



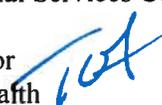
401 Hathaway Building • Cheyenne, WY 82002
Phone (307) 777-7656 • 1-866-571-0944
Fax (307) 777-7439 • www.health.wyo.gov



Thomas O. Forslund
Director

Mark Gordon
Governor

MEMORANDUM

Date: January 8, 2019
To: Joint Labor, Health, and Social Services Committee Members
From: Thomas O. Forslund, Director
Wyoming Department of Health 
Subject: HealthStat SFY 2018 Final Reports
Ref: F-2019-101

The Wyoming Department of Health (WDH) is pleased to submit its SFY 2018 Final HealthStat Reports which summarize the performance of 57 WDH programs. These reports are one part of the WDH performance management system, HealthStat, which also includes regular, integrated meetings with WDH senior leadership 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 changes have been made from previous years in accord with changes in funding, program administration, and to facilitate external reporting and internal program management.

- Division of Health Care Financing
 - Reporting for Nursing Home benefits, the Program of All-Inclusive Care for the Elderly (PACE), and the Community Choices Waiver (CCW) has been combined into a single 'Long Term Care Summary' report for ease of comparison between programs.
 - The federal Electronic Health Record incentive program has ended and the program has been removed from this report.
- Behavioral Health Division
 - All Acquired Brain Injury (ABI) Waiver clients have transitioned to the Supports Waiver or the Comprehensive Waiver and the ABI Waiver has been removed from this report.
- Public Health Division
 - Suicide prevention efforts have been transferred to the Injury Prevention Program.

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

TOF/CC/jg

c: Governor Mark Gordon



HealthStat 2018 Final Reports

December 15, 2018

HealthStat 2018: A Foreward

HealthStat is a performance management initiative that began in 2011. HealthStat is now entering its eighth 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.

Table of Contents

Division of Health Care Financing (Medicaid)	1
Medicaid Overview.....	3
Medicaid Members.....	4
Financial Stewardship.....	6
Provider Network.....	9
Health Outcomes.....	12
Programs.....	16
Long Term Care Summary.....	16
KidCare CHIP.....	20
Patient Centered Medical Home (PCMH).....	23
Care Management Entity.....	27
Medication Donation Program.....	31
Benefits.....	35
Behavioral Health.....	35
Dental.....	39
Pharmacy.....	43
Psychiatric Residential Treatment Facilities (PRTF).....	47
Administrative Functions.....	50
Medicaid Customer Service Center.....	50
Eligibility Long Term Care Unit.....	53
Third Party Liability.....	56
Behavioral Health Division	60
Comprehensive Waiver.....	61
Court Supervised Treatment (CST) Programs.....	64
Early Intervention and Education Program (EIEP), Part B.....	67
Early Intervention and Education Program (EIEP), Part C.....	70
Mental Health Outpatient Treatment.....	73
Mental Health Residential Treatment.....	76
Substance Abuse Outpatient Treatment.....	79
Substance Abuse Residential Treatment.....	82
Supports Waiver.....	85

Public Health Division	88
Community Health Section	90
Child Health.....	90
Chronic Disease Prevention.....	94
Immunization Program	97
Injury Prevention.....	100
Public Health Nursing	103
Healthy Baby Home Visitation Program.....	106
Substance Abuse Prevention Program	109
Tobacco Prevention and Control Program	113
Women and Infant Health.....	116
Women, Infants and Children (WIC) Program	119
Wyoming Cancer Program	122
Youth & Young Adult Health Program.....	125
Health Readiness and Response Section	129
Community Medical Access and Capacity (CMAC) Program	129
Community Services Program.....	132
Healthcare Preparedness Program (HPP)	135
Healthcare Workforce Recruitment, Retention and Development	138
Office of Emergency Medical Services (OEMS).....	141
Office of Health Equity.....	144
Public Health Emergency Preparedness (PHEP).....	147
Trauma Program	151
Public Health Sciences Section.....	154
Communicable Disease Prevention Program	154
Communicable Disease Treatment Program	157
Infectious Disease Epidemiology	160
Public Health State Laboratory	163
Aging Division	167
Legal Services & Legal Developer Program.....	168
Long Term Care Ombudsman.....	171
Title III-B Supportive Services.....	174
Title III-C1 Congregate Nutrition Program.....	177
Title III-C2 Home Delivered Meal Program.....	181

Title III-E National Family Caregiver Support Program.....	185
Wyoming Home Services.....	188
Appendix A: Program Budget Strings	191

WDH | Division of Healthcare Financing

Information contained in this section includes:

- Medicaid Overview
 - Medicaid Members
 - Financial Stewardship
 - Provider Network
 - Health Outcomes
- Programs
 - Long Term Care Summary
 - KidCare CHIP
 - Patient Centered Medical Home (PCMH)
 - Care Management Entity (CME)
 - Medication Donation Program
- Benefits
 - Behavioral Health
 - Dental
 - Pharmacy
 - Psychiatric Residential Treatment Facilities (PRTF)
- Administrative Functions
 - Medicaid Customer Service Center

- Eligibility Long Term Care Unit
- 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 2016	SFY 2017	SFY 2018
Total Claims Cost (millions)*	\$554.6M	\$556.3M	\$567.5M
Average Monthly Enrollment	66,696	63,247	60,263
Cost per Person (PMPM)	\$687	\$689	\$674**

* By claim paid date. Only includes Medicaid expenses paid through the MMIS; therefore, expenses for administration, Medicare buy-in premiums, Medicaid Part- D clawback, and provider taxes are excluded. For additional financial information, please see the Medicaid Annual Report.

**Value with a 0-month claim lag.

Program Cost Notes

- Funded via federal medical assistance percentage (FMAP) and state general funds. FMAP as follows:
 - Claims: generally 50%, 90% for family planning and 88% for former CHIP children.
 - Administration: generally 50%, 75% for medical and eligibility determination staff
 - MMIS and WES operations and minor updates: 75%
 - Large technology replacements and system changes: 90%
- Administration expenses are 4% to 5.5% of total cost, excluding large capital improvements.

Program Staffing

- Total: 102 FT, 7 AWEC
- 27 FT, 1 AWEC in Eligibility Unit
- 25 FT in Behavioral Health Division ID/DD Waivers
- 12 FT in Provider Services Unit
- 6 FT, 5 AWEC in AIMS/WINGS Unit
- 8 FT in Program Integrity Unit
- 8 FT in Medicaid Home Care Unit
- 6 FT in Medicaid Fiscal
- 5 FT, 1 AWEC in Leadership & Administration
- 5 FT in Health Management, THR, HIE

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



Wyoming Medicaid – Member Monitoring

PROGRAM CORE PURPOSE

Wyoming Medicaid provides health care coverage to qualified individuals.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Estimated % and # of Uninsured Wyoming Children under Age 19, Under 138% of Federal Poverty Level (FPL) (CY 2016 regional average** – 7.5%)	N/A	N/A	10.4% 3,221 (CY 2013)	10.6% 3,332 (CY 2014)	12.9% 3,825 (CY 2015)	12.9% 3,596 (CY 2016)	N/A
Estimated % and # of Uninsured Wyoming Adults Age 18 to 64, Under 138% of FPL* (CY 2016 regional average** – 24.7%)	N/A	N/A	37.9% 22,437 (CY 2013)	33.1% 19,340 (CY 2014)	31.4% 17,008 (CY 2015)	30.1% 16,425 (CY 2016)	N/A
Estimated % and # of Uninsured Wyoming Children under Age 19, All Incomes* (CY 2016 regional average** – 5.0%)	N/A	N/A	7.1% 10,049 (CY 2013)	6.7% 9,503 (CY 2014)	8% 11,399 (CY 2015)	8.2% 11,687 (CY 2016)	N/A
Estimated % and # of Uninsured Wyoming Adults Age 18 to 64, All Incomes* (CY 2016 regional average** – 12.2%)	<16% by 2018 (WDH Strategic Plan)	<16% by 2018 (WDH Strategic Plan)	19.3% 68,779 (CY 2013)	17.1% 60,856 (CY 2014)	15.5% 54,927 (CY 2015)	15.6% 54,527 (CY 2016)	N/A

* 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Enrolled Members (unique count, total SFY)	88,642	91,062	88,775	84,785	80,475	N/A*	N/A*	N/A*	N/A*
% of State Population Enrolled in Medicaid*	15.2% (583,334)	15.5% (586,102)	15.2% (584,910)	14.6% (579,315)	13.7% (589,250)	N/A*	N/A*	N/A*	N/A*
Member Months	844,694	896,103	815,075	781,641	743,735	N/A*	N/A*	N/A*	N/A*
Average Monthly Enrollment	70,389	74,628	66,696	63,247	60,263	N/A*	N/A*	N/A*	N/A*
Recipients (unique count of members who used at least one service)	72,660	74,062	73,067	71,720	68,611	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, 2017 (NST-EST2017-01). SFY 2018 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 Affordable Care Act (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%.
- In addition, for members meeting certain additional standards of need, Wyoming Medicaid also covers institutional levels of care such as hospice, nursing homes, and intermediate care facilities. As an alternative to individuals meeting institutional level of care need, Wyoming Medicaid also provides home and community based support services through waivers to support individuals staying in their homes and communities. These types of services have not traditionally been covered by other forms of insurance.

Wyoming Medicaid – Financial Monitoring

PROGRAM CORE PURPOSE

Wyoming Medicaid provides health insurance coverage for qualified low-income individuals and monitors costs related to specific Medicaid programs.

OUTCOMES								
Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018*
Per Member Per Month (PMPM)		N/A	N/A	\$609	\$585	\$687	\$689	\$674
Children PMPM	Children	N/A	N/A	\$189	\$190	\$213	\$214	\$217
	Foster Care Children	N/A	N/A	\$647	\$604	\$566	\$575	\$564
	Newborns	N/A	N/A	\$636	\$657	\$674	\$655	\$758
Non-Disabled Adults PMPM	Family-Care Adults	N/A	N/A	\$459	\$437	\$452	\$432	\$453
	Former Foster Care	N/A	N/A	\$61	\$464	\$372	\$307	\$346
	Pregnant Women**	N/A	N/A	\$928	\$762	\$1,036	\$969	\$980
Aged Individuals PMPM	Community Choices***	N/A	N/A	\$1,645	\$1,654	\$1,719	\$1,631	\$1,496
	Nursing Home	N/A	N/A	\$3,738	\$3,763	\$4,347	\$4,285	\$3,963
	PACE	N/A	N/A	\$2,504	\$2,483	\$2,440	\$2,388	\$2,178
Disabled Individuals PMPM	Acquired Brain Injury	N/A	N/A	\$4,151	\$4,165	\$3,816	\$3,722	\$3,623
	Adults with ID/DD	N/A	N/A	\$5,488	\$5,243	\$5,421	\$5,029	\$4,692
	Children with ID/DD	N/A	N/A	\$2,400	\$2,490	\$2,569	\$2,339	\$2,197
	Suppl. Security Income (SSI)	N/A	N/A	\$733	\$730	\$781	\$762	\$714
Benchmark PMPM****	CHIP (Plan A)	N/A	N/A	N/A	N/A	\$237	\$246	\$267
	Child Marketplace	N/A	N/A	N/A	N/A	\$261	\$283	\$452
	Adult Marketplace	N/A	N/A	N/A	N/A	\$525	\$560	\$693

*As of 7.2.18, no claims lag. Will change significantly as providers bill additional claims.

** 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.

****Kid Care Chip premium for SFY 2018 is \$266.80 (Plan A) and 2018 Marketplace child premium is \$451.78 (lowest price gold plan with \$750 deductible and \$7,350 max out of pocket). 2018 adult Marketplace premium is for a 40-yr old, non-smoker \$693.12 (lowest price gold plan with \$750 deductible and \$7,350 max out of pocket)

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018*	2015 Q1+Q2	2015 Q3+Q4	2016 Q1+Q2	2016 Q3+Q4
OUTPUTS									
Recipients (unique count of members who received services)	72,660	74,062	73,067	71,720	68,611	N/A*	N/A*	N/A*	N/A*
Enrollment	88,642	91,062	88,775	84,785	80,475	N/A*	N/A*	N/A*	N/A*
Member Months	843,001	897,281	815,075	781,641	743,735	N/A*	N/A*	N/A*	N/A*
Claims Expenditures (by service date)**	\$513.0	\$524.5	\$559.6	\$538.7	\$500.7	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
% Enrolled that used services	82.0%	81.3%	82.3%	84.6%	85.3%	N/A*	N/A*	N/A*	N/A*
Cost per Recipient	\$7,060	\$7,082	\$7,659	\$7,511	\$7,298	N/A*	N/A*	N/A*	N/A*
Cost per Enrolled Member	\$5,787	\$5,760	\$6,304	\$6,354	\$6,222	N/A*	N/A*	N/A*	N/A*
*As of 7.2.18, no claims lag. Will change significantly. **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 by dividing claims expenditures by the number of 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 – Comprehensive and Supports – to replace the Adult Developmentally Disabled (DD), Child DD, and Acquired Brain Injury (ABI) waivers. Members from Adult DD waiver completed transitioning to the two new waivers by September 30, 2014, with transitions of Child DD occurring by June 30, 2015; the ABI transition was completed in 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.
- Per capita spending on healthcare in Wyoming was \$8,320 in 2014. This equates to \$693.33 per month per Wyoming resident. The United States per capita figure was \$8,045 in 2014. More recent data was not available at the time of reporting (<http://kff.org/other/state-indicator/health-spending-per-capita/>). An annualized per capita spending for Medicaid members would be \$8,088 (preliminary) in SFY 2018 based on the SFY 2018 Medicaid member average PMPM.
- A potential valid benchmark for the children population would be:
 - The Wyoming Kid Care Chip program. Kid Care Plan A does not have copays and had a premium cost of \$266.80/month in SFY 2018.
 - An 80% actuarial value Marketplace plan (gold plan with lowest cost sharing) for a Wyoming child (0-18) was \$451.78 per month in 2018 in Laramie County with a \$750 deductible and \$7,350 maximum out of pocket. (<https://www.healthcare.gov/see-plans/#/>)
- A potential benchmark for the family care adult population could be a 2018 Marketplace plan for Wyoming. In Laramie County, an 80% actuarial value plan (gold plan with lowest cost sharing) had a \$693.12 monthly premium for a 40-year old (non-smoker) with a \$750 deductible and \$7,350 maximum out of pocket. Online: <https://www.healthcare.gov/see-plans/#/>
- Wyoming Medicaid was asked to reduce its state general fund budget by \$54.4 million for the 2017-2018 biennium. Additionally, when state general funds are reduced, there is a loss of federal matching funds. In addition to the reduction of state general funds, the division estimated an additional loss of approximately \$28.1 million in federal matching funds. As a result, the total reduction was estimated to be approximately \$82.5 million for the 2017-2018 biennium. In March 2018, a one-time appropriation of \$21.4 million state general funds was funded by the Legislature. The general fund shortfall position without the technology projects carryforward was \$12.5 million. The technology projects carryforward added an additional \$6.95 million. The WDH froze \$10.6 million internally to cover the Medicaid deficit; adding this brought the final position to a shortfall of \$8.8 million.



Wyoming Medicaid – Provider Network

PROGRAM CORE PURPOSE

Wyoming Medicaid ensures client access to an adequate and accessible healthcare provider network through the management of provider enrollment and reimbursement.

OUTCOMES – PROVIDER ENROLLMENT

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Physicians	% of Licensed and Practicing	>99%	>99%	99% + (est.)	99% + (est.)	99% + (est.)	99%+ (est.)	99%+ (est.)
	# In-State	N/A	N/A	1,671	1,800	1,891	1,786	1,915
	# Out-of-State	N/A	N/A	6,552	7,664	7,472	7,133	6,785
Nursing Facilities*	% of In-State	100%	100%	100%	100%	100%	100%	100%
	# In-State	N/A	N/A	39	55	55	57	56
	# Out-of-State	N/A	N/A	15	21	19	20	15
Hospitals**	% of In-State	100%	100%	100%	100%	100%	96.8%	96.7%
	# In-State	N/A	N/A	29	30	31	31	31
	# Out-of-State	N/A	N/A	331	310	270	234	201
Pharmacies	% of In-State	>95%	>95%	86% (est.)	95%*** (est.)	98.5%	100%	100%
	# In-State	N/A	N/A	127	132	131	134	126
	# Out-of-State	N/A	N/A	90	101	93	98	90
Dentists	% of Licensed and Practicing	>85%	>85%	76%	78%	79%	79%	72%
	# In-State	N/A	N/A	300	324	327	346	343
	# Out-of-State	N/A	N/A	137	131	142	143	135

(-) 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
Physician rates as a % of the regional average		121%	111%	111%	93%	-	N/A	N/A	N/A	N/A
Nursing facilities % cost coverage with the upper payment limit (UPL)*		87%	83%	91%	91%	89.4%	N/A	N/A	N/A	N/A
Hospital % cost coverage with the qualified rate adjustment (QRA)**	Inpatient	83%	85%	90%	99%	-	N/A	N/A	N/A	N/A
	Outpatient	67%	68%	66%	99%	-	N/A	N/A	N/A	N/A
Dental rates as a % of the estimated provider cost***		96%	88%	90%	91%	-	N/A	N/A	N/A	N/A
% of hospital inpatient days paid by Medicaid		15.89%	13.41%	13.77%	13.93%	-	N/A	N/A	N/A	N/A
EFFICIENCIES										
ALL Claims Processing Time (days)	Service to Bill	26.9	27.4	29.2	33.6	35.7	N/A	N/A	N/A	N/A
	Turnaround Time, Receipt to Payment	4.4	4.6	4.2	4.4	3.95	N/A	N/A	N/A	N/A
	Service to Payment	31.3	32	33.3	38	39.6	N/A	N/A	N/A	N/A
% of all claims denied		9.7%	10.6%	12.9 %	13.7%	12.7%	N/A	N/A	N/A	N/A
(-) 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 ** in-state hospitals only *** Based on the 2016 ADA Survey of Dental Fees and Expenses										

STORY BEHIND THE PERFORMANCE

- 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.”
- 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, whenever 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 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 of \$8,414,886 to the nursing facility appropriation. 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 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 to ensure 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) Electronic claims mandate implemented July 1, 2015, and, 4) Mandatory inclusion of the ordering, referring, prescribing, and attending provider on all claim types in preparation for 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. This included outpatient hospitals and ambulatory surgical centers. Provider participation has been closely monitored through implementation of various policy and rate changes.



Medicaid Health Outcomes

Program Description

These initiatives measure, monitor, and promote improved health outcomes. Metrics include process compliance, effectiveness, safety, efficiency, and timely healthcare.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost*	\$5,446,785	\$2,703,070	\$2,601,280
People Enrolled**	88,775	84,785	80,406
Cost per Person	\$61.35	\$31.88	\$31.70
Non-600 Series	100%	100%	100%

* Excludes Administrative and Claims Costs

** All Medicaid, All Ages

2018 Program Cost Notes

- Optum Health Management = \$1,330,050
- Patient Centered Medical Home = \$784,530
- Seattle Children’s Hospital = \$480,375
- Baby Showers = \$5,000
- Diabetes Incentives = \$1,325
- All costs are 50% Federal and 50% State funded

Program Staffing

- 2.5 FTE
 - Medical Director = 0.75 FTE
 - Contract Manager = 0.5 FTE
 - Data Analysts = 1.0 FTE
 - DUPRE = 0.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The program metrics apply to the entire Medicaid population.
- CMS Core Measures are used for the outcome metrics.
- Key indicators of health management include the rate of emergency room visits and inpatient admissions.
- PMPM (per member per month) is used as a measure of efficiency across various disciplines and client ages.

Events that have Shaped this Program

- Development of the Wyoming Super Utilizer Program (WySUP).
- Optum Healthcare Solutions is contracted to provide total population, targeted conditions, and complex case management. Contract term is 7/1/16 to 6/30/20.
- Seattle Children’s Hospital provides three different support services for our providers.
- The Patient Centered Medical Home program requires practices to adhere to best standards around patient care coordination and quality improvement.



Medicaid Health Outcomes

PROGRAM CORE PURPOSE

The core purpose of these initiatives is to improve the prevention, screening, diagnosing, and managing of acute and chronic diseases in Wyoming Medicaid clients.

OUTCOMES

Performance Metric*		CY 2018 Target	CY 2019 Target	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
(W15-CH) % of Children with 6+ Well Visits (15 Months Old)	Medicaid	>38%	>40%	N/A	29.9%	30.0%	35.6%	-
	National	N/A	N/A	N/A	60.1%	60.8%	59.3%	-
(W34-CH) % of Children with 1+ Well Visit (Age 3-6)	Medicaid	>55%	>60%	51.3%	46.2%	49.5%	53.0%	-
	National	N/A	N/A	67.4%	66.9%	68.0%	66.9%	-
(AWC-CH) % of Adolescents with 1+ Well Visit (Age 12-21)	Medicaid	>40%	>42%	37.0%	31.5%	34.2%	37.9%	-
	National	N/A	N/A	43.5%	45.5%	45.1%	44.7%	-
(PQ101-AD) Rate of Diabetes Inpatient Admits per 100,000 Member Months (Age 18+)	Medicaid	<17	<17	11.0	11.2	17.6	17.1	-
	National	N/A	N/A	N/A	N/A	18.5	17.9	-
(OHD-AD) Rate of High Dosage Opioids per 1,000 Opioids (Age 18-64)	Medicaid	<25	<25	33.32	33.02	30.62	26.59	-
	National	N/A	N/A	N/A	N/A	N/A	N/A	-

- Data is not yet available and will be reported in early 2019.

* These metrics are part of the CMS Core Measure set, and are reported for the previous calendar year (i.e. values under CY2017 above is based on CY2016 data). National Benchmarks represent the median. Online:

<https://data.medicare.gov/browse?category=Quality&limitTo=datasets&sortBy=newest>

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

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Emergency Room Visits per 1,000 Member Months	58.9	58.3	58.6	60.4	62.7	N/A*	N/A*	N/A*	N/A*
Inpatient Admissions per 1,000 Member Months	12.1	11.3	11.9	11.6	11.1	N/A*	N/A*	N/A*	N/A*
Seattle Children's Hospital	# of Med Reviews	N/A	N/A	N/A	13	28	N/A*	N/A*	N/A*
	# of Completed MDT*	N/A	N/A	N/A	119	153	N/A*	N/A*	N/A*
	# of PAL Calls**	N/A	N/A	N/A	226	304	N/A*	N/A*	N/A*
# of Clients Enrolled in Diabetes Incentive Program	N/A	N/A	70	86	60	N/A*	N/A*	N/A*	N/A*
# of Baby Showers	N/A	N/A	3	5	4	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
PMPM	Home Health	\$4	\$6	\$12	\$13	\$3	N/A*	N/A*	N/A*
	PRTF***	\$18	\$15	\$14	\$16	\$16	N/A*	N/A*	N/A*
	Hospital Outpatient	\$34	\$34	\$36	\$33	\$32	N/A*	N/A*	N/A*
	Behavioral Health	\$36	\$38	\$43	\$38	\$33	N/A*	N/A*	N/A*
	Pharmacy	\$49	\$53	\$60	\$64	\$78	N/A*	N/A*	N/A*
	Physician	\$72	\$67	\$73	\$74	\$71	N/A*	N/A*	N/A*
	Hospital Inpatient	\$87	\$83	\$94	\$87	\$88	N/A*	N/A*	N/A*
	Nursing Home	\$85	\$78	\$102	\$110	\$114	N/A*	N/A*	N/A*
	Total Waivers	\$140	\$126	\$146	\$153	\$176	N/A*	N/A*	N/A*
	Other Services	\$84	\$86	\$107	\$116	\$104	N/A*	N/A*	N/A*
	Overall Medicaid	\$609	\$585	\$686	\$703	\$715	N/A*	N/A*	N/A*
	Age 0-21	\$310	\$307	\$351	\$368	\$395	N/A*	N/A*	N/A*
	Age 22-64	\$1,210	\$1,087	\$1,213	\$1,206	\$1,185	N/A*	N/A*	N/A*
	Age 65+	\$1,380	\$1,364	\$1,634	\$1,641	\$1,572	N/A*	N/A*	N/A*
# of Unique Members	Age 0-21	59,697	60,682	57,823	54,049	48,465	N/A*	N/A*	N/A*
	Age 22-64	22,742	24,703	25,546	24,499	22,043	N/A*	N/A*	N/A*
	Age 65+	6,439	6,614	6,596	6,753	6,648	N/A*	N/A*	N/A*
% of Unique Members	Age 0-21	67.2%	66.0%	64.3%	63.4%	62.8%	N/A*	N/A*	N/A*
	Age 22-64	25.6%	26.9%	28.4%	28.7%	28.6%	N/A*	N/A*	N/A*
	Age 65+	7.2%	7.2%	7.3%	7.9%	8.6%	N/A*	N/A*	N/A*

* MDT (Multi-Disciplinary Team)
** PAL (Provider Assistance Line)
*** PRTF (Psychiatric Residential Treatment Facility)
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

WYHealth Functions

- **Total Population Health Management** - education and support on how to manage health and wellness.
- **Targeted Case Management** - Targeted Case Management is aimed at clients with high risk and 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 Agency has defined certain conditions (including diabetes, asthma, cardiovascular, pulmonary disease (COPD), high-risk pregnancy) the Agency reserves the right to add or consider additional conditions.
- **Complex Case Management** - also referred to as the Wyoming Super Utilizer Program or WYSUP, is for individuals who are at risk of demonstrating poor health outcomes, experiencing fragmented health care delivery, have high cost utilization of services, or whose pattern of health services access may indicate an inappropriate utilization of health care resources and would benefit from intensive case management services.
- **Nurse Call Line** - 24/7 nurse line for clients to inquire about health problems or doctor's direction.

Patient Incentives

- **Diabetes Choice Rewards** - Designed to engage diabetic patients in education and monitoring for a year to improve diabetes control.
- **Baby Showers** - We cooperate with Public Health Nurses and local communities to bring all the maternal and child health programs together with local providers in public health nurse office lead events in each community. WYHealth is present to discuss their programs and promote the Family Health mobile phone application. These community events connect Medicaid and Non-Medicaid women with resources in both their community and statewide.

Practice Support

- **Seattle Children's Hospital** – Provides three different supports for our providers. First, the Provider Assistance Line (PAL) that is available for any child in Wyoming so their physician or nurse can call for assistance in the diagnosis and management of children with psychiatric issues; this also applies to adults with developmental disabilities, and they can also provide telehealth consultations for children enrolled in Medicaid. Second, they provide an assessment and recommendations for children prior to Multi-Disciplinary Team (MDT) hearings, reducing the numbers admitted to psychiatric residential treatment facilities (PRTFs). Third, they provide a mandatory second opinion to providers who exceed normal drug utilization.
- **Pharmacy Care Management** - The goal of this program is to utilize a clinical pharmacist at Wyoming Medicaid's Pharmacy Benefit Manager (Change Healthcare) who has access to pharmacy claims information, to assist in coordinating care for clients with complex or expensive medication regimens. The clinical pharmacist will be in contact with prescribers to ensure all providers involved in a case are aware of one another and to encourage high quality prescribing practices based on clinical guidelines and individual client claims history. The pharmacist will also contact clients to encourage medication adherence, provide answers to clinical questions, and direct clients to their provider with treatment concerns.
- **Patient Centered Medical Home (PCMH)** – This program requires practices to adhere to best standards around patient care coordination, team-based care, population management, patient-centered access and continuity, care management and support, and performance and quality improvement. Our PCMHs also work closely with WYHealth on targeted and complex case management clients.
- **Data Analytics** - Data analytics help Medicaid and practices to identify outliers, to help our providers focus on previously unidentified needs, and to calculate the CMS child and adult Medicaid Core Measures.
- **Medicaid Waiver Quality and Safety Oversight** - We have developed a Quality Assurance committee to meet CMS Home and Community Based Waiver sub-assurances around patient safety, abuse, neglect exploitation, and death.



Medicaid Long Term Care Summary

Program Description

Wyoming Medicaid offers long term care to individuals meeting a nursing home level of care through the Community Choice Waiver (CCW), the Program of All-Inclusive Care for the Elderly (PACE), and Nursing Homes (NH).

Summary

SFY	2016	2017	2018
Total Long Term Care Expenditures*	\$157,284,269	\$164,744,930	\$170,227,185
Unique People Served	4,510	4,740	4,876
Cost per Person	\$28,347	\$27,915	\$34,911

Community Choice Waiver (CCW)

SFY	2016	2017	2018
Total Program Cost (by service date)	\$37,124,283	\$38,554,005	\$40,484,581
Unique People Served	2,322	2,471	2,613
Cost per Person	\$15,988	\$15,603	\$15,494

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

SFY	2016	2017	2018
Total Program Cost (by service date)	\$2,942,611	\$3,496,938	\$3,502,181
Unique People Served	121	141	167
Cost per Person	\$24,319	\$24,801	\$20,971

Nursing Homes (NH)

SFY	2016	2017	2018
Total Program Cost (by service date)**	\$87,776,603	\$90,268,202	\$89,234,036
Unique People Served	2,349	2,416	2,395
Cost per Person	\$37,368	\$37,363	\$37,258
Provider Tax & Gap Payments***	\$29,440,772	\$32,425,785	\$37,006,387
Total Program, Tax, and Gap Costs	\$117,217,375	\$122,693,987	\$126,240,423

*Includes CCW, PACE, and NH (w/ Tax and Gap)

**Costs include Nursing Facility & Swing Bed taxonomies, does not include Tax/Gap payments so comparisons can be made with CCW/PACE on claims paid.

***Paid with 50% provider funding and 50% federal funding (i.e. no state general funds)

Program Cost Notes

- All programs are 50% federal, 50% state general funds

Program Staffing

- CCW: 4.75 FTE
- PACE: 0.5 FTE
- NH: 0.25 FTE

Program Metrics

- Comparison of enrollment, expenditures, member months between long term programs.
- Comparison of LT-101 scores, emergency room rates, and inpatient rates between long term care programs.

Events that have Shaped this Program

- In SFY 2017, the Long-Term Care (LTC) waiver program was combined with the Assisted Living Facility (ALF) waiver to form the Community Choices Wavier (CCW) program.
- In SFY 2013, PACE began and the only provider is located in Cheyenne and serves the Cheyenne area. The provider is Cheyenne Regional Medical Center (CRMC).
- After an extensive public process, an updated nursing facility Rate Model was approved and implemented effective July 1, 2015. The new rate model is a hybrid price, cost, and acuity adjusted model for four cost categories: exempt costs, property costs, healthcare costs subject to acuity adjustments, and operating costs (including laundry, housekeeping, routine supplies, etc.)



Medicaid Long Term Care Summary

PROGRAM CORE PURPOSE

Provide access to long term care services for individuals who meet a nursing home level of care in the least restrictive setting.

OUTCOMES

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Community-based Program (CCW or PACE)	% of LTC enrolled members	N/A	59%	49%	52%	54%	55%	57%
	% of LTC Member Months	N/A	58%	48%	51%	53%	54%	56%
	% of LTC Expenditures	N/A	27%	23%	25%	25%	26%	26%
Total Cost for Extraordinary Care Clients (% of total NH w/ tax & gap costs)*		N/A	< 1%	\$1,436,290 (1.4%)	\$1,470,960 (1.4%)	\$1,481,129 (1.3%)	\$1,221,211 (1.0%)	\$840,239 (0.7%)
Average LT-101 Score**	CCW	N/A	N/A	N/A	N/A	22.7	23.2	23.1
	PACE	N/A	N/A	N/A	N/A	25.5	24.3	24.5
	Nursing Home	N/A	N/A	N/A	N/A	32.5	32.9	32.6
Rate of ER visits (per 1,000 members months)***	CCW	N/A	<121.2	118.7	120.4	113.1	121.2	131.0
	PACE****	N/A	<27.3	37.1	29.6	38.1	27.3	39.2
	Nursing Home	N/A	<36.1	39.4	38.6	37.3	38.1	36.1
Rate of inpatient admits (per 1,000 members months)***	CCW	N/A	<8.0	8.5	8.0	7.2	8.7	8.0
	PACE****	N/A	<64.2	55.0	54.9	58.0	64.2	79.1
	Nursing Home	N/A	<3.0	1.9	2.3	3.7	3.5	1.6

LTC (Long Term Care) CCW (Community Choice Waiver) PACE (Program for All Inclusive Care) NH (Nursing Home) ER (Emergency Room)

* These are NH clients only.

** A higher LT-101 score indicates a need for a greater level of care.

*** A lower rate is better.

**** # of admits and visits are self-reported from the PACE provider (CRMC)

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

N/A* LT-101 was scored differently prior to SFY 2016 so is not comparable

OUTPUTS AND EFFICIENCIES										
Performance Metric		SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS										
# of unique enrolled*	CCW	1,926	2,124	2,322	2,471	2,613	N/A*	N/A*	N/A*	N/A*
	PACE	63	97	121	141	167	N/A*	N/A*	N/A*	N/A*
	Nursing Home	2,301	2,285	2,349	2,416	2,395	N/A*	N/A*	N/A*	N/A*
Member Months	CCW	18,369	19,776	21,643	22,912	24,922	N/A*	N/A*	N/A*	N/A*
	PACE	512	911	1,206	1,464	1,606	N/A*	N/A*	N/A*	N/A*
	Nursing Home	20,092	19,667	20,255	20,854	20,860	N/A*	N/A*	N/A*	N/A*
Expenditures as % of Total Medicaid	CCW	5.9%	6.2%	6.6%	7.2%	8.1%	N/A*	N/A*	N/A*	N/A*
	PACE	0.2%	0.4%	0.5%	0.6%	0.7%	N/A*	N/A*	N/A*	N/A*
	Nursing Home	14.6%	14.0%	15.7%	16.8%	17.8%	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES										
Per Member Per Month (PMPM) – total costs	CCW (waiver & medical)	\$1,644	\$1,648	\$1,715	\$1,683	\$1,624	N/A*	N/A*	N/A*	N/A*
	PACE	\$2,504	\$2,482	\$2,440	\$2,389	\$2,181	N/A*	N/A*	N/A*	N/A*
	NH (w/o tax & gap)	\$3,734	\$3,747	\$4,334	\$4,329	\$4,278	N/A*	N/A*	N/A*	N/A*
	NH (w/ tax & gap)	\$5,281	\$5,294	\$5,787	\$5,883	\$6,052	N/A*	N/A*	N/A*	N/A*
PMPM Index to NH (w/o tax & gap)	CCW (waiver & medical)	44%	44%	40%	39%	38%	N/A*	N/A*	N/A*	N/A*
	PACE	67%	66%	56%	55%	51%	N/A*	N/A*	N/A*	N/A*
	NH (w/o tax & gap)	100%	100%	100%	100%	100%	N/A*	N/A*	N/A*	N/A*
PMPM (Per Member Per Month) *If an individual transitioned across programs, they are counted multiple times. (-) Indicates data not complete due to partial SFY N/A* indicates data not available on a quarterly basis										

STORY BEHIND THE PERFORMANCE

- **CCW**
 - In July 2016, the Long-Term Care (LTC) waiver program was renewed for another five years and the name was changed to the Community Choices Waiver (CCW) program. Assisted living services were added at that time.
 - The phase-out of the Assisted Living Facility (ALF) waiver program was completed on June 30, 2017, and all ALF participants were transitioned to the CCW program.

- **PACE**
 - 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 a nursing home level of care.
 - This program started February 1, 2013 in Cheyenne with Wyoming PACE at Cheyenne Regional Medical Center (CRMC) as the sole provider. PACE has exceeded the initial enrollment estimates and continues to grow. The PACE provider expanded their facility at their current location in December 2014, as they were nearing capacity for their facility.
 - Wyoming PACE has started remodeling a building as a new facility in order to expand again as they are exceeding capacity for their current facility.
 - Rate changes were submitted to CMS for approval on April 1, 2018 for SFY2019 as follows:
 - \$2,450.37 for Medicaid/Medicare clients
 - \$3,276.94 for Medicaid only clients
 - Federal audit procedures for the PACE program have been updated nationwide to narrow the components of the federal review. States have assumed the responsibility for oversight of the environmental standards, contracts, and enrollment and disenrollment procedures.

- **Nursing Home (NH)**
 - The Nursing Home Reform Act (1987) created a mandate by the U.S. Congress which designated direction to State Medicaid Agencies for ultimate oversight of Pre-admission Screenings and Resident Review (PASRR) to avoid inappropriate institutionalization of persons with a mental illness or mental retardation. PASRR helps ensure that clients are served appropriately at home, in a waiver program, in a nursing facility, or in another setting.
 - Nursing Homes may be subject to a quarterly Case Mix Index (CMI), or acuity adjustment, that is based on the weighted average assessment for each Medicaid resident in the nursing facility in the prior quarter where a Minimum Data Set (MDS) assessment was completed and successfully transmitted. The higher average Medicaid patient acuity indicates the facility is accepting more challenging or harder to place residents, and is reflected in their quarterly per diem rate. The average acuity score is continually monitored by Medicaid staff. In SFY18, the acuity score was 0.9.
 - The DART chart project that began in SFY15 ensures that all residents with Medicare remain Medicare primary to the full maximum allowable days.
 - Extraordinary Care is for clients that require services beyond the average NH resident; their cost and service requirements must clearly exceed supplies and services covered under a facility's per diem rate, and require prior authorization.
 - 100% of Wyoming nursing facilities participate in Wyoming Medicaid.
 - The Long Term Care Advisory Group (LTCAG) replaced the Nursing Home Advisory Group (NAG) in SFY15. Nursing facility providers, combined with hospice, home health, community choices waiver providers, and members from the Nursing Home Associations ensure there is a broader base of knowledge and expertise surrounding long term care and assist the State with policy, coverage, rate, and other Medicaid issues and decision-making.



Kid Care CHIP

Program Description

The Wyoming Kid Care Children’s Health Insurance Program (CHIP) is a contracted capitated program between the Wyoming Department of Health and a private insurance company to provide medical, vision, and dental insurance to all Kid Care CHIP enrolled children. Kid Care CHIP is intended for uninsured, low-income children between birth and eighteen years of age living in a household with income between 134% and 200% of the Federal Poverty Level.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$10,612,056	\$10,534,583	\$11,693,766
People Served	5,967	5,782	5,143
Cost per Person	\$1,778	\$1,822	\$2,274
Non-600 Series*	6.6%	5.5%	7.4%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Kid Care CHIP is currently funded at 88% federal, 12% state general fund.
- Kid Care CHIP funding decreases to 76.5% federal, 23.5% state general fund as of October 1, 2019.
- Kid Care CHIP funding decreases to 65% federal, 35% state general fund as of October 1, 2020.

Program Staffing

- 3 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Medical and dental provider networks have high participation.
- CHIP children receiving primary care reporting is under review; medical and dental service utilization in general is fluctuating.
- CHIP enrollment data and premiums including comparable PMPM with children in Medicaid and K03 children (former KidCare CHIP, prior to the mandatory expansion under the Affordable Care Act) showing the price comparison.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for multiple years showing consumer satisfaction.

Events that have Shaped this Program

- In 2001, the Wyoming Legislature and the Wyoming Department of Health decided Kid Care CHIP would be a contracted capitated program with a Wyoming insurance company to provide benefits and claims administration; since 2001, Blue Cross Blue Shield has provided that service.
- The Affordable Care Act of 2010 increased the income guidelines for Medicaid causing 1,252 Kid Care CHIP children to transition to Medicaid (K03 children tracked in Medicaid).
- In January 2018, Kid Care CHIP was approved for 10 years at the federal level. This same legislation lowered the CHIP funding, taking away the 23% bump.



Kid Care CHIP

PROGRAM CORE PURPOSE

The Wyoming Children’s Health Insurance Program (CHIP) provides health care coverage to qualified children of uninsured, low-income families.

OUTCOMES

Performance Metric*	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
% of Wyoming Medical Providers in Network	N/A	90%	4,308/4,900 87.9%	4,363/4,939 88.3%	4,549/5,146 88.4%	4,834/5,465 88.5%	4,890/5,511 88.7%	
% of Wyoming Dental Providers in Network	N/A	92%	279/297 93.9%	312/335 93.1%	335/368 91.0%	362/397 91.2%	365/400 91.3%	
% of CHIP Children with at least one Visit with a Primary Care Provider**	N/A	63%	4,280/8,307 51.5%	2,961/5,891 50.3%	2,901/5,967 48.6%	3,017/5,782 52.2%	3,124/5,143 60.7%	
% of CHIP Children Receiving any kind of Dental Service	N/A	58%	3,565/8,307 42.9%	2,787/5,891 49.8%	3,093/5,967 51.8%	3,012/5,782 52.1%	2,926/5,143 56.9%	
CAHPS Positive Response Rates ***	Customer Service	N/A	N/A	N/A	87.9%	92.1%	92.1%	83.0%
	Getting Care Needed	N/A	N/A	N/A	93.3%	90.8%	94.2%	83.9%
	Getting Care Quickly	N/A	N/A	N/A	95.4%	94.2%	96.6%	93.2%
	Dr. Communicating Well	N/A	N/A	N/A	94.9%	98.5%	93.8%	96.5%

*The data in the first four metrics are sourced from BCBS and Delta Dental using a standard methodology to count unique people across both insurers. This started in SFY18 and previous years in this HealthStat were updated using the same methodology. Previous HealthStat forms will differ.

**The Primary Care Providers include General Practice, Family Practice, Internal Medicine, OB/GYN, Pediatrics, Physician Assistants, FQHC, RHC, and IHS.

***Consumer Assessment of Healthcare Providers and Systems.

(-) 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of Unique Children Enrolled	8,307	5,597	5,967	5,782	5,143	N/A*	N/A*	N/A*	N/A*
Monthly Average Enrollment	5,300	3,306	3,545	3,459	3,490	N/A*	N/A*	N/A*	N/A*
% of CHIP Children Receiving any kind of Medical Service	71.9% 5,974/ 8,307	67.0% 3,947/ 5,891	67.5% 4,026/ 5,967	70.7% 4,088/ 5,782	70.0% 3,601/ 5,143	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
CHIP Premium (Plan A)	N/A	N/A	\$237	\$246	\$267	N/A*	N/A*	N/A*	N/A*
Per Member Per Month	Medicaid	\$189	\$190	\$213	\$214	\$217	N/A*	N/A*	N/A*
	K03	N/A	N/A	N/A	\$195	\$213	N/A*	N/A*	N/A*
Child Marketplace*	N/A	N/A	\$261	\$283	\$452	N/A*	N/A*	N/A*	N/A*
<p>*An 80% actuarial value Marketplace plan (gold plan with lowest cost sharing) for a Wyoming child (0-18) was \$452 per month in 2018 in Laramie County with a \$750 deductible and \$7,350 maximum out of pocket. Online: https://www.healthcare.gov/see-plans/#/</p> <p>(-) 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</p>									

STORY BEHIND THE PERFORMANCE

- Kid Care CHIP covers children from ages 0 through 18 that do not qualify for Medicaid and do not have other insurance. The Federal Poverty Level for Kid Care CHIP is 134% to 200%.
- Kid Care CHIP pays a premium to BCBS of Wyoming each month for each child to provide insurance benefits. There are three plans available for Kid Care CHIP based on whether the child is Native American (Plan A) and their income level (Plans B and C). Each Plan has a different co-pay amount. Plan A has the smallest number of participants but has seen some growth recently.
- Kid Care CHIP participating provider networks have high participation except Niobrara County which does not have any dentists and in Sweetwater County, only 19 of the 29 dentists are participating.
- According to the 2016 Small Area Health Insurance Estimates (SAHIE), 2,004 children are uninsured in the Kid Care CHIP age/income category (under 19 years of age with family income of 134% FPL to 200% FPL). There are 5,600 uninsured children under 19 years of age with family income below 200% FPL. Kid Care CHIP is required to conduct outreach and educate families regarding the CHIP program.



Patient Centered Medical Home

Program Description

The Patient Centered Medical Home (PCMH) program promotes improved primary care processes and health outcomes. The strategies used by participating practices include reviewing members' Continuity of Care Documents, reporting on Clinical Quality Measures, and meeting the qualifications and standards of a national health care accrediting bodies.

Program Expenditures and People Served

	2016	2017	2018*
Total Program Cost	\$400,898	\$813,454	\$784,530
People Served	11,162	15,908	19,000
Cost per Person	\$6 PMPM	\$6 PMPM	\$3 PMPM No Recognition \$6 PMPM Recognized**
Administrative Cost	\$100,000	\$50,000	\$25,000

* SFY 2018 data as of October 24th, 2018

** Must be recognized by NCQA, URAC, or JACHO

Program Cost Notes

- The program and administrative costs are funded with 50% Federal and 50% State General Funds
- Administrative cost for the program is an estimated \$25,000 annually and have decreased over time as the program has stabilized

Program Staffing

- 0.25 FTE divided among a team of 7 individuals
- 0 AWEC
- 0 Other

Program Metrics

- 14 practices are National Committee for Quality Assurance (NCQA) recognized and eligible to participate in the PCMH program; however, only 11 of NCQA recognized practices currently participate as of June 30th, 2018.
- 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 of those practices 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 quality of care, which is monitored through the reporting of clinical 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 PCMH was approved by CMS in September 2014.
- The PCMH program launched January 1, 2015 with 3 early adopter practices.
- The program is evaluated and strategies adjusted each calendar year.



Patient Centered Medical Home (PCMH)

PROGRAM CORE PURPOSE

The PCMH program promotes a care delivery model whereby patient treatment is coordinated through their primary care physician/practitioner. The goal is to decrease hospital utilization by increasing office visits for screenings and improving case management of chronic diseases.

OUTCOMES

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018*
% of Eligible Medicaid Members Served by a PCMH		25%	30%	3%	13%	20%	25%
ER Rate per 1,000 Member Months	PCMH	N/A	75.00	116.45	80.75	82.82	77.77
	Non-PCMH (benchmark)	N/A	N/A	67.32	64.19	61.67	63.84
Inpatient Rate per 1,000 Member Months	PCMH	N/A	15.00	18.72	17.25	17.69	15.76
	Non-PCMH (benchmark)	N/A	N/A	13.55	13.16	11.72	11.44
CY Average Percent for Clinical Quality Measures (CQMs) for All Participating Clinics	Breast Cancer Screening	45%	45%	33%	45%	40%	39%
	Childhood Immunization	46%	48%	35%	43%	44%	45%
	Diabetes Hemoglobin	31%	40%	31%	36%	41%	45%
	Controlling High Blood Pressure	77%	70%	66%	74%	67%	66%
	Colorectal Cancer Screening	53%	53%	33%	34%	48%	43%

(-) Indicates data not yet available

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

* SFY 2018 data as of October 24th, 2018

OUTPUTS AND EFFICIENCIES								
Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018*	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS								
# of Practices Participating	3	7	13	18	N/A*	N/A*	N/A*	N/A*
% and # of Medicaid Eligible NCQA Practices Participating	19% (3/16)	38% (6/16)	59% (10/17)	85% (11/13)	N/A*	N/A*	N/A*	N/A*
% and # of Medicaid Providers in Participating Practices**	3% (20/ 584)	6% (36/ 665)	19% (130/ 686)	19% (147/ 724)	N/A*	N/A*	N/A*	N/A*
% and # of Wyoming Super Utilizer Program (WySUP) members in a PCMH	N/A	N/A	48% (359/ 750)	52% (367/ 590)	N/A*	N/A*	N/A*	N/A*
Required Number of Reported CQMs	9	9	9	12	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES								
Eligible WY NCQA Recognized Clinics Participating /Total Clinics Participating in Program	3/3	6/7	10/13	11/18	N/A*	N/A*	N/A*	N/A*
Total # of Continuity of Care Documents (CCDs) Viewed	N/A	5,901	13,912	14,893	N/A*	N/A*	N/A*	N/A*
Per Member Per Month Cost (PMPM)	PCMH	\$995	\$747	\$734	\$714	N/A*	N/A*	N/A*
	Non-PCMH (benchmark)	\$702	\$804	\$819	\$860	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 * SFY 2018 data as of October 24th, 2018 ** Taxonomies used - 207R00000X, 207Q00000X, 208D00000X, 208000000X, 363L000000X, 363LA2200X, 363LP0200X, 363LF0000X, 363LP2300X, 363LC1500X – these represent Family Practice Physicians, Internist, Pediatricians, and Nurse Practitioners								

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 on Accreditation of Healthcare Organizations (JCAHO), or Utilization Review Accreditation Commission (URAC) recognized or in process.
 - Must follow the guidelines of these recognitions
 - Must submit 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)
- Quarterly review meetings are held the following month of each quarter; submitted data, dashboards, and provider scorecards are reviewed with each participating practice at these meetings.
- Providers have access to the PCMH dashboard, allowing them to monitor their performance and identify areas of improvement.
- The program has aligned the current 12 Clinical Quality Measures (CQMs) with those for Meaningful Use (MU) to avoid unnecessary burden to participants' time and cost of creating reports. The original 9 CQMs also followed this structure.
- Originally, 29 practices were interested in becoming recognized as a PCMH. Many practices have since dissolved, or been acquired by larger practices. Currently, there are 18 practices and an additional 7 practices could potentially join the program as of March 31st, 2018.
- The additional Per Member Per Month (PMPM) rates for PCMH have been adjusted over the years to encourage practices to gain accreditations from Health Care Associations (NCQA, URAC, & JACHO) and to maintain them:
 - On January 1, 2016 the PCMH PMPM rate paid to practices was raised from \$3 to \$6
 - On January 1st, 2018 the PCMH PMPM rate paid to practices was adjusted for practices that are recognized by NCQA, URAC or JACHO to receive an additional \$6 PMPM and practices that are in the process of obtaining a recognition are paid an additional \$3 PMPM. The practices in process have one year of billing to obtain recognition or they are removed from the program until they receive recognition.
- The American College of Physicians defines high-value care as health care that balances clinical benefit with costs and harms with the goal of improving patient outcomes. The Institute of Medicine defines it as “the best care for the patient, with the optimal result for the circumstances, delivered at the right price.”

Medicaid Care Management Entity (CME)

Program Description

Provide community-based alternatives to institutional care for Medicaid-covered youth (4-20 years of age), who are experiencing serious emotional disturbance (SED) using the authority granted under the Medicaid 1915 (b) & (c) waivers and State Plan Targeted Case Management Services to execute a risk-based contract with a single care management entity who provides an evidence-based intensive care coordination model called “high fidelity wraparound” (HFWA).

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$5,846,527	\$4,663,605	\$4,605,389
People Served	328	431	494
Cost per Person	\$17,824	\$10,820	\$9,323
Non-600 Series*	0%	10%	10%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funding is 50% federal & 50% state general funds
- The PMPM base is \$1,541.89 (\$50.69 per diem/unit of service)
- Potential of rate increase (up to 5%) for performance measure outcomes met, by quarter
- SFY18 CME claims were adjusted to the SFY17 rate of \$1,541.89 PMPM pending CMS approval of the SFY18 actuarial certification

Program Staffing

- 1 FTE
- Other: Contractor, Magellan Healthcare Inc., and Navigant Consulting, Inc. and their actuarial subcontractors Lewis & Ellis

Program Metrics

Waiver criteria for enrollment requires that youth must be enrolled in Medicaid, be 4-20 years of age, and at risk for out-of-home placement as defined by youth who:

- received two hundred days or more of behavioral health services within a year; or,
- currently meet a psychiatric residential treatment facility (PRTF) level of care or are placed in a PRTF; or,
- currently meet acute psychiatric stabilization hospital level of care or had an acute psychiatric hospital stay in the last 365 days; or,
- are enrolled with the Children’s Mental Health waiver; or,
- are Medicaid enrolled, have been referred to the CME, and meet clinical eligibility and federal SED criteria.

Events that have Shaped this Program

- Due to changes to the Centers for Medicare and Medicaid Services (CMS) regulations applicable to risk-based capitated payments, CMS requested that the CME move from the current risk-based capitated payment methodology to an administrative service organization contracting model that pays the CME an administrative service payment for each enrolled participant while reimbursing the CME network providers under a fee for service methodology.
- The SFY17 CME rates have recently been approved by CMS and a mass rate adjustment occurred to return money to the State. The SFY18 claims have also been adjusted using the SFY17 amount pending CMS approval of the SFY18 rate certification submitted.



Medicaid Care Management Entity (CME)

PROGRAM CORE PURPOSE

Through access to community based intensive care coordination services, the CME seeks to reduce the rate of admissions, institutional length of stay, and frequency of readmissions for youth with serious emotional disturbance (SED) ages 4 through 20 years. Overall cost of care for enrolled youth must be the same or less cost than non- participating Medicaid youth with SED.

OUTCOMES

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of all youth served who were served for 6+ months		60%	60%	N/A	N/A	54% (196/ 363)	54% (233/ 431)	47% (230/ 494)
% and # of youth served 6+ months who graduated		20%	50%	N/A	N/A	20% (40/ 196)	24% (56/ 233)	47% (107/ 230)
# (%) of youth (with 6+ months enrollment) with an admit to:	Psychiatric Residential Treatment Facility (PRTF)	10%	10%	N/A	N/A	25 (13%)	24 (10%)	13 (6%)
	Detention Center	5%	3%	N/A	N/A	12 (6%)	12 (5%)	9 (4%)
	Acute Psychiatric Hospital	12%	5%	N/A	N/A	23 (12%)	12 (5%)	19 (8%)
	Overall*	20%	12%	N/A	N/A	47 (24%)	48 (21%)	36 (16%)
% and # of youth served 6+ months moving from a lower level of care to institutional care at 6 months post discharge		<5%	<2%	N/A	N/A	0.5% (1/196)	0% (0/233)	-
*As youth may be admitted to more than one of these inpatient settings, summing across the types will not equal the number for overall youth with an admission. (-) 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 2014	SFY 2015	SFY 2016	SFY 2017**	SFY 2018***	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4	
OUTPUTS										
% and # of youth discharged	N/A	N/A	40% (131/ 328)	45% (194/ 431)	60% (295/ 494)	N/A*	N/A*	N/A*	N/A*	
# of CME youth served	N/A	N/A	328	431	494	284	353	367	358	
# of Recipients using additional services	Family Care Coordination	N/A	N/A	328	431	494	284	353	367	358
	Family Support Partner	N/A	N/A	153	213	219	145	167	170	151
	Youth Support Partner	N/A	N/A	N/A	19	26	9	10	15	20
	Respite Services	N/A	N/A	21	14	5	10	10	5	0
EFFICIENCIES										
# served and total Medicaid cost per youth	all youth	N/A	N/A	328 \$55,175	431 \$26,960	494 \$23,640	N/A*	N/A*	N/A*	N/A*
	youth served 6+ months	N/A	N/A	196 \$39,663	233 \$21,165	230 \$24,856	N/A*	N/A*	N/A*	N/A*
	graduated youth****	N/A	N/A	40 \$42,275	56 \$11,914	107 \$14,898	N/A*	N/A*	N/A*	N/A*
# served and total Medicaid cost per PRTF youth (non-CME):	N/A	N/A	236 \$55,197	228 \$57,265	228 \$58,027	N/A*	N/A*	N/A*	N/A*	
<p>* "Disenrolