, 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, and Emergency Support Function #8 (Public Health and Medical Services) partners to identify gaps in preparedness, determine specific priorities, and develop plans for building and sustaining healthcare specific capabilities.
- In November 2016, CMS published final rules requiring 17 provider types to develop and train personnel on emergency operations plans and to participate in community disaster exercises. This rule will be enacted in November 2017.

Hospital Preparedness Program (HPP)

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of essential member agencies participating in a HCC ¹	75%	75%	66% (21/32)	52% (80/154)	58% (84/144)	62% (84/136)	74% (95/129)
% and # of other potential member agencies participating in a HCC ²	25%	25%	1% (2/160)	6% (9/157)	9% (15/171)	17% (31/180)	30% (54/181)
% and # of hospital member agencies which achieve full NIMS compliance ^{3,4}	75%	75%	N/A	N/A	11% (3/27)	26% (6/23)	58% (15/26)

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY16 Q1+Q2	SFY16 Q3+Q4	SFY17 Q1+Q2	SFY17 Q3+Q4
OUTPUTS									
Number of ABLIS trainings ⁵	6	4	4	7	8	2	5	3	5
Number of HFR trainings ⁶	15	6	8	11	8	7	4	6	2
EFFICIENCIES									
Cost per student for ABLIS training	\$564 (\$66,000/ 117)	\$530 (\$44,000/ 83)	\$620 (\$44,000/ 71)	\$324 (\$46,585/ 144)	\$357 (\$53,240/ 149)	\$343 (\$13,390/ 39)	\$319 (\$33,475/ 105)	\$344 (\$19,965/ 58)	\$366 (\$33,275/ 91)
Cost per student for HFR training	\$434 (\$75,000/ 173)	\$441 (\$30,000/ 68)	\$427 (\$38,000/ 89)	\$450 (\$49,000/ 109)	\$293 (\$36,000/ 123)	\$574 (\$31,000/ 54)	\$327 (\$18,000/ 55)	\$321 (\$27,000/ 84)	\$231 (\$9,000/ 39)

STORY BEHIND THE PERFORMANCE

1. Essential member agencies of a Healthcare Coalition are defined as Hospitals, Emergency Medical Services agencies, Emergency Management agencies, and Local Health Departments. This measure aligns with the 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, including long-term care facilities, home health, hospice, behavioral health agencies, and specialty clinics as well as other similar agencies. The definition was updated in SFY 2017; numbers may differ slightly from what was reported in previous years due to the change in methodology. This measure aligns with Healthy People 2020 Objectives PREP-18.1 & 18.2. The denominator is the total number of other healthcare facilities as identified within the HPP grant Notice of Award (NOA).
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. The definition was updated in SFY 2017; numbers may differ slightly from what was reported in previous years due to the change in methodology. 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.
4. The Pandemic and All Hazards Preparedness Reauthorization Act (PAHPRA) benchmark for NIMS requires that at least 75% of hospitals involved in healthcare coalitions address the 11 NIMS implementation activities for hospitals.
5. Advanced Burn Life Support (ABLS) training increases medical surge capabilities as well as provider capability in providing care to burn patients. The certification is valid for four (4) years. This is vital because of the lack of burn centers in Wyoming.
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. This training helps to ensure that healthcare workers are prepared to provide care to patients contaminated by hazardous materials.

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), and provides education and clinical resources, monitoring vaccine storage and handling, determines immunization coverage rates, and processes vaccination exemption requests related to school attendance.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$4,409,809.05	\$5,365,174.60	\$4,508,668.27
People Served	123,570	117,811	141,910
Cost per Person	\$35.68	\$45.54	\$31.77
Non-600 Series*	39%	33%	33%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funding from the Centers for Disease Control and Prevention (CDC) Vaccines for Children Grant and 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 position, federally-funded

Program Metrics

- Approximately 126 public and private healthcare providers receive state and federally-purchased vaccines through the Immunization Unit.
- More than 164,297 doses of pediatric and adult vaccines were distributed to enrolled providers through the Public Vaccine Programs during SFY 2017.
- As of October 25, 2017, the WyIR contained information for 7,725,156 vaccinations.

Events that have Shaped this Program

- In 2006, the Wyoming Childhood Immunization Act passed which authorized state funding for vaccines to be administered to children who do not qualify for the federal Vaccines for Children (VFC) Program, this change identified Wyoming as a Universal Purchase State. Wyo. Stat. Ann. § 35-4-139 established the Wyoming Vaccinates Important People (WyVIP) Program.
- In 2011, four (4) vaccines were eliminated from the WyVIP Program due to funding limitations, changing Wyoming's status to a Universal Select Purchase State.
- Starting in 2011, Meaningful Use activities greatly increased the demand for interoperability between electronic health record (EHR) systems and the WyIR.
- In 2013, Wyo. Stat. Ann. §33-24-157 required pharmacies to report immunizations to the WyIR.
- Wyo. Stat. Ann. §§ 14-4-116, 21-4-309, and 35-4-101.



Immunization Unit

PROGRAM CORE PURPOSE

The Immunization Unit's core purpose is to provide education, support and resources to immunization partners and stakeholders to ensure that Wyoming residents are protected against vaccine-preventable diseases.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Coverage Estimate for 4:3:1:3:3:1:4 ¹	65%	80%	61%	44%	57%	61%	57%
Missed Opportunity Rate ²	8%	2%	15%	16%	19%	2%	3%
Compliance Visit Score ³	N/A	88%	N/A	N/A	N/A	80% (97 visits)	82% (117 visits)
Publicly Supplied Vaccine Waste (doses administered/doses distributed) ⁴	3%	2%	4.5% (8,110/ 196,612)	5% (19,003/ 169,840)	5% (9,123/ 174,762)	3% (6,186/ 166,858)	3% (4,930/ 164,437)
Coverage Among Children in Kindergarten ⁵	N/A	98%	N/A	N/A	96.8% 14-15 SY*	96.8% 15-16 SY*	(-) 16-17 SY*

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of Compliance Visits Conducted	N/A	N/A	140	114	117	64	50	68	49
# of Pediatric Doses Shipped	N/A	165,155	169,657	161,073	158,357	87,371	73,702	90,095	68,262
# of Facilities Active within the WyIR	N/A	137	174	195	200	N/A*	N/A*	N/A*	N/A*
# of Providers Enrolled in a pediatric PVP ⁷	N/A	125	129	128	126	123	125	129	129
EFFICIENCIES									
Cost per Compliance Visit ⁸	N/A	N/A	\$118	\$135	\$98	N/A*	N/A*	N/A*	N/A*
Cost of Wasted Vaccine Per Provider ⁹	\$1,011 (\$126,393/ 125)	\$1,757 (\$219,643 / 103)	\$1,950 (\$251,555/ 129)	\$1,270 (\$158,724 /125)	\$1,177 (\$143,554 /91)	N/A*	N/A*	N/A*	N/A*
WyIR Cost per Facility ¹⁰	N/A	N/A	N/A	\$1,586 (\$333,345 /195)	\$1,667 (\$309,208 /195)	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

Wyoming Rates 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.

¹ Childhood coverage level includes 4 Dtap, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, and 4 Pneumococcal vaccines. Ages 19 to 35 months.

² This measure evaluates children ages 19-35 months. Missed opportunities are when a child receives a vaccine and was eligible to receive another vaccine but did not. The significant reduction in missed opportunities from SFY 2015 to SFY 2016 is a direct result of stronger education and interventions provided by Immunization Unit staff during the Assessment, Feedback, Incentive, and Exchange (AFIX) visits.

³ No less than 50% of providers enrolled in a Public Vaccine Program (PVP) receive an annual Compliance Visit. This visit produces an overall score and a storage and handling score. The compliance criteria are based on best practices as defined by the Centers for Disease Control and Prevention (CDC) Vaccines for Children (VFC) Program. Scores were not available until SFY 2016.

⁴ The percentage of vaccine waste refers to the number of doses wasted divided by the number of doses distributed of publicly-supplied vaccines provided to immunization providers through the Wyoming PVP (VFC Program, Wyoming Vaccinates Important People Program (WyVIP) Program, Adult Hepatitis Program, and Vaccines for Uninsured Adults Program). The CDC threshold for acceptable vaccine waste is 5%. The Immunization Unit has made great efforts since 2013 to reduce vaccine waste by educating providers and utilizing the WyIR for vaccine management. Vaccine waste due to expiration alone was reduced from CY 2014-CY 2015 by \$79,937.22 or 55%.

⁵ CDC School Vaccination Assessment Report. Average percentage includes 2 doses of MMR, 4 doses DTP/DTPaP/DT, 2 doses Varicella, 3 doses Hepatitis B, and 3 doses Polio.

⁶ The WyIR is the Immunization Information System (IIS) utilized by the Department to serve as the centralized repository of immunization information for Wyoming residents.

⁷ “Pediatric PVPs” refers to the VFC Program, and the WyVIP Program.

⁸ A Compliance Visit is conducted for no less than 50% of providers enrolled in the VFC Program.

⁹ The denominator for this measure is the number of providers who reported waste, not the total number of enrolled providers. The total cost of vaccine waste is driven by the type of vaccine lost and may fluctuate even as overall vaccine waste decreases. For example, the increase in the cost of vaccine waste from 2014 to 2015 was due to a switch from the HPV4 to the HPV9 vaccine, which required providers to dispose of any unused HPV4 vaccine they may have already had in stock. The HPV vaccine is one of the most expensive vaccines on the formulary.

¹⁰ This measure is calculated by taking the costs associated with the WyIR (maintenance and annual technical assistance) and dividing it by the number of facilities enrolled with the WyIR. These costs see a regular increase over time; however, as the Immunization Unit moves to mandatory reporting to the IIS and allowing child care facilities to enroll, we expect to see the cost per facility decline.

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

	2015	2016	2017
Total Program Cost	\$728,589	\$776,992	\$761,108
People Served	584,153	586,107	585,501
Cost per Person	\$1.32	\$1.32	\$1.30
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- FY 17 federal funding through the CDC Epidemiology and Laboratory Capacity Grant is \$639,500
- FY17 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. 0.03/100,000).
- Wyoming incidence of Pertussis, Measles, and Mumps is below the national incidence (3.6/100,000 vs. 6.53/100,000).
- Wyoming incidence of Salmonellosis, Shigellosis, and *E. coli* is below the national incidence (15.37/100,000 vs. 22.64/100,000).

Events that have Shaped this Program

- The emergence of Zika Virus infections 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 existing and emerging diseases that pose a threat to Wyoming residents.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Average # of days to complete case investigations	3	3	2.9	2.7	2.3	2.6	2.8*
# of enteric disease outbreaks detected and investigated by the program through case surveillance and reporting and # of other outbreaks investigated	>5 (>8/1M population)	>5 (>8/1M population)	21 enteric 5 other	16 enteric 10 other	16 enteric 17 other	8 enteric 11 other	5 enteric 16 other
Wyoming pediatric (<18yo) influenza mortality incidence (# per 100,000 population) (national rate)	At or below U.S. incidence	At or below U.S. incidence	0.0 (0.02)	0.0 (0.05)	0.17 (0.05)	0.0 (0.02)	0.0 (0.03)
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	12.01 (7.86)	10.6 (9.54)	5.8 (6.03)	3.6 (6.53)	-
Wyoming incidence (# per 100,000 population) of <i>Salmonella</i> , <i>Shigella</i> , and <i>E. coli</i> (enteric diseases) (national rate)	At or below U.S. incidence	At or below U.S. incidence	14.75 (U.S. 19.5)	35.43 (U.S. 21.8)	29.40 (U.S. 23.9)	15.37 (U.S. 22.64)	-

*Data thru 9/30/17
(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of initial case reports detected by Program through surveillance	4,245	2,806	5,396	2,924	5,585	982	1,942	677	4,908
# of influenza surveillance reports created by Program	40	40	40	40	40	20	20	20	20
EFFICIENCIES									
Cost per case investigated	\$149	\$243	\$135	\$265	\$136	N/A*	N/A*	N/A*	N/A*
N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

- The program continues to be a leader in the United States in the area of prion disease investigations. Although no cases of human prion disease have been linked to Chronic Wasting Disease to date, the program coordinates surveillance efforts with the Wyoming Game and Fish Department. The program conducts risk analysis for all reported cases of Creutzfeldt-Jacob Disease and participates in a national risk assessment with the Centers for Disease Control and Prevention.
- The emergence of Zika Virus infections have 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 can then be shared with the CDC National Zika Pregnancy 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 Report in October, 2016.
- The state incidence of enteric diseases is below the national incidence. Contact with farm and ranch animals continues to be common risk factor for enteric diseases in Wyoming.

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

	2015	2016	2017
Total Program Cost	\$131,040	\$112,308	\$118,082
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- The Wyoming Injury Prevention Program is funded through the Centers for Disease Control & Prevention, Preventive Health and Health Services Block Grant and the National Highway Traffic Safety Administration, Highway Safety Federal 402 Grant.
 - 56% Tobacco Settlement Funds
 - 41% Federal Funds
 - 3% State General Funds

Program Staffing

- 1.0 FTE (Coordinator and half time Epidemiologist)
- 0.5 AWEC
- 0 Other

Program Metrics

- The three leading causes of unintentional injury-related deaths in Wyoming are motor vehicle crashes, poisonings, and falls (WY Vital Statistics Services (VSS), 2004-2015).
- In Wyoming, the unintentional injury-related death rate is approximately 18 times higher than the homicide rate, and 2.5 times higher than the suicide rate (WY VSS, 2004-2015).
- The three leading causes of non-fatal unintentional injury-related hospitalizations are falls, motor vehicle crashes, and other transportation - ATVs, snowmobiles, equine-related events, etc. (WY Hospital Discharge Data [WHDD], FY2009-2015).
- In Wyoming, the unintentional injury-related hospitalization rate is approximately 35 times higher than the assault rate, and 7 times higher than the self-harm rate (WHDD, FY2009-2015).
- In 2015, fatal unintentional injuries in Wyoming cost an estimated \$423,501,000 in combined medical and work lost costs (CDC Cost of Injury Reports, WY VSS).

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.

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	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of Tai Chi: Moving for Better Balance (TCMFBB) participants with an improved Timed Up & Go (TUG) test score ¹	85%	90%	N/A	N/A	N/A	84% (27/53)	86% (84/131)
% and # of TCMFBB participants completing the course	75%	80%	N/A	N/A	N/A	59% (32/53)	74% (97/131)
# of Wyoming counties with TCMFBB instructors	10	12	N/A	N/A	N/A	8	13
Rate (# per 100,000 population) of non-fatal unintentional injury-related fall hospitalizations among Wyoming residents ages 65+ ² (national rate)	N/A	650	577.1 ³ (1005.7) ⁴	805.6 ³ (1033.8) ⁴	655.3 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of WY residents who have completed the TCMFBB course	N/A	N/A	N/A	32	97	N/A	32	53	44
# of helmets purchased for distribution	N/A	N/A	N/A	369	0	N/A	369	0	0
EFFICIENCIES									
Cost per individual for TCMFBB (course participants and instructors)	N/A	N/A	N/A	\$41.75 (\$1,837 /44)	-	\$41.75 (\$1,837 /44)	N/A*	N/A*	N/A*

N/A indicates data not yet available due to the creation of a new metric
N/A* indicates measure not available on a quarterly basis or for quarters indicated
- indicates data not yet available

STORY BEHIND THE PERFORMANCE

¹Tai 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 Timed Up & Go (TUG) test assesses the functional mobility of participants. TUG times of greater than 12 seconds are associated with higher fall risk.

²This 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.

³Wyoming Hospital Discharge Data is currently available through State Fiscal Year 2015. Conversion from ICD-9-CM coding to ICD-10-CM coding occurred in October 2015 and analysis of comparability between the two coding systems is not yet complete.

⁴Healthcare 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. 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. The most current year available is 2014.

Integrated Cancer Services Program

Program Description

The Integrated Cancer Services Program provides screenings, advocacy, and education to Wyoming residents. The Program works under the Wyoming Cancer Control Act, Wyo. Stat. § 35-25-203 through 35-25-205. The Program operates the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP) and the Wyoming Colorectal Cancer 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 and promotes the screening programs.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$2,948,325	\$3,461,627	\$3,629,192
People Served	1,867	1,733	1,872
Cost per Person	\$1,579	\$1,997	\$1,939
Non-600 Series*	43%	62%	43%

* 600 series is defined as direct service contracts.

Program Cost Notes

- WBCCEDP activities are funded with federal dollars, state general funds, tobacco settlement funds, and private grants.
- WCCSP activities are funded through state general and tobacco settlement funds.
- WCCCP activities are funded by federal dollars and tobacco settlement funds.

Program Staffing

- 10 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The WBCCEDP has been in existence since 1997; over 8,786 women have received clinical services and 361 breast cancers, and 43 cervical cancers and 634 high-grade cervical pre-cancers have been detected.
- WCCSP has existed since 2007; 4,126 Wyoming residents have received colonoscopies; 48.8% had polyps removed, 27.1% had pre-cancerous polyps, and 74 had colon cancer.
- 2011/12 was the first year of the colorectal 10-year/re-screen policy. Since 2011, 551 clients have been re-screened; 59.2% had polyps removed; 33.8% had pre-cancerous polyps; and 2% had colon cancers.
- Wyoming healthcare providers have written off more than \$7,000,000 of the clinical costs over the past five years for the WBCCEDP alone.

Events that have Shaped this Program

- Wyoming's cancer screening rates are low: 62.4% for breast cancer screening (U.S. 78.1%); 73.9% for cervical cancer screening (U.S. 82.8%); and 63.8% for colorectal cancer screening (U.S. 69.3%) (Behavioral Risk Factor Surveillance System [BRFSS] 2016).
- WBCCEDP must comply with certain CDC policies that designate how the program is structured and implemented (e.g. program components, funding and match ratio, designated covered services, data collection, and staffing).
- Federal legislation mandates that WBCCEDP-enrolled women diagnosed with breast or cervical cancer or high-grade cervical pre-cancer be transitioned to their state's Medicaid program for cancer treatment.
- WBCCEDP received a CDC Outstanding Program Performance Award in 2009 (the last time these were awarded).
- In 2017, the WBCCEDP, WCCSP, and WCCCP fully integrated into one program, pooling resources and providing consistent service to Wyoming residents.

Integrated Cancer Services Program

PROGRAM CORE PURPOSE

The core purpose of the Integrated Cancer Services program is 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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of women aged 40 years and older who received a mammogram in the last two years statewide*	-	78.1%	-	65.2% ¹ (2048/3092)	-	61% ¹ (1359/2111)	-
% of women who have received a Pap test in the last 3 years aged 21 and older statewide*	-	78.5%	-	77.2% ¹ (1360/2055)	-	70.2% ¹ (948/1449)	-
% of people ever having an endoscopy aged 50 and above statewide*	-	69.3%	-	61.8% ¹ (3019/4519)	-	65.2% ¹ (2228/3197)	-
% of first time screening through the program with positive adenoma tissue	21%	25%	30.4% (118/388)	37.1% (136/367)	36.6% (110/300)	30.1% (102/339)	25.8% (55/213)
% and # of positive Fecal Immunochemical Tests	13%	7%	N/A	N/A	9.6% (9/94)	16% (24/150)	26.7% (93/348)

*Data from the Behavioral Risk Factor Surveillance Survey (BRFSS)

(-) Indicates data available every two years through Behavioral Risk Factor Surveillance System

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of women served through the program	913	724	390	391	534	206	185	255	279
# of clients who receive a colonoscopy through the program	390	370	305	345	348	193	152	193	155
# of Fecal Immunochemical Test distributed through program	N/A	N/A	94	150	238	89	61	80	158
EFFICIENCIES									
% of clients whose time from breast cancer screening to diagnosis > 60 days	11.5% (17/148)	9.7% (10/103)	7.9% (6/76)	5.1% (4/79)	-	N/A*	N/A*	N/A*	N/A*
% of clients whose time from cervical cancer screening to diagnosis > 90 days	8% (2/25)	13% (3/23)	18.2% (2/11)	12.5% (1/8)	-	N/A*	N/A*	N/A*	N/A*
N/A indicates data not available due to the creation of a new metric (-) Indicates data not yet available N/A indicates data not available on a quarterly basis*									

STORY BEHIND THE PERFORMANCE

- ¹ Data is a weighted measure and therefore the numerator and denominator do not equal the percentage.
- All numbers for testing are state fiscal year-to-date as of June 30, 2017. Providers have one year from the date of service to bill the program, as per federal rule.
- The program reimburses for screening services at the Medicaid/Medicare rates.
- In 2011, 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 detection 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.
- WCCEDP has the highest CDC data rating possible with a 0% error rate and full compliance with 11 core performance indicators.
- The Fecal Immunochemical Test (FIT) is funded through a grant from the American Cancer Society (ACS). The program continues to partner with the State Public Health Lab for processing of the FITs.

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 with the aim of improving the health status of Wyoming's populations most affected by health disparities.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$137,420	\$137,420	\$90,072
People Served	1,120*	1,666*	1,306*
Cost per Person	\$123	\$82	\$69
Non-600 Series**	99%	99%	99%

*This number includes all people trained: WDH and partners.

** 600 series is defined as direct service contracts.

Program Cost Notes

- 100% state-funded for SFY 2017.

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Priorities for 2016-2017: 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.
- 99% of PHD staff are now internally trained in health equity.
- The number of professionally trained interpreters in Wyoming increased from 0 in 2015-2016 to 12 in 2016-2017.
- Program utilization of interpreting services increased from 79 calls in 2016 to 143 calls in 2017.

Events that have Shaped this Program

- 2013: CLAS Standards enhanced.
- 2013: PHD Strategic Map listed "Promote Health Equity and Health Literacy" as a foundational element.
- 2014: Public Health Accreditation Board (PHAB) standards have "health equity" and "cultural competence" elements throughout.
- 2014: Public Health Division, Health Equity Workgroup formed .
- 2016: Telelanguage Contract began.
- 2017: Health Equity introduction at the Wyoming Department of Health new employee orientation begins.
- 2017: Health Equity course required for all Public Health Division staff.



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 (WDH) programs and partnerships across the state.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of WDH staff with current training in health equity ¹	10%	40%	3% (46/ 1,450)	4% (62/ 1,450)	17% (214/ 1,240)	5% (70/ 1,240)	33% (458/ 1,381)*
% and # of Public Health Division (PHD) staff trained on health equity ²	20%	100%	N/A	N/A	88% (204/ 231)	16% (38/ 231)*	99% (241/ 242)*
% and # of PHD programs evaluated ³	60%	100%	N/A	N/A	7% (2/26)	62% (16/26)	87% (21/24)
% and # of PHD programs utilizing interpreter services ⁴	15%	20%	N/A	N/A	N/A	N/A	16% (4/24)
% and # of PHD programs utilizing translation services ⁵	20%	35%	N/A	N/A	N/A	N/A	29% (7/24)

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

*Previously participants were “counted” regardless of whether or not the same person attended several trainings; this year counts changed to only non-duplicates.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of Health Equity trainings offered	6	8	44	41	30	13	28	10	20
# of people trained ⁶	204	201	1,120	1,666	1,306	698	968	662	644
# of programs evaluated	0	0	2	16/26*	21/26	9**	0**	1**	4**
# of interpreted calls ⁷	N/A	N/A	N/A	79	143	22	57	22	121
EFFICIENCIES									
Cost per training attendee ⁸	\$36 \$7,430/ 204	\$58 \$11,600/ 201	\$138 \$26,960/ 195	\$3.07 \$5120.82/ 1,666	\$2.45 \$3204.44/ 1,306	\$2.33 \$1626.34 /698	\$3.61 \$3494.48 /968	\$.83 \$552/ 662	\$4.11 \$2652.44/ 644

* Pilot programs included in the 2016 count due to updated survey.

** Numbers of programs completing survey per quarter.

STORY BEHIND THE PERFORMANCE

¹ To ensure WDH/PHD staff understand disparities and the resulting health outcomes in WY, WDH staff are encouraged to participate in health equity and cultural competency training annually. Years 2013 and 2016 count numbers of training attendees, potentially resulting in duplicates if staff attended more than one training in the year. “Training” includes any of the options offered from cultural competency training to the Unnatural Causes video series to health equity. The 2017 numbers only count non-duplicated staff.

² PHD staff were offered more varied training options in SFY 2017 to include webinars, the Unnatural Causes video series, and cultural competency. The Health Equity Workgroup (HEW) also selected a course that is mandated for all PHD employees and is built into the onboarding process for new PHD staff.

³ In 2015, the Health Equity Workgroup (HEW) piloted a program survey on health equity. The results drove language changes to the survey, the creation of a health equity intranet website, a list of in-house resources, and assistance tailored to program needs. The survey was designed to gauge adherence to CLAS standards and progress on the National Partnership for Action strategic priorities (National Stakeholder Strategy for Achieving Health Equity). As of 2016, 21 units have completed the survey and the HEW created a baseline to move the PHD forward to the health equity principle.

⁴ This reflects Public Health Division programs utilizing the telephonic interpretation services provided by the Telanguage services contract. Seven programs contributed financially to the contract the first year and 10 programs utilized the services in the contract.

⁵ This reflects Public Health Division programs utilizing the translation services provided under the Telanguage Language services contract.

⁶ “People trained” here reflects external partners as well as internal staff. This includes not just classes offered, but webinars, some of which extended nationwide.

⁷ This reflects the number of calls interpreted for PHD programs.

⁸ This reflects 900 series expenditures and internal staff time for organization and prep.

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

	2015	2016	2017
Total Program Cost	\$4,004,515	\$4,749,210	\$3,993,826
People Served	584,153	585,501	585,501
Cost per Person	\$6.86	\$8.11	\$6.82
Non-600 Series*	54%	53%	59%

*600 series is defined as direct service contracts.

Program Cost Notes

- 100% Federal Funding Cooperative Agreement with CDC for July 1, 2016 - June 30, 2017 for FY 2017
- 10% match requirement was partially met by Public Health Nursing in kind contributions (31.6%)
- Ebola / Zika Supplemental funding - \$1,124,426 received late 2015 with spending in 2016 and 2017.

Program Staffing

- 11 FTE (plus 3 funded positions in the Wyoming Public Health Lab)
- 1 AWEC
- 1 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.
- 23 of 25 counties and tribal nations met all contract deliverables (quarter ending June 30, 2017).
- PHEP operates a 24/7/365 emergency notification and disease reporting hotline for the Wyoming Department of Health (WDH) with on-call epidemiologists, laboratorians, and other professionals.
- In SFY17 there were 167 calls, comparable to SFY16 with 132. The CDC's ability to reach WDH through a 24/7 phone line is a CDC metric. In SFY17, 2 test calls were completed successfully.
- 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 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, which ended June 30, 2017.
- 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 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. PHEP serves as the ESF #8 lead for the agency.
- WDH activated the Incident Management Team for the Ebola Virus Disease preparedness activities.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Time, in minutes, for Immediate After Hours Assembly of WDH Incident Management Team in person or virtually ¹ (national average)	<60*	<60	14 (39)	10 (-)	15 (-)	23 (-)	41 (-)
WDH Jurisdictional Risk Assessment (JRA) Score (updated every 3 years) ²	90%	85%	80%	N/A	N/A	76%	N/A
Wyoming (state) score for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency ³	Established (3.0/4.0)	Established (3.0/4.0)	100% (US avg. 99%)	100% (US avg. 99%)	100% (US avg. 99%)	Established (3.3)	-
Average county scores for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency ³	90% (69% - PAHPA CRI Benchmark for FY15)	Established 3.0/4.0	87.5% (22 counties)	92.5% (22 counties)	93.3% (21 counties)	96.9% (21 counties)	Established 3.5 (23 counties)
County and tribal public health responders completing respirator fit testing ⁴	95%	95%	91.4% (287/314)	93.8% (242/258)	83.9% (256/305)	86.1% (223/259)	87.9% (227/258)

*CDC and Healthy People 2020 target
N/A indicates data not available
(-) indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of courses of antibiotics compared to estimated number of key personnel identified ⁵	5,060/ 5,060	0/ 5,060	3,313/ 5,060	3,313/ 5,060	5,644/ 5,060	3,313/ 5,060	3,313/ 5,060	3,313/ 5,060	5,644/ 5,060
# of CDC 24/7 no notice bidirectional contact drill for epidemiology and lab staff	2/2	2/2	4/4	2/2	2/2	0/0	2/2	1/1	1/1
% of WDH Incident Management Team trained to role requirements for WDH response management	63% (15/23)	72% (18/25)	77% (21/27)	87.5% (14/16)	71.4% (20/28)	14/16	14/16	16/25	20/28
EFFICIENCIES									
Cost Per Public Health Response Coordinator or county/tribal responder per session: Use of webinar and conference call vs. on-site	\$3.71/ \$396.97	\$3.11/ \$394.80	\$5.57/ \$388.37	-	-	-	-	-	-
N/A indicates data not yet available due to the creation of a new metric (-) indicates data is no longer tracked									

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 advance notice. SFY 2017 was a physical assembly. U.S. average last reported by CDC in SFY 13.

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 Centers for Disease Control and Prevention, 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) was 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 material. It was utilized at state and local levels to assess state and local plans to receive, stage, store, and distribute SNS assets during a public health emergency. In 2015, the Cities Readiness Initiative (CRI) jurisdictions and the state were evaluated utilizing the new tool, Medical Countermeasures Operational Readiness Review (MCM ORR) which did not result in a percentage score. CRI MSA helps cities effectively respond to large-scale public health emergencies requiring life-saving medications and medical supplies. The MCM ORR evaluates not only the plans, but also the ability to operationalize the plans as demonstrated in real world incidents or exercises and determines a status for each jurisdiction: Status: 1 – Early, 2 – Intermediate, 3 – Established, 4 – Advanced. The CDC goal/expectation is for each agency to meet standards for a rating of "Established" by 2022.

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 Wyoming will need 5,060 courses. In 2014, the PHEP cache of antibiotics expired. PHEP has since purchased approximately 111% of the needed amount. 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.

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

	2015	2016	2017
Total Program Cost	\$3,241,261	\$3,733,937	\$3,566,647
People Served	584,153	585,501	585,501
Cost per Person	\$5.5	\$6.38	\$6.09
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Program cost for FY17 decreased due to a decline in chemical testing volume. Revenues also declined, however the amount of grant funding received almost doubled.
- In FY17 total expenditures were broken down as follows:
 - General Funds - 57% of total expenditures
 - Revenues from lab fees - 8% of total expenditures
 - Federal grants - 35% of total expenditures

Program Staffing

- 28 FTE (20 state funded, 7 federal funded, 1 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 in order 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.

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 private health care providers with timely, cost effective, and quality assured public health laboratory services and technical support.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Accuracy of competency/proficiency tests performed ¹	98%	98%	99.3% 147/148	99.7% 194.5/195	99.1% 315/318	99.2% 395/398	99.8% 468/469
Average time (in days) from specimen receipt to result reporting in Microbiology and Preparedness (Tb culture excluded) ²	1.3	1.3	1.3	1.31	1.29	1.22	1.26
% and # of Microbiology clients receiving real-time laboratory results ³	75%	80%	0%	0%	36.3%	58.6% 337/575	70.2% 501/714
# of non-WPHL employees trained ⁴	200	200	N/A	N/A	246	207	487
# of newly validated tests ⁵	≥ 5	≥ 5	1	0	5	7	5

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of Chemistry samples tested (# confirmed)	33,192 (N/A)	30,460 (N/A)	33,527 (12,095)	34,726 (12,418)	17,398 (8,507)	18,271 (6,546)	16,455 (5,872)	9,073 (4,594)	8,325 (3,913)
# of Microbiology tests performed	31,682	36,033	37,018	39,224	40,180	19,887	19,337	19,959	20,221
# of trainings provided	N/A	N/A	13	11	22	5	6	7	15
# of Litigation Support Packages provided	N/A	N/A	132	154	125	58	96	69	56
# of times court testimony provided	N/A	N/A	77	42	36	18	24	20	16
EFFICIENCIES									
Cost per test ⁶	\$39.87	\$42.25	\$42.27 <u>2,982,394</u> 70,454	\$46.41 <u>4,008,104</u> 86,368	\$53.97 <u>3,566,647</u> 66,085	\$44.55 <u>1,991,373</u> 44,704	\$48.40 <u>2,016,731</u> 41,664	\$51.59 <u>1,734,636</u> 33,626	\$56.44 <u>1,832,010</u> 32,459
% of expenses from revenues ⁷	N/A	N/A	17.5% <u>517,633</u> 2,967,094	32.1% <u>1,287,200</u> 4,008,104	8.1% <u>288,985</u> 3,566,647	27.2% <u>541,354</u> 1,991,373	37.0% <u>745,846</u> 2,016,731	5.9% <u>102,217</u> 1,734,636	10.2% <u>186,767</u> 1,832,010
% of expenses from Federal Grant (no match)	N/A	N/A	13.8% <u>409,614</u> 2,967,094	16.8% <u>672,889</u> 4,008,104	34.8% <u>1,242,570</u> 3,566,647	16.9% <u>336,445</u> 1,991,373	16.7% <u>336,445</u> 2,016,731	35.8% <u>621,285</u> 1,734,636	33.9% <u>621,285</u> 1,832,010

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

STORY BEHIND THE PERFORMANCE

¹This metric accounts for the accuracy of the analytic stage of laboratory testing. The accuracy of competency and proficiency tests performed by all laboratory sections were 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%, the Lab has set its target for these sections at 97% for an overall target of 98%.

²Time 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 ≤ 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 (e.g., 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.

³This 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.

STORY BEHIND THE PERFORMANCE , CONTINUED

⁴People 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. Large trainings were held on site at the Law Enforcement Academy and DFS and Probation and Parole offices. In SFY17 the lab was named as a Regional Training Lead Laboratory for Whole Genome Sequencing (WGS). Therefore the measure for SFY17 includes laboratorians trained in the WGS training program, which received national attention.

⁵Before the laboratory can add a test to its test menu, the test must be validated. Tests added in SFY2015 include: qPCR for Ebola virus, Influenza B lineage determination, fecal occult blood testing, respiratory viral panel testing, and a more rapid West Nile virus testing platform. Tests added in SFY2016 include: Triplex PCR for Zika, Chikungunya, and Dengue viruses, Zika MAC ELISA, blood parasite smears, qPCR for pertussis, E-tests for various types of drug susceptibility testing, whole genome sequencing for enteric pathogens and a new oral fluid collection device for drugs of abuse testing. **Tests added in SFY2017 include:** E-tests for carbapenem and cephalosporin testing (grant aim), qPCR for KPC and NDM-1 (grant aim), a phenotypic test for Carbapenem Resistant Enterobacteriaceae (grant aim), a 4th Generation HIV Combo Ag/Ab EIA (to be compliant with recommendations), and the Geenius HIV ½ Confirmatory Assay (out of necessity). Tests targeted for addition in SFY18 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 VIM and OXA-48 (grant aim), a *Rickettsia* qPCR assay (newly available via LRN), and a HCV targeted sequencing assay (grant aim). The Chemical testing lab is intent upon adding new tests in SFY18, however it is too early to determine which tests those will be.

⁶The 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. 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. In SFY17 the large increase in cost per test is directly related to a drop in chemical testing laboratory volume.

⁷In 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 SFY16, 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. 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. The large decrease in this percent for SFY17 is due to a decrease in Chemical Testing Program revenues.

Public Health Nursing (PHN)

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 3 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

	2015	2016	2017
Total Program Cost	\$7,630,742	\$8,636,577	\$7,860,744
People Served	113,187	107,088	94,299
Cost per Person	\$67.42	\$80.64	\$83.36
Non-600 Series*	97%	85%	92%

*600 series is defined as direct service contracts.

Program Cost Notes

- Funding provided by state general funds and the county contribution (35%) is required for salaries and benefits for State PHN employees working in the counties.
- Total program costs are mostly salary costs, including the counties' 35%; does not include other expenses paid by counties. It also includes funding for Natrona and Sweetwater county contracts in 2016 and 2017.
- Number of participants represents both direct care services and classes provided through PHN; **reports in prior years included only direct care service recipients.**

Program Staffing

- 88 State PHN positions in 20 counties and PHN administration (70 FTE, 18 PT)
- 2 AWEC positions
- ~63 other County PHN positions, including PHN staff from the 3 independent counties

Program Metrics

- Public health infrastructure and services are provided to Wyoming residents through the Wyoming Public Health Division, State Public Health Nursing, and locally through county Public Health Nursing offices.
- In SFY17, PHN provided direct care services to 10,897 people in 46,294 visits. Classes were provided to 83,402 participants in 28,277 clinics and classes (some class participant numbers may be repeat participants). These numbers have decreased due to fewer county nursing positions being filled. However, the average number of people served per nurse is higher in 2017 (678 people per nurse) than in 2016 (407 people per nurse).
 - Currently clinics and classes are tracked together; a 2018 redesign of the Public Health Nursing Informatics (PHNI) system will separate clinics from classes to improve data collection and program evaluation capabilities. Clinics and classes occur throughout the essential service areas including Maternal & Child Health, Chronic Disease/Wellness, and Communicable disease, among others.
- Each \$1 spent on public health programming generally returns \$5.06 in savings (APHA, 2013). Approximately \$39,775,365 in future savings to the State of Wyoming's social and health care systems may be realized from 2017 Public Health Nursing services alone.

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 continues to work on assessing and strengthening PHN's infrastructure, policy, and efficiencies to most effectively direct resources to serving the residents of Wyoming.

Public Health Nursing (PHN)

PROGRAM CORE PURPOSE

Promote, protect, and improve health; prevent disease and injury in Wyoming through assurance of access to healthcare, education, health information, and essential services while engaging the public and community partners through outreach, collaboration, and ongoing assessment of communities to build a culture of health.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# of WY adult residents reached through outreach activities*	3,801	4,472	6,179	5,703	4,937	3,456	4,065
% of eligible Children with Special Health receiving case management services through PHN	100%	100%	NA	NA	NA	100% (643/643)	100% (655/655)
# of communicable disease screens conducted by PHN**	7,013	8,511	7,926	7,866	6,376	7,783	7,639
% of Ryan White-eligible, HIV-infected Wyoming residents receiving PHN case management	85%	85%	NA	NA	NA	100% (186/186)	75% (137/183)
% of referred elderly clients assessed for long term care Medicaid waivers through PHN	95%	95%	NA	NA	NA	NA	87% (4267/4911)

NA indicates data not available due to the creation of a new metric

*Participants were tracked in SFY17 for adult services only

**Includes screenings for sexually transmitted diseases and tuberculosis. Target is a 10% increase over previous year.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
% of Wyoming PHNs involved in community partnerships and coalitions	NA	NA	NA	NA	65% (51/78)	NA	NA	65% (51/78)	65% (51/78)
# of outreach events and classes delivered by PHN	2,673	2,845	3,110	3,464	3,200	1,702	1,762	1,391	1,809
% and # of Wyoming adult immunizations administered by a PHN office	46.8% (43,541/92,881)	48% (41,483/86,226)	43.6% (37,096/84,879)	34.6% (36,902/106,829)	26.8% (32,091/119,513)	NA*	34.6% (36,902/106,829)	NA*	26.8% (32,091/119,513)
EFFICIENCIES									
Nursing time in dollars spent completing data entry tasks** (# of hours)	NA	NA	NA	\$413,764 (14,064)	\$354,453 (12,048)	\$206,252 (7,010)	\$207,512 (7,053)	\$185,721 (6,312)	\$168,733 (5,735)
% of PHN hours spent on Maternal Child Health services for TANF clients ⁶	63.3%	60.2%	58%	60.3%	60.1%	58.5%	58.1%	59.1%	59.1%
Vaccine wastage costs for all PHN offices***	\$4,473	\$8,734	\$6,913	\$4,892	\$669	\$1,717	\$3,175	\$599	\$70
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 **Based on PHN average salary of \$29.42/hr; does not include program materials. ***Actual total cost of vaccine wastage (price varies per vaccine brand and type) as documented in the Wyoming Immunization Registry (WyIR).									

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 3 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 79 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 implements 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 independent counties is not currently included in the overall picture of PHN outputs and efficiencies; however, they will be included in performance reports beginning in SFY 2018.
- A client satisfaction survey was not conducted during SFY17, as was done in previous years. PHN will consider conducting one in SFY18.

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

	2015	2016	2017
Total Program Cost	\$3,256,311	\$3,256,311	\$3,060,784
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	10%	10%	13%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Programs are funded with State General Funds, Federal Funds, and State Tobacco Funds.
- Federal Funds include the following grants and cooperative agreements: Substance Abuse Prevention and Treatment Block Grant, Strategic Prevention Framework-Partnerships for Success, and Prescription Drug Opioid Overdose Prevention.
- Amounts above do not reflect administrative costs (100-500 series).

Program Staffing

- 2.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Alcohol abuse 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.
- According to the Value of Prevention, Potential Cost Savings From Delaying Youth Alcohol Use in Wyoming report (WYSAC, 2017), in 2014, an estimated 389 cases of future alcohol use disorders were avoided due to prevention efforts in Wyoming communities.
- The potential cost savings of delaying the onset of alcohol use for the 2014 senior high school class (389 cases) is approximately \$122 million.

Events that have Shaped this Program

- Since 2001, Wyoming communities have pursued a comprehensive approach to preventing underage alcohol use, adult binge drinking, and other substance abuse through evidence-based strategies that impact the entire population.
- This program's strategies and funding have been integrated with the Tobacco Prevention and Control Program's strategies and funding to create greater impacts at the community level.
- Beginning in SFY 2018, suicide prevention activities have been relocated to the Injury Prevention Program (IPP) and will be reported on the IPP performance documents.

Substance Abuse and Suicide Prevention Program

PROGRAM CORE PURPOSE

Reduce suicide, adult binge drinking, and underage alcohol use.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Adult Binge Prevalence % and # of Wyoming adult men who currently consume 5 or more drinks or adult women who currently consume 4 or more drinks on an occasion at least once in the past 30 days ¹ (national average)	15%	15%	16.6% (619/3228) (16.8%)	17.2% (561/5966) (16%)	16% (511/5211) (16.3%)	18.4% (486/4336) (-)	-
Youth Prevalence Percentage of Wyoming high school students who have consumed alcohol within the past 30 days ²	30%	30%	-	33.6% (2,038/6,047)	-	31.6% (1,752/5,570)	-
Adult and Youth Use Percentage of fatal crashes with a blood alcohol content (BAC) of .08 or higher ³ (national average)	28%	28%	28% (24/87) (31%)	32% (48/150) (31%)	38% (56/145) (29%)	-	-
Suicide Wyoming suicide death rates per 100,000 ⁴ (national rate)	20	20	22.1 (13)	20.5 (12.9)	26.2 (13.26)	24.2 (-)	-

(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Beverage Server Trainings	3,113	3,234	3,547	3,158	2,668	1,193	1,965	1,069	1,599
Suicide Risk Assessment Trainings Conducted ⁵ (# trained)	169 (4,283)	242 (8,120)	282 (13,502)	370 (16,642)	109 (6,355)	196 (8,297)	174 (8,345)	58 (2,031)	78 (4,324)
Alcohol Compliance Checks No Infractions	86.9% 929/ 1,069	85% 1,033/ 1,215	86.5% 1,073/ 1,240	86% 1,213/ 1,410	-	N/A*	N/A*	N/A*	N/A*
Prevention Strategies Implemented in Communities ⁵	182	402	145	141	167	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Suicide Risk Assessments Trainings Cost per Attendee	\$7.58 (\$34,125/ 4,498)	\$4.20 (\$34,125/ 8,120)	\$1.62 (\$21,846/ 13,502)	\$1.89 (\$21,846/ 11,569)	\$2.46 (\$15,624/ 8,697)	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

Trends

- Since the beginning of comprehensive alcohol use prevention in 2001, underage alcohol use has decreased from almost 55% to 31.6% in 2016. (Prevention Needs Assessment [PNA])
- Adult driving under the influence rate (DUI) has been steadily decreasing since 2008. The rate in 2008 was 1,311 arrests per 100,000, decreasing to 699 arrests per 100,000 in 2015. (DCI)
- The rate of suicide deaths in Wyoming has remained stable over the past 15 years whereas the national rate has increased 24% from 10.5 to 13 deaths per 100,000 population. (CDC)

Efficiency

- Cost per attendee of suicide risk assessment trainings has decreased as a result of more attendees per training.

Current Efforts

- The SASPP utilizes the Public Health Approach to prevention with environmental prevention strategies. Environmental prevention strategies are based on the fact that people's behavior, including their use of alcohol and other drugs, is shaped by their environment, such as the messages and images delivered by the mass media, the norms of their communities and other social groups, the availability of alcohol, and so forth. Prevention is implemented at the community level in all 23 counties and the Wind River Indian Reservation.
- The SASPP received federal funding for the purchase of naloxone and training/education on opioid abuse and associated consequences in SFY 2017.
- In an effort to sustain capacity for suicide prevention in the light of budget cuts, as of July 1, 2017, suicide prevention activities have been moved to the Injury Prevention Program.

Challenges

- Wyoming has the lowest beer tax (\$.02 per gallon) and spirits tax (\$.025 per 100 milliliters) in the nation
- YRBSS data is not currently collected in Wyoming; underage alcohol use percentages will be taken from the PNA, which is Wyoming specific, and there will not be a national comparison until YRBSS is collected again.

Data Sources

1. Behavioral Risk Factors Surveillance System (BRFSS)
2. Prevention Needs Assessment.
3. National Highway Traffic Safety Administration (NHTSA).
4. Vital Statistics
5. Prevention Intervention Planning and Reporting (PIPR)

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

	2015	2016	2017
Total Program Cost	\$5,441,740	\$5,234,969	\$4,670,579
People Served	585,501	585,501	585,501
Cost per Person	NA	NA	NA
Non-600 Series*	45%	45%	45%

* 600 series is defined as direct service contracts.

*Yearly expenditures may be different since contracts are on a biennium basis and program funds may be expended unevenly across fiscal years.

Program Cost Notes

- Program is funded as follows: 21% State General Funds; 10% Federal Funds, 69% State Tobacco Funds.
- Amounts above do not reflect administrative costs (100-500 series).

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 (18.9%, 2016 BRFSS)
 - Youth smoking rates (12%, 2016 PNA)
 - Exposure to secondhand smoke in workplaces (91% of employed adults report smoking is never allowed in indoor areas of their workplace, 2015 ATS)
 - In FY17, there were 3,779 enrollments in the Wyoming Quit Tobacco Program with an overall quit rate of 30%.

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. In 2010, smoking cost the state of Wyoming \$239,631,163 in direct healthcare costs (WYSAC, 2012). This does not include costs incurred due to diseases from secondhand smoke.
- Wyoming Statutes § 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 science-based. The statutes also require 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.



Tobacco Prevention & Control Program

PROGRAM CORE PURPOSE
Reduce tobacco use in Wyoming.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of Wyoming employed adults surveyed who report that smoking is never allowed in indoor areas of their workplace	92%	92%	WY: 90.9% (1,088/1,204)	WY: 90.7% (1,940/2,146)	WY: 91% (2,047/2,232)	-	-
% and # of Wyoming adults surveyed who currently smoke	18.5%	18.5%	WY: 20.6% (973/6,315) U.S.: 19.0%	WY: 19.5% (875/6,078) U.S.: 18.1%	WY: 19.1% (773/5,281) U.S.: 17.8%	WY: 18.9% (624/4,393) U.S.: 17.1%	-
% of Wyoming high school students surveyed who smoked cigarettes on one or more of the past 30 days (national average)**	15%	11%	17.4% (15.7%)	16%*	15.7% (11%)	12%**	-

(-) Indicates data not yet available

* Intervening years between national survey dates for which national data is unavailable

** FY 2015 is the last year of YRBS data; youth rates will be taken from the PNA and will not have a national comparison.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4	
OUTPUTS										
WQTP Enrollment (Wyoming Quit Tobacco Program)	Total	3,918	2,552	2,571	4,743	3,779	2,165	2,578	1,663	2,116
	Pregnant women	23	36	32	27	17	16	11	7	10
	American Indian Commercial Tobacco Program	*	*	*	8	28	3	5	10	18
# of PHN Referrals	*	20	46	44	-	29	15	-	-	
Media Impressions (mass, digital, social)	29,886	15,707	7,383	32.3M	27.5M	*	32.3M	*	27.5M	
# of policies implemented in communities	18	22	17	16	11	9	7	8	3	
EFFICIENCIES										
Avg. Cost per WQTP Enrollee	\$306 (1.2M /3,918)	\$357 (913,273 /2,552)	\$355 (913,273 /2,571)	\$193 (913,273 /4,743)	\$242 (913,273 /3,779)	NA*	NA*	NA*	NA*	

* Intervening years between survey dates for which data is unavailable

(-) Data is currently 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% (2006-2015). (Data from the 2015 Adult Tobacco Survey)
- 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. (Data from the Youth Risk Behavior Surveillance Survey)
- The majority of Wyoming adults support smoke free laws for indoor workplaces (78%) and restaurants (77%). Additionally, 50% of adults support smoke free casinos & clubs and 46% support smoke free bars. (Data from the 2015 Adult Tobacco Survey)

Challenges:

- Wyoming does not have a comprehensive, 100% smoke-free state statute.
- Wyoming has one of the lowest cigarette tax rates in the nation at \$0.60/pack.
- YRBSS data is not currently collected in Wyoming; youth smoking rates will be taken from the Prevention Needs Assessment (PNA), which is Wyoming specific, and there will no longer be a national comparison.

Value added to the WQTP:

- Chantix is provided for free to qualified enrollees. This removes economic barriers for enrollees who wish to use the most effective prescription medication for tobacco cessation.
- A Pregnant - Postpartum Program that has demonstrated success was added to the Quitline services.
- The American Indian Commercial Tobacco Program (AICTP) has been operational since August 2015 providing culturally appropriate cessation services to American Indian populations.

Current Efforts:

- The WQTP began offering Chantix for free in February 2016 and continued to do so in FY17. According to the most recent WQTP evaluation report, the quit rate for enrollees who used Chantix is 39% and the overall program quit rate is 30%.
- 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 WQTP. In 2017, there was slightly less budget applied to media placement.
- 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.
- The WQTP is working with Medicaid and Sweetwater Memorial Hospital to integrate tobacco cessation services with the Electronic Health Records (EHR) system of Medicaid and Sweetwater Memorial Hospital. This integration provides an efficient and HIPAA compliant method for health care providers to refer patients to the WQTP, and also allows providers to receive information about a patient's tobacco cessation progress. They are both now in the testing phase.

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
- PNA – Prevention Needs Assessment

Trauma Program

Program Description

The Wyoming Trauma Program serves every Wyoming resident by maintaining and improving the Wyoming Trauma System infrastructure and the clinical care of the trauma patient through education, support, and regulation. This is a mandated state program per W.S. § 35-1-801 et seq.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$168,060	\$216,838	\$154,860
People Served	586,107	585,501	585,501
Cost per Person	\$0.29	\$0.37	\$0.26
Non-600 Series*	92%	100%	100%

* 600 series is defined as direct service contracts

Program Cost Notes

- \$110,000 General Fund
- 84% General Fund and 16% Federal Fund (Highway Safety Grant (registry), FLEX Grant (Stop the Bleed training kit for each hospital))

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- All 28 Wyoming acute care facilities are mandated to participate in the Trauma System. Specific emergency & medical standards are evaluated & reviewed to ensure quality patient care in each facility every three years for continued compliance.
- Provides the mandatory Trauma Patient Registry for all acute care facilities.
- Provided support to Trauma Regions through travel reimbursement, technical support & guidance.
- Provided technical registry & programmatic support to facilities on 48 documented occasions in CY2014, 56 in CY2015, 75 in CY2016, and 35 in CY2017 (year-to-date as of 9/1/2017). Provided 55 documented data report requests or assistance with writing reports for stakeholders in CY2014, 56 in CY2015, 35 in CY2016, and 58 CY2017 (year-to-date as of 9/1/2017). Data report requests include State Health Officer, WDH programs, hospitals, and external partners.
- Complete redesign and upgrade to the trauma registry to include distinct and separate sites per requests from facilities using the American College of Surgeons for trauma hospital verification. The ACS requires additional registry data. The state program absorbed all costs and there was no cost to the hospitals for this service.

Events that have Shaped this Program

- Unintentional injury is the #1 killer of Wyoming residents ages 1-44 years.
- Traumatic injury results in more years of potential life lost than any other disease, including cancer and heart disease. Decreasing clinical and system of patient care adverse events is the core of the Wyoming Trauma Program.
- 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, this increased in July 2016 to 54%, and has decreased to 25% in 2017.

Wyoming Trauma Program

PROGRAM CORE PURPOSE

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

OUTCOMES							
Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of facilities actively contributing to the Trauma Patient Registry ²	96%	96%	93% 26/28	89% 25/28	93% 26/28	100% 28/28	100% 28/28
% of facilities with full designation status (3 year status) running total ¹	68%	68%	64% 18/28	64% 18/28	54% 13/28	61% 17/28	61% 17/28
% of RURAL facilities with full designation status (3 year status) running total	70% 18/26	70% 18/26	N/A	N/A	58% 15/26	61% 16/26	64% 17/26
% ED trauma patient overall dwell times <2 hours; calendar year ⁴	22%	22%	21.3%	20.9%	20.2%	18%	-
% of ED trauma patient dwell times <2 hours for injured patients requiring transfer to definitive care; calendar year ⁴	N/A	28%	N/A	N/A	N/A	29%	-
(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of facility site reviews conducted	6	12	11	14	14	2	12	1	13
# of Regional Trauma Councils meeting quarterly (5 total) ³	4	5	5	3	4	2	3	4	4
# of educational opportunities sponsored to improve facility compliance	3	2	2	2	2	1	1	2	0
% and # of facilities sending representation to at least one sponsored educational opportunity per year	96% 27/28	86% 25/28	96% 27/28	96% 27/28	93% 26/28	75% 21/28	64% 18/28	93% 26/28	-
# of trauma records in Trauma Registry by WY acute care facilities	3,480	3,369	3,906	4,295	4,061*	2,266	2,029	2,255*	1,806*
EFFICIENCIES									
Cost per trauma registry record (\$22,800/# records)**	\$6.55 (\$22,800/ 3,480)	\$6.77 (\$22,800/ 3,369)	\$5.84 (\$22,800 / 3,906)	\$5.31 (\$22,800/ 4,295)	\$5.61 (\$22,800/ 4,061)	\$5.11 (\$11,400/ 2,266)	\$6.20 (\$11,400/ 2,029)	\$5.06 (\$11,400/ 2,255)	\$6.31 (\$11,400/ 1,806)

(-) Indicates data not yet available

* indicates year-to-date as of 9/1/2017

STORY BEHIND THE PERFORMANCE

- There is a demonstrated 15-20% improved survival rate for injured patients who are cared for in an established trauma system.
- The Trauma Programs work toward the prevention of mortality & morbidity associated with clinical medical and surgical care after an injury is sustained by a patient.
- Unintentional injury is the #1 killer of Wyoming residents ages 1-44 years.
- During the years of 2004 to 2013, Wyoming's all injury-related, age-adjusted death rate (82 per 100,000) was approximately 30% higher than the US injury-related, age-adjusted death rate (58 per 100,000). <https://health.wyo.gov/publichealth/prevention/wipp/wyoming-injury-facts/>
- Wyoming's work related traumatic injury death rate is consistently ranked 1st or 2nd highest in the nation annually. (<https://wwwn.cdc.gov/Niosh-whc>)

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. 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 seriously injured has been identified in regions with an established and functioning trauma system.

Definitions

1. *Full Designation Status:* Facility meets all standards and will be re-reviewed in three (3) years.
Provisional Designation 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 injuries. Such data are primarily designed to ensure quality trauma care and outcomes in individual facilities and trauma systems, and provide useful data for the surveillance of injury morbidity and mortality. The Wyoming Trauma Registry does not include all injuries sustained in the state; injuries based on set criteria are incorporated in this data bank. Wyoming acute care facilities are required to submit this data.
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 ED 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 optimize the chance of survival. Patients who require transfer to a higher level of care should be transferred in two (2) hours or less. Examples of variables that cause a high dwell time for transferred patients may be internal system barriers, challenges in finding definitive facilities to admit patients, waiting for emergency transport, and weather. Other than weather, variables can be influenced to decrease dwell time.
5. *Rural Trauma Hospital:* A Wyoming hospital or acute care facility not designated as a Regional Trauma Hospital.

**Record numbers may increase as facilities enter data. There is not a hard stop on accepting records.



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

	2015	2016	2017
Total Program Cost	\$1.9M ⁺	\$2.2M ⁺	\$1.7M ^{+^}
People Served	n/a	n/a	n/a
Cost per Person	n/a	n/a	n/a
Non-600 Series*	11.8%	12.4%	14%

*600 series are defined as direct service contracts.

⁺Includes required Title V State matching funds used to support Healthy Baby Home Visitation Program and PHN provision of MCH services at the local level.

[^]2017 funding levels do not include salary and benefits for MCH support staff.

Program Cost Notes

- The Women & Infant Health Program uses blended funds (State General Funds, Title V Maternal Child Health (MCH) Services Block Grant and Newborn Screening Trust and Agency funds).
- State matching funds are required for the Title Block Grant (\$3 for every \$4 Title V); state match must remain at 1989 levels or higher.
- The WIHP partners with Public Health Nursing (PHN) to jointly implement the Healthy Baby Home Visitation (HBHV) Program. See the HBHV Snapshot for additional details.

Program Staffing

- 2.0 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) preventing 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 Wyoming babies.

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, leading to adoption of final 2016-2020 MCH priorities in summer 2015.
- Wyoming is participating in a Collaborative Improvement and Innovation Network (CoIIN) developed to reduce infant mortality and the NewSTEPS 360 quality improvement initiative to improve timeliness in 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 practices supportive of breastfeeding in birthing facilities through implementation of the Wyoming 5-Steps to Breastfeeding Success program.
- Since 2014, the Program has facilitated and led a Coordinated Efforts to Improve Maternal and Infant Health Workgroup, which focuses on reducing rates of maternal smoking and pre/early-term birth, and improving access to risk-appropriate perinatal care.
- The Newborn Screening Program revised the rules under Wyo. Stat. Ann. §§ 35-4-801, -802 to add Critical Congenital Heart Disease to the newborn screening panel, effective September 12, 2017.



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 2017 Target	CY 2018 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	95.8% 6,430/ 6,709
% and # of mothers who breastfeed their infants through 6 months of age (non-exclusive) (National Immunization Survey) ¹	59%	60%	55.6% 4,235/ 7,617	56.6% 4,355/ 7,693	58.1% 4,456/ 7,669	59.5% 4,393/ 7,384
% and # of infants born to women who smoked during first trimester of pregnancy (VSS)	15%	15%	15.8% 1,207/ 7,617	15.8% 1,216/ 7,693	15.7% 1,207/ 7,669	13.6% 1,007/ 7,384
% and # of very low birth weight (≤3lbs 4oz) infants born at facilities with appropriate level of care (VSS)	65%	68%	65.9% 56/85	67.0% 69/103	58.2% 46/79	62.0% 62/100
% and # of infants born preterm (<37 weeks) (VSS)	9%	9%	10.2% 779/ 7,617	10.5% 811/ 7,693	9.6% 736/ 7,669	9.5% 698/ 7,384

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2016 Q1+Q2	SFY 2016 Q3+Q4	SFY 2017 Q1+Q2	SFY 2017 Q3+Q4
OUTPUTS									
# of pregnant women enrolled in the Quit Line ²	23	36	32	27	17	N/A	N/A	16	11
# of individuals attending Certified Lactation Counselor training sponsored/supported by MCH ³	N/A	20	6	19	25	5	14	0	25
# of women enrolled in Maternal High Risk (MHR) ⁴ Program	29	28	22	28	20	17	12	14	7
# of infants enrolled in Newborn Intensive Care (NBIC) ⁴ Program	40	37	54	62	49	31	31	31	18
EFFICIENCIES									
Cost per first newborn screen (# of first screens completed) ⁵	N/A	\$70.57 (6,868)	\$74.21 (6,932)	\$81.90 (6,786)	\$84.20 (6,298)	N/A*	N/A*	N/A*	N/A*
Cost per first & second newborn screens (# of first and second screens completed) ⁵	N/A	\$37.63 (12,879)	\$39.50 (13,018)	\$43.40 (12,812)	\$43.99 (12,055)	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 **Data not yet available

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 health care 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 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 New data point in 2016.
- ³ MCH sponsored Certified Lactation Counselor (CLC) continuing education for 25 Public Health Nurses, to attend the WIC Baby Behavior conference on May 9-10, 2017. In August 2017, MCH sponsored CLC training for 15 public health nurses who had no previous CLC training.
- ³ SFY Totals are unduplicated. Duplicates may be present between quarters, as individuals can be enrolled more than one quarter.
- ⁵ A second screen between 7-14 days of life is highly recommended and does not incur any additional costs to the program when performed. The amount the WDH charges providers for the transport and processing of newborn screens will increase on December 1, 2017 by \$7 per screen in order to accommodate the increased costs associated with newborn screening in the state.

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

	2015	2016	2017
Total Program Cost	\$10,073,503	\$10,336,967	\$9,590,893
People Served**	17,737	16,974	15,938
Cost per Person	\$567.94	\$608.99	\$601.76
Non-600 Series*	18.6%	16.1%	17.4%

** People served is an unduplicated count of individuals served in the federal fiscal year; previous Snapshots reported an average monthly case load

* 600 series is defined as direct service contracts

Program Cost Notes

- Additional direct service expenditures not included in the 600 series equal \$4,892,238 for 2015-2017 combined.
- Total FY17-18 Budget of \$24,221,150 includes 6% GF, 73% FF, 21% infant formula rebates.

Program Staffing

- 45.4 Total FTE (8.9 state office, 36.5 local agencies)
 - 39 state positions: 15 FT; 12 PT; 12 AWEC
 - 12 county positions: 1 FT; 11 PT
 - 9 hospital positions: 4 FT; 5 PT

Program Metrics

- From 2015-2017, an average of 10,192 pregnant, postpartum, and breastfeeding women, infants, and young children were served each month by WIC.
- In federal fiscal year 2017, 15,938 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-two 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 mandated for the country by 2020.
- Wyoming participates with 22 other states, territories, and tribal organizations in the National Association of State Procurement Officials (NASPO) ValuePoint 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.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of survey respondents who met with a breastfeeding peer counselor and found it helpful	92%	93%	92.5% (319/ 345)	91.7% (309/ 337)	91.6% (1,024/ 1,118)	91.6% (1,024/ 1,118)	92.8% (1,106/ 1,192)
% and # of survey respondents who indicate that WIC helped them eat more vegetables and fruits	82%	83%	83.3% (716/ 859)	87.7% (615/ 701)	82% (1,790/ 2,184)	80% (2,121/ 2,652)	84% (1,949/ 2,320)
% of cash value benefits spent on fresh fruits and vegetables by WIC participants	70%	71%	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)	70.9% (\$567,154/ \$799,885)
% of WIC infants who were ever breastfed (initiation) ¹	81.9%	81.9%	N/A	N/A	N/A	79%	80%
% of WIC infants who are exclusively breastfeeding at 3 months ²	46.2%	46.2%	N/A	N/A	N/A	33%	34%

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Average # of women served/month ³	2,753	2,774	2,620	2,590	2,363	2,613	2,566	2,440	2,287
Average # of children (ages 1-5) served/month ³	5,949	5,775	5,449	5,162	5,036	5,220	5,103	5,076	4,996
Average # of infants (ages 0-1) served/month ³	2,618	2,620	2,462	2,498	2,396	2,439	2,557	2,485	2,307
Average # of nutrition education contacts/month ⁴	2,281 3 rd & 4 th qtr. only	2,502	3,050	3,071	3,171	2,998	3,143	3,166	3,176
Average # of referrals documented/month ⁵	687 3 rd qtr. only	758	973	1,303	2,835	1,196	1,409	2,855	2,815
EFFICIENCIES									
Average monthly food cost/participant/month	\$47.07 (\$532,407/ 11,319)	\$49.29 (\$550,528/ 11,169)	\$47.93 (\$504,844/ 10,531)	\$48.24 (\$494,488/ 10,249)	\$47.16 (\$461,985/ 9,795)	\$48.48 (\$498,002/ 10,273)	\$48.02 (\$490,974/ 10,226)	\$47.26 (\$472,703/ 10,001)	\$47.06 (\$451,266/ 9,589)
Average nutrition education cost/participant/month ⁶	\$5.10 (\$57,362/ 11,256)	\$5.72 (\$63,008/ 11,016)	\$5.49 (\$57,178/ 10,420)	\$5.51 (\$56,216/ 10,197)	\$5.39 (\$51,697/ 9,599 {through 9/30/17}	\$4.39 (\$44,902/ 10,244)	\$6.66 (\$67,531/ 10,141)	\$4.90 (\$48,141/ 9,820)	\$5.89 (\$55,254/ 9,378) {through 9/30/17}

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 infants 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. In 2016, WIC was the recipient of a \$25,952 breastfeeding performance award from the Food and Nutrition Service of USDA for outstanding achievement in improving breastfeeding rates among WIC participants.

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 Supplemental Nutrition Assistance Program (SNAP) benefits, and limited resources available for program outreach.

⁴ 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 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.

⁶ Nutrition education cost per participant per month is calculated based upon the federal fiscal year vs. state fiscal year in order to better reflect accurate cost per participant. WIC is required to spend at least 1/6 of all nutrition services administration funds on nutrition education or be subject to funding penalties.

Youth and Young Adult Health

Program Description

The purpose of the Youth and Young Adult Health Program (YAYAHP) is to ensure that all Wyoming youth and young adults (ages 12-24) are healthy and ready to learn, work, and transition successfully to adulthood. The priorities of the YAYAHP are to promote healthy and safe relationships among adolescents, increase access to quality and preventive health care, and promote healthy development within the youth and young adult population, including adolescents with special health care needs.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$605,923	\$443,383	\$363,157+
People Served	101,318	99,529	96,494^
Cost per Person	N/A	N/A	N/A
Non-600 Series*	23%	22%	29%

* 600 series is defined as direct service contracts.

+Expenditures are from state fiscal year 2017

^Population estimates from calendar year 2016.

Program Cost Notes

- Federally funded: Title V, Rape Prevention Education (RPE), Personal Responsibility Education Program (PREP), and Preventive Health and Health Services Block Grant (PHHSBG)
- Program costs decreased from 2016 to 2017 as the YAYAHP developed a strategic plan to respond to 2016-2020 Title V priorities.

Program Staffing

- 1.1 FTE
- 0.1 AWEC
- 0 Other

Program Metrics

- 1 in 5 Wyoming middle and high school students report using alcohol in the last 30 days. Alcohol use is strongly related to unintended teen births and teen dating violence.
- In 2016, there were 26.2 births per 1,000 women ages 15 to 19 years in Wyoming. This is a decrease from 29 births per 1,000 women ages 15 to 19 years in 2015 but is still higher than the national average of 20.3 births per 1,000 women ages 15 to 19 years.
- Medicaid Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) data indicates that only 27.7% of Medicaid eligible adolescents (10-20 years old) received the recommended EPSDT visit with their doctor in 2016.
- In 2016, 2,425 high school and college students participated in evidence-based, sexual violence prevention programming through the RPE Program. This was a significant increase from 622 high school and college students in 2015.

Events that have Shaped this Program

- MCH priorities for 2016-2020 were identified by the Maternal and Child Health Needs Assessment and include adolescent-specific priorities of Healthy and Safe Relationships for and Preventive and Quality Care. The third program priority of Promoting Healthy Development within the youth and young adult population is foundational to the YAYAHP.
- The Youth and Young Adult Health Program has established collaborations with several partners within the Wyoming Department of Health, including Medicaid, Immunization Unit, Substance Abuse and Suicide Prevention Program, Communicable Disease Prevention Program, Public Health Nursing (PHN), and Behavioral Health, lending adolescent expertise and educating programs on best practices and evidence-based interventions for the youth and young adult populations.

Youth and Young Adult Health Program

PROGRAM CORE PURPOSE

The purpose of the Youth and Young Adult Health Program (YAYAHP) is to ensure that all Wyoming youth and young adults (ages 12-24) are healthy and ready to learn, work, and transition successfully to adulthood.

OUTCOMES

Performance Metric	CY2017 Target	CY2018 Target	CY2012	CY2013	CY2014	CY2015	CY2016
% middle and high school students reporting no alcohol use in last 30 days ¹ (PNA)+	N/A	79%	76.4%	N/A	78.6%	N/A	80.2%
% and # of WyPREP participants that reported they were much more likely or somewhat more likely to resist or say no to peer pressure after completing the program ² (PREP post-assessment) *	75%	78%	N/A	N/A	N/A	70% (262/376)	72% (340/473)
Rate of births (per 1000) among 15 - 19 year old girls ³ (WY & NVSS) (national rate)	28	25	34.6 (29.4)	29.8 (26.6)	30.3 (24.2)	29.0 (22.3)	26.2 (20.3)
% and # of Medicaid eligible adolescents (10-20 years) who received at least one ESPDT screen ⁴ (Medicaid)** (national average)	32%	32%	25.0% (5,140/ 18,516) (46.7%)	26.3% (5,448/ 18,586) (49.1%)	24.6% (5,380/ 19,689) (45.6%)	23.9% (5,310/ 20,218) (46.1%)	27.7% (5,546/ 18,163) -
% of adolescents with special health care needs who received services necessary to make transitions to adult health care ⁵ (NSCH)+ (national average)	N/A	20%	N/A	N/A	N/A	N/A	16.5% (17.9%)

(-) indicates data not yet available

* This measure is for State Fiscal Year.

** This measure is for Federal Fiscal Year.

+ The PNA and the NSCH are both weighted surveys, so no numerator or denominator is reported.

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of youth and young adults participating in evidence-based programming through the Rape Prevention Education (RPE) grant ⁶	N/A	N/A	N/A	622	2,425	N/A*	N/A*	N/A*	N/A*
# of communities (city/town) participating in comprehensive reproductive health education (WyPREP) ²	N/A	N/A	4	10	10	4	10	10	10
# of clinics serving adolescents participating in quality improvement projects through the AYA CoIIN. ⁴	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	0
EFFICIENCIES									
Dollars spent / Youth receiving comprehensive reproductive health education ²	N/A	N/A	\$2,272 /90	\$96 /439	\$160.00 /1,403	N/A*	N/A*	N/A*	N/A*
(-) Indicates data not yet available 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 priorities of the YAYAHP are to promote healthy and safe relationships among adolescents, increase access to quality and preventive health care, and promote healthy development within the youth and young adult population, including youth and young adults with special health care needs. These priorities were determined by the Title V Needs Assessment.

¹The Prevention Needs Assessment (PNA) survey is sponsored by the Wyoming Department of Health and endorsed by the Wyoming Department of Education. The PNA measures a wide variety of attitudes, beliefs, and perceptions that have been shown to be related to alcohol, tobacco, and drug use along with violent and problem behaviors. It is administered every other year in even years to 6th, 8th, 10th, and 12th graders in Wyoming. The YAYAHP measures zero alcohol use in the last 30 days because many unhealthy behaviors are linked to alcohol use. Also, the YAYAHP implements strategies to reduce multiple risk factors for youth.

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

³The YAYAHP partners with Public Health Nursing (PHN) and the Communicable Disease Prevention Program in activities to reduce the teen birth rate in Wyoming through WyPREP implementation and increasing availability of services.

⁴Early, Periodic, Screening, Diagnosis, and Testing (EPSDT) measure. From the CMS-416 report (total eligible receiving at least one screen / total eligible who should receive at least one screen). The YAYAHP is working with Medicaid, CHIP, the Wyoming Primary Care Association, and other internal and external partners on the Adolescent and Young Adult Health Collaborative Improvement and Innovation Collaborative (AYAH CoIIN) to improve EPSDT rates for Wyoming youth and young adults. The AYAH CoIIN is currently in the process of choosing pilot clinics for quality improvement efforts.

⁵From the National Survey of Children's Health with Special Health Care Needs. This measure was changed in 2016 and will now be released annually with state-level estimates available every 2-3 years. Previous data are not included as they are no longer comparable to the new measure.

⁶The Rape Prevention Education (RPE) grant focuses on primary prevention of sexual violence among adolescents—stopping the behavior before it happens. The Wyoming Coalition against Domestic Violence and Sexual Assault (WCADVSA), an RPE sub-recipient, works within the counties to implement primary prevention activities.

WDH | Aging Division

Information contained in this section includes:

- 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

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, which 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 that will provide 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

	2015	2016	2017
Total Program Cost	\$72,503	\$69,072	\$68,259
People Served	302	179	238
Cost per Person	\$240.08	\$385.88	\$286.80
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 over a 10-30% match to the Federal funds.

Program Staffing

- 0.1 FTE
- 0 AWEC

Program Metrics

- In SFY 2017, 238 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 2017, total client hours performed by the provider equaled 1,204.75.
- In SFY 2017, the average number of hours spent/client was 5.06.
- The average cost per client for FY 2017 (Federal and State fund) is \$286.80. Average cost (Federal & State fund) per hour is \$56.66.
- The average cost savings per client in SFY 2017, based on an average of \$250.00/hour cost for private legal assistance, equaled \$1,265.00
- 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, clothing, shelter, medicine, transportation, etc.
- No criminal cases are accepted through this program.
- A total of 19 hours of outreach and public education were provided by the Legal Services grantee in SFY 2017.

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 spent per client has increased to 5.06 hours from 4.65 hours per client for fiscal year 2017.
- 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."

Legal Services and Legal Developer Program

PROGRAM CORE PURPOSE

The Legal Service and Legal Developer program delivers free civil legal assistance to older individuals with the most social and/or economic needs.

OUTCOMES

Performance Metric	SFY 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of Wyoming's population who are age 60 and older who received legal services	1 %	1%	0.02% (274/ 115,774*)	0.02% (253/ 120,582*)	0.02% (302/ 120,710*)	0.01% (179/ 129,213*)	0.01% (238/ 129,213*)
Sum of posting amount for respective grant year	N/A	N/A	N/A	\$75,366	\$72,503	\$69,072	\$68,259

* Denominator data is reported from the United States Census Bureau, Wyoming Population 60 Years and Over in the United States.
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Total # of cases	274	253	302	179	238	90	89	121	117
Total # of hours	944.75	1,128.75	892.25	833	1,204.75	444.75	388.25	671.25	533.5
Average hours per client	3.44	5.24	2.95	4.65	5.06	4.94	4.36	5.55	4.56
EFFICIENCIES									
Average cost per unduplicated client	\$231.70	\$297.89	\$240.08	\$385.90	\$286.80	\$400.32	\$371.31	\$268.64	\$305.59

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 and about 95% 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 often the abusers. Although there are extreme cases of elder abuse, abuse may be 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, 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, often takes place at home. Neglect often occurs with older adults who live alone, relying on visiting family members and paid care givers to provide care. These older adults may be in deteriorating physical and mental health. Fear, dignity, and pride usually prohibit them from reporting the neglect and exploitation to seek care.
- No waiting list; the program serves all older adults regardless of funding. Legal Services utilizes other grant funds and resources to cover services for these individuals.

Long Term Care Ombudsman Program

Program Description

Title VII of the Older Americans Act, 1965, as amended, requires the State Unit or Area Unit on Aging 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 people about prevention of physical, financial, mental, and verbal abuse. There is one contractor, Wyoming Senior Citizens, Incorporated, statewide for these services.

Program Expenditures and People Served

	FFY2015	FFY2016	FFY2017
Total Program Cost	\$279,797	\$267,281	\$258,842
People Served	N/A*	2,056	1,542
Cost per Person	N/A*	\$130	\$168
Non-600 Series**	4.14%	5.26%	1.8%

* Data omitted due to data quality issues in FFY 2015.

** 600 series is defined as direct service contracts.

Program Cost Notes

- 50.81% federal funds
- 48.88% state funds
- 0.31% local funds (not required; local contractor will supply additional funds as available)

Program Staffing

- 1 FTE
- 3 FTE through contractor
- 0 AWEC
- 0 Other

Program Metrics

- Evaluate caseloads (200 in 2017) and activity level (1,342 activities completed in 2017), including location of cases (i.e. in-home care, institutional), cases closed, type of cases, cases opened, and program activities completed.
- All complaints or requests for assistance are reported monthly to State Long-Term Care Ombudsman through the OmbudsManager Data System.
- All licensed nursing homes, assisted living facilities, and boarding homes in the state are to be visited quarterly, per federal regulation. Other agencies visited by the LTC Ombudsman are senior centers, hospices, adult day cares, home health companies, and individuals' homes.

Events that have Shaped this Program

- No additional funding for the Ombudsman or Elder Abuse Prevention is expected from federal or state fund.
- Three full-time Regional Long Term Care Ombudsmen are employed to cover the entire State of Wyoming with a caseload of 1,556 facility beds per Regional Ombudsman; this past year there has been no turnover in Regional Ombudsmen. This retention has enabled the program to work on stakeholder relationships and foster those in order to benefit recipients of long-term care services.
- The primary types of complaints that the program receives are those regarding discharges and residents' rights.

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	FFY 2017 Target	FFY 2018 Target	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017
% of complaints fully resolved to the satisfaction of the complainant per year.	58%	60%	**	**	**	34.53%	52.21%
% of complaints partially resolved to the satisfaction of the complainant per year	25%	16%	**	**	**	16.60%	17.26%
% of complaints not resolved to the satisfaction of the complainant per year	0%	0%	**	**	**	4.15%	3.98%
# of complaints related to 'Autonomy, Choice, Exercise of Rights, Privacy' that were resolved	N/A	60%	**	**	**	52.94%	65.52%
# of complaints related to 'Admission, Transfer, Discharge, Eviction' that were resolved	N/A	60%	**	**	**	53.06%	58.18%

(-) Indicates data not yet available

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

* Indicates that this data point is an outlier due to the closures of two nursing facilities

** Indicates quality data not available due to changes in the data system.

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of visits to all LTC facilities/services by an Ombudsman	**	**	**	334	319	194	140	159	160
% of nursing homes, assisted living facilities, & boarding homes (78 total) visited by an Ombudsman quarterly	**	**	**	78.2%	98.7%	N/A*	N/A*	N/A*	N/A*
# of cases closed	**	**	**	403	200	246	157	110	90
# of complaints received	**	**	**	572	231	384	188	125	106
# of activities completed	**	**	**	1,653	1,342	987	666	646	696
EFFICIENCIES									
Cost per person served (Cases opened + Activities / Total \$)	**	**	**	\$130	\$168	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 * Indicates FFY measure ** Indicates quality data not available									

STORY BEHIND THE PERFORMANCE

- The first promulgated federal rules for the Long Term Care Ombudsman Program went into effect July 1, 2016. Previously, LCTOP functions were stated within the Older Americans Act but did not have promulgated federal rules, resulting in significant variation in the interpretation and implementation of the program from state to state. Changes to comply with the rule include moving supervision of the State Long-Term Care Ombudsman from the Aging Division to the Director's Office, with direct supervision from the Administrator of the Office of Privacy, Security, and Contracts, to avoid conflict of interest with Office of Healthcare Licensing & Surveys (also in the Aging Division), and updated program policies and procedures that have been approved by the program's federal partners.
- There has been zero turnover in the regional ombudsman positions in the past 14 months. Employee retention has enabled the program to work on stakeholder relationships in order to benefit recipients of long-term care services.
- The program is moving forward with new ways of performing its functions, including, new resident packets for residents in nursing homes, assisted living, and boarding homes, and changing the travel logistics of quarterly visits in order to provide more quality time with residents.

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

	2015	2016	2017
Total Program Cost (Federal and State)	\$2,047,735	\$1,783,940	\$1,690,542
People Served (Unduplicated Count)	17,220	17,451	16,930
Cost per Person	\$118.92	\$102.23	\$99.85
Non-600 Series*	25%**	25%**	25%**

* 600 series is defined as direct service contracts.

** This program shares administrative costs with Title III-C1, C2, and E. Up to 10% of OAA Title III funds can be allocated for administrative costs, per the AOA Fiscal Guide for OAA for Titles III and VII, April 2004.

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

- 0.70 FTE
- 0 AWEC
- 0 Other

Program Metrics

In SFY 2017, Title III-B had a total of 36 grantees covering 23 counties in Wyoming. These grantees served a total of 16,930 clients, or 13.1% of Wyoming's adults aged 60 and older, based on 2017 Census data. A total of 737,355 unit of services were 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.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of Wyoming's population (age 60 and older) served	13.1% (16,930/ 129,213*)	13.5%	13.7% (15,829/ 115,774*)	14.6% (17,632/ 120,582*)	14.3% (17,220/ 120,710*)	13.5% (17,451/ 129,213*)	13.1% (16,930/ 129,213*)
# of Clients who received III-B Services	17,501	17,000	15,829	17,632	17,220	17,451	16,930
# of clients who received transportation services	1,884	2,100	1,894	2,283	2,237	2,237	1,891
# of clients who received assisted transportation services	N/A	600	661	764	834	772	559
#of outreach services provided	3,377	1,100	1,275	1,380	1,388	1,363	1,051

(*) Denominator data is reported from the United States Census Bureau, Wyoming population 60 years and older in the United States.
N/A indicates data not available due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Total # of clients served	15,829	17,632	17,220	17,451	16,930	N/A	N/A	13,217	13,227
Total # of Title III-B Services units provided	545,246	720,710	726,442	755,662	737,355	359,942	395,855	365,596	371,759
Units of transportation services provided	103,918	160,500	164,260	168,056	185,229	74,438	93,626	89,111	96,118
Units of assisted transportation services provided	40,469	62,956	68,366	61,640	56,776	32,348	29,292	28,212	28,564
Units of outreach services provided	67,059	80,858	80,858	83,693	71,106	43,737	39,923	34,655	36,450
EFFICIENCIES									
Cost per client (Federal & State funds)	\$89.46	\$68.12	\$103.92	\$87.12	\$87.66	\$56.37	\$56.44	\$59.80	\$52.45
Cost per unit (Federal and State funds)	\$2.28	\$1.67	\$2.46	\$2.01	\$2.01	\$2.13	\$1.91	\$2.16	\$1.87

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 2017, Title III-B served approximately 13.1% (16,930/129,213*) of Wyoming's total population age 60 and older adults in SFY 2017.
- 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 3,164 clients who live below 100% of the federal poverty level, 6,288 clients who live alone, and 592 clients who are minorities in SFY 2017.
- The total numbers of clients served has shown a decrease from year to year due to data collection becoming more defined; CLS started to obtain unduplicated client counts in SFY 2013.

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 referral to additional services. This program gives priority to older adults with greatest economic need and social need, including low-income minority persons, low-income individuals who have a high nutritional risk score, and individuals who live alone.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$1,875,703	\$1,906,051	\$1,719,596
People Served	17,772	17,623	17,945
Cost per Person	\$105.54	\$108.16	\$95.83
Non-600 Series*	25%**	25%**	25%**

* 600 series is defined as direct service contracts.

** This program shares administrative costs with Title III-B, C2, and E. Up to 10% of OAA Title III funds can be allocated for administrative costs, per the AOA Fiscal Guide for OAA for Titles III and VII, April 2004.

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

Program Metrics

- In SFY 2017 Title III-C1 Congregate Nutrition Program had a total of 35 grantees covering 23 counties in Wyoming. These grantees served a total of 17,945 eligible clients representing approximately 13.89% of Wyoming's population of adults age 60 and older based on 2016 Census data. These 17,945 eligible clients received a total of 643,927 meals that they may not have otherwise received.
- The Title III-C1 Congregate Nutrition Program targets older adults who live alone to prevent social isolation and loneliness. In SFY 2017 a total of 5,890 clients age 60 and older who live alone were provided services.

Events that have Shaped this Program

- In FY17 all Title III programs switched to a reimbursement payment process. The decrease in total program cost was due to the reimbursement process vs. paying in advance. The difference is \$129,192 +/- which is approximately 1/12 of the contracted amounts.
- The contract amounts are always based on a closed federal year, therefore FFY17's contract amount was based on FFY15's meal counts. Numbers may differ slightly from previous years due to contract payment reconciliation.
- As the expected annual average growth rate of people between ages 65-79 is expected to be approximately 3.3% per year, the nutrition program must be capable of serving an increasing number of clients each year. The nutrition program must also be prepared to reach and recruit an increasing number of potential clients.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% and # of WY population served age 60 and older with income <100% of federal poverty level	N/A	27.08% (3,250/ 12,000)	38.84% (3,349/ 8,623)	37.41% (3,269/ 8,739)	33.5% (3,287/ 9,813)	26.65% (3,170 ^A / 11,895 ^B)	26.04% (3,098/ 11,895 ^C)
% and # of clients age 60 and older served with high nutrition risk	N/A	15.28% (2,750/ 18,000)	17.64% (3,100/ 17,572)	17.61% (2,996/ 17,016)	16.58% (2,905/ 17,525)	15.84% (2,745/ 17,329)	15.00% (2,635/ 17,574)
% and # of WY population age 60 and older served who live alone	17.07%* (7,000/ 41,000)	20.00% (6,000/ 30,000)	22.34% (6,095/ 27,279)	20.17% (5,921/ 29,359)	18.57% (5,962/ 32,105)	19.48% (5,830/ 29,923)	19.68% (5,890/ 29,923)
% and # of WY population age 60 and older served who are of a minority population	16.66%* (500/ 3,000)	4.55% (500/ 11,000)	5.19% (433/ 8,336)	4.52% (441/ 9,767)	5.12% (417/ 8,088)	4.20% (440/ 10,466)	4.65% (487/ 10,466)
Total % of WY population served age 60 and older	15.70%* (18,850/ 120,000)	13.85% (18,000/ 130,000)	15.18% (17,572/ 115,774)	14.11% (17,016/ 120,582)	14.52% (17,525/ 120,710)	13.41% (17,329/ 129,213)	13.60% (17,574/ 129,213)

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

* Targets from SFY17 are not updated with the new data source and therefore have different census data than the reported outcome percentages.

^A Data is collected via the voluntary Aging Needs Evaluation Summary completed by clients participating in the congregate nutrition program.

^B Denominator data is reported from the United States Census Bureau, Wyoming Population 60 Years and Over in the United States.

^C Data from the Census Bureau for 2017 is not available. Data from the Census Bureau for 2016 was used as a reference for all SFY 2017 metrics, with the exception of metric “% of clients age 60 and older served with high nutrition risk”.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Total number of meals provided to clients age 60 and older	637,317	629,460	643,139	640,168	632,745	327,627	312,541	317,059	315,686
Total units of Nutrition Education provided to clients age 60 and older	12,018.50	2,538.75	1,386	6,312	13,544	229.75	6,082.25	6,507	7,037
Total units of Nutrition Counseling provided to clients age 60 and older	73	53.50	53.50	84.75	48	53.25	31.50	30.25	17.75
Total number of meals provided to all eligible clients	643,960	636,085	651,478	649,648	643,927	331,892	317,756	321,911	322,016
Total units of Nutrition Education provided to all eligible clients	12,466.50	3,225.75	1,989	6,518	13,714	371.75	6146.25	6,575	7,139
Total units of Nutrition Counseling provided to all eligible clients	73	53.75	72.75	147	48	115.50	31.50	30.25	17.75
EFFICIENCIES									
Average total cost per meal	\$8.69	\$9.02	\$9.83	\$9.50	-	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	\$0.25	\$0.20	\$0.19	\$0.20	\$0.19	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	\$2.52	\$2.32	\$2.44	\$2.52	\$2.40	N/A*	N/A*	N/A*	N/A*

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

STORY BEHIND THE PERFORMANCE

- The following metric was added during SFY17: “% of WY population age 60 and older served <100% of federal poverty level”. The Federal Poverty Level 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 following metric was added during SFY17: “% of clients served with high nutrition risk”. Client data for the nutrition program is gathered from the Nutrition Risk Assessment which is included in the Aging Needs Evaluation Summary. Individuals scoring a high nutrition risk are recommended to discuss their nutrition score with their dietitian or health professional, or are offered nutrition counseling services.
- The average cost per meal was updated from years SFY13 through SFY16. Previous years had reported an average facility cost. The methodology was updated to weight for facility size to determine an average cost per individual meal versus per facility. The average cost per meal is based on the total program cost (federal, state, local match, and program income).
- In SFY14 and SFY15 the nutrition education changed from a per client count to an aggregate count resulting in a large decrease in units provided for nutrition education. At the end of FFY15 the nutrition education changed from an aggregate count to a per client count. The large decrease in units provided for SFY16 Q1+Q2 is due to error in reporting per/client units.
- “served” is defined as the following services: meals, nutrition education and nutrition counseling. Reported data from the Aging Division data management system includes unduplicated clients who received any of the three services offered.
- All outcomes include collected data of clients served age 60 and older. The Congregate nutrition program provides services to clients who are not 60 and older that meet the eligibility criteria. Percentages for the outcomes metrics do not include eligible clients served that are under the age of 60.
- Congregate meals is not a means-tested program. Clients receiving services can refuse to complete the Aging Needs Evaluation Summary that is used to collect pertinent data. Clients must be given the opportunity to voluntarily contribute toward the cost of meals, but they cannot be denied service because they cannot or will not contribute.
- All outcomes, outputs, and efficiencies are reported on a State Fiscal Year. The Congregate nutrition program reports and is funded on a Federal Fiscal Year. Data collected via the Aging Division data management system is point-in-time. Data may change until the end of the program reporting period.

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 referral to additional services. This program gives priority to older adults with the greatest economic and social need, including low-income minority persons, low-income individuals who have a high nutritional risk score, and individuals who live alone.

Program Expenditures and People Served

	2015	2016	2017
Total Program Cost	\$1,525,485	\$1,603,994	\$1,452,547
People Served	5,051	4,890	4,904
Cost per Person	\$302.02	\$328.02	\$296.20
Non-600 Series*	25%**	25%**	25%**

* 600 series is defined as direct service contracts.

** This program shares administrative costs with Title III-B, C1, and E. Up to 10% of OAA Title III funds can be allocated for administrative costs, per the AOA Fiscal Guide for OAA for Titles III and VII, April 2004.

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

Program Metrics

- In SFY 2017 Title III-C2 Home Delivered Nutrition Program had a total of 34 grantees covering 23 counties in Wyoming. These grantees served a total of 4,904 eligible clients representing approximately 3.80% of Wyoming's population of adults age 60 and older based on 2016 Census data. These 4,904 eligible clients received a total of 543,602 meals that they may not have otherwise received.
- The Title III-C2 Home Delivered Nutrition Program targets older adults who live alone to prevent social isolation and loneliness. In SFY17 a total of 2,445 clients who live alone were provided services.

Events that have Shaped this Program

- In FY17 all Title III programs switched to a reimbursement payment process. The decrease in total program cost was due to the reimbursement process vs. paying in advance, as had been done in previous years. The difference is \$94,184 +/- which is approximately 1/12 of the contracted amounts.
- The contract amounts are always based on a closed federal year, therefore FFY17's contract amount was based on FFY15's meal counts. Numbers may differ slightly from previous years due to contract payment reconciliation.
- As the expected annual average growth rate of people between ages 65-79 is expected to be approximately 3.3% per year, the nutrition programs must be capable of serving an increased number of clients each year. The nutrition programs must also be prepared to reach and recruit an increased number of potential clients.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
% of WY population age 60 and older served with income <100% of federal poverty level	N/A	14.17% (1,700/ 12,000)	18.68% (1,611/ 8,623)	17.99% (1,572/ 8,739)	16.22% (1,592/ 9,813)	13.19% (1,568 ^A / 11,895 ^B)	13.23% (1,574/ 11,895 ^C)
% of clients age 60 and older served with high nutrition risk	N/A	50.00% (2,500/ 5,000)	43.93% (2,162/ 4,922)	45.78% (2,192/ 4,788)	45.73% (2,271/ 4,966)	47.58% (2,277/ 4,786)	49.23% (2,364/ 4,802)
% of WY population age 60 and older served who live alone	6.28%* (2,575/ 41,000)	8.33% (2,500/ 30,000)	9.66% (2,636/ 27,279)	8.60% (2,525/ 29,359)	8.18% (2,627/ 32,105)	8.25% (2,468/ 29,923)	8.20% (2,445/ 29,923)
% of WY population age 60 and older served who are of a minority population	6.16%* (185/ 3,000)	1.90% (200/ 10,500)	1.72% (143/ 8,336)	1.60% (156/ 9,767)	2.00% (162/ 8,088)	1.58% (165/ 10,466)	1.67% (175/ 10,466)
Total % of WY population served age 60 and older	4.16%* (5,000/ 120,000)	3.85% (5,000/ 130,000)	4.08% (4,922/ 115,774)	3.97% (4,788/ 120,582)	4.11% (4,966/ 120,710)	3.70% (4,786/ 129,213)	3.72% (4,802/ 129,213)

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

* Targets from SFY17 are not updated with the new data source and therefore have different census data than the reported outcome percentages.

^A Data is collected via the voluntary Aging Needs Evaluation Summary completed by clients participating in the home delivered nutrition program.

^B Denominator data is reported from the United States Census Bureau, Wyoming Population 60 Years and Over in the United States.

^C Data from the Census Bureau for 2017 is not available. Data from the Census Bureau for 2016 was used as a reference for all SFY 2017 metrics, with the exception of metric "% of clients age 60 and older served with high nutrition risk".

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Total number of meals provided to clients age 60 and older	519,632	516,610	512,264	527,119	536,209	262,624	264,495	266,897	269,312
Total units of Nutrition Education provided to clients age 60 and older	11,022	5,275	954.25	7,818	14,493.75	70	7,748	7,346.75	7,147
Total units of Nutrition Counseling provided to clients age 60 and older	76.50	155.50	135.75	170.50	281.50	74	96.50	128.25	153.25
Total number of meals provided to all eligible clients	526,326	522,770	518,187	533,619	543,602	265,425	268,194	270,817	272,785
Total units of Nutrition Education provided to all eligible clients	11,301	5,765	1,574.75	8,066	14,630.75	186	7,880	7,417.75	7,213
Total units of Nutrition Counseling provided to all eligible clients	76.50	156.50	138.50	170.50	281.50	74	96.50	128.25	153.25
EFFICIENCIES									
Average total cost per meal	\$8.45	\$8.21	\$9.39	\$8.57	-	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	\$0.25	\$0.20	\$0.19	\$0.20	\$0.19	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	\$2.52	\$2.32	\$2.44	\$2.52	\$2.40	N/A*	N/A*	N/A*	N/A*
(-) Indicates data not yet available N/A* indicates data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

- The following metric was added during SFY17: “% of WY population age 60 and older served <100% of federal poverty level”. The Federal Poverty Level 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 following metric was added during SFY17: “% of clients served with high nutrition risk”. Client data for the nutrition program is gathered from the Nutrition Risk Assessment which is included in the Aging Needs Evaluation Summary. Individuals scoring a high nutrition risk are recommended to discuss their nutrition score with their dietitian or health professional, or are offered nutrition counseling services.
- The average cost per meal was updated from years SFY13 through SFY16. Previous years had reported an average facility cost. The methodology was updated to weight for facility size to determine an average cost per individual meal versus per facility. The average cost per meal is based on the total program cost (federal, state, local match, and program income).
- In SFY14 and SFY15 the nutrition education changed from a per client count to an aggregate count resulting in a large decrease in units provided for nutrition education. At the end of FFY15 the nutrition education changed from an aggregate count to a per client count. The large decrease in units provided for SFY16 Q1+Q2 is due to error in reporting per/client units.
- “served” is defined as the following services: meals, nutrition education and nutrition counseling. Reported data from the Aging Division data management system includes unduplicated clients who received any of the three services offered.
- Home Delivered meals is not a means-tested program. Clients receiving services can refuse to complete the Aging Needs Evaluation Summary that is used to collect pertinent data. Clients must be given the opportunity to voluntarily contribute toward the cost of meals, but they cannot be denied service because they cannot or will not contribute.
- All outcomes include collected data of clients served age 60 and older. The home delivered nutrition program provides services to clients who are not 60 and older that meet the eligibility criteria. Percentages for the outcomes metrics do not include eligible clients served that are under the age of 60.
- All outcomes, outputs, and efficiencies are reported on a State Fiscal Year. The home delivered nutrition program reports and is funded on a Federal Fiscal Year. Data collected via the Aging Division data management system is “point in time”. Data may change until the end of the program reporting period.

National Family Caregiver Support Program

Program Description

The National Family Caregiver Support Program provides support to Caregivers, 18 and older, who are caring for a person who is 60 years old or older or who has Alzheimer's or related dementia at any age, or is an older 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

	2015	2016	2017
Total Program Cost	\$775,652	\$753,410	\$621,567
People Served	508	411	377
Cost per Person	\$1,527	\$1,833	\$1,649
Non-600 Series*	15%**	15%**	15%**

* 600 series is defined as direct service contracts.

** This program shares administrative costs with Title III-B, C1, and C2. Up to 10% of OAA Title III funds can be allocated for administrative costs, per the AOA Fiscal Guide for OAA for Titles III and VII, April 2004.

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 National Caregiver Support Program & 0.5 FTE SAMs database support)
- 0 AWEC
- 0 Other

Program Metrics

- 22% of Caregivers are 18 to 59 years old, a decrease of 4% from SFY2016 to SFY2017.
- 78% of Caregivers are 60 and older, an increase of 2% from SFY2016 to SFY2017.
- Twelve grantees provide services to Caregivers in 18 counties in Wyoming.
- Two grantees provide services to Older Relative Caregivers who are taking care of child(ren) 17 years of age or younger. Services provided to Older Relative Caregivers are: Information, Assistance (Case Management), Counseling/Support Groups/Trainings, Respite and Supplemental Services (chore, homemaking, personal emergency response systems, etc.).

Events that have Shaped this Program

- The Caregiver program was implemented in 2001.
- The Caregiver program also serves Older Relative Caregivers, age 55 and older, raising grandchildren, 17 years of age or younger in two 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. Years when state funds have not been available the providers had to make the match themselves.
- FFY2010, 2014, 2015, 2016 and 2017 the Caregiver program received no state funds.
- Social Assistance Management Software (SAMS) data entry may have over-counted Caregivers in the past prior to FFY2014.



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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Number of unduplicated Caregivers Served	500	400	684	624	508	411	377
Number of Outreach events (estimated number of consumers outreached to)	1,300	1,200	1,210 (21,488)	1,274 (24,545)	1,742 (32,411)	928 (15,014)	1,141 (35,036)
Provider's Caregiver Evaluation Avg Score	13/30	11/30	11/30	12/30	12/30	11/30	11/30
Provider's Caregiver Evaluation Avg Score on newly enrolled Caregivers	16/30	12/30	N/A	11/30	11/30	12/30	9/30
Difficulty Finding Caregiver Services	2%	2%	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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of respite units	16,089	9,959	8,647	8,682	5,296	4,256	4,427	2,689	2,607
# of counselings/support group/training units	2,147	1,889	1,586	1,187	1,264	525	663	565	699
# of supplemental services units	6,445	7,727	6,685	5,736	5,225	3,036	2,700	2,635	2,590
EFFICIENCIES									
Average cost per caregiver	\$1,033	\$1,005	\$1,222	\$1,448	\$1,320	\$1,379	\$1,466	\$1,055	\$669

(-) 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

- Each grantee has 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. Years when state funds have not been available the providers have to make the match themselves.
- FFY 2010, 2014, 2015, 2016 and 2017 the Caregiver Program received no state funds.
- Annual tracking of each National Family Caregiver Support Program Provider's Caregiver Evaluation score in October 2012 changed to semi-annual 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 there are services available to assist them.
- Less than 1% of caregivers surveyed in FFY2015 and FFY2016 said finding services was difficult. No survey was conducted in FFY2017.

Wyoming Home Services

Program Description

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

	2015	2016	2017
Total Program Cost	\$4,168,574	\$4,279,425	\$4,037,483
People Served	2,257	2,156	1,900
Cost per Person	\$1,847	\$2,075	\$2,125
Non-600 Series*	3.67%	4.05%	1.73%

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY 2017 was the first year that the program operated under reimbursements.
- The total program cost for SFY 2017 reflects a \$1,353,524 budget cut for BFY17.
- The SFY 2017 funding sources for WyHS Program come from: State allocation \$2,496,259.00 (62%); Local matching funds of \$1,113,900 (27%); and Program Income (client contributions) \$427,324 (11%).

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Number of people served. For SFY 2017, WyHS served 1,900 people.
- Cost of services per person. For SFY 2017, WyHS services cost \$2,125 per client.
- Program income generated. For SFY 2017, WyHS program income was \$427,324.
- Number of potential clients on the waiting list. In SFY 2017, the WyHS waiting list ranged from a low of 89 to a high of 145. The waiting list shows the need for the services, however worker shortage is often a barrier to service.
- Services to be provided in every county. In 2017, 23 county wide programs served 1,900 clients.

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.
- There is an increase in prospective clients on the waiting list.
- This program has had the same amount of state funds allocated to its general fund budget for State fiscal years 2008-2015. In SFY 2017, the program received a reduction in state general funds of \$1,353,524 for the biennium.
- SFY 2017 is the first year the program has operated under a reimbursement model.

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 2017 Target	SFY 2018 Target	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
# of people served	2,357	2,400	2,322	2,328	2,257	2,156	1,900
% of WyHS Clients with an ADL of 2 or higher	85%	85%	1,789 (77%)	1,812 (78%)	1,761 (78%)	1,599 (74%)	1,378 (78%)
% of WyHS Clients with an IADL of 2 or higher	98%	98%	2,216 (95%)	2,257 (97%)	2,185 (97%)	2,081 (97%)	1,724 (97%)
Average # of people on the waiting list	0	0	84	82	83	76	111

(-) 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 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# of adult protective services (APS) reports	88	113	159	137	200	74	63	113	87
# of service units provided	N/A	N/A	93,446	94,540	84,269	47,667	46,839	41,327	42,942
# of homemaking units provided	N/A	N/A	50,694	51,585	48,265	25,839	25,746	23,733	24,532
# of personal care units provided	N/A	N/A	14,819	14,648	12,936	7,473	7,175	6,321	6,615
EFFICIENCIES									
Average cost per person	\$1,790	\$1,820	\$1,832	\$2,075	\$2,125	\$1,160	\$831	\$667	\$660
Average cost per unit of services	N/A	\$41	\$44	\$47	\$44	\$43	\$31	\$44	\$44

(-) 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 on 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 the program.
- 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.
- SFY 2017 sources
 - State general fund: \$2,496,259.00 (62%)
 - Local matching funds of \$1,113,900 (27%)
 - Program Income (client contributions) \$427,324 (11%).

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

Community Choices Waiver	0483
Electronic Record Incentive Program	0404
Eligibility Customer Service & Call Center	0401
Eligibility Long Term Care Unit	0401
Health Management.....	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
Native American Healthcare.....	0471
Nursing Facilities	0463
Patient Centered Medical Home	0460, 0461
Program of All-Inclusive Care for the Elderly (PACE)	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), Part B.....	2510
Early Intervention and Education Program (EIEP), Part C.....	2510
Mental Health Outpatient Treatment.....	2506

Mental Health Residential Treatment.....	2508
Substance Abuse Outpatient Treatment	2507
Substance Abuse Residential Treatment.....	2509
Supports Waiver.....	0486

Public Health Division

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
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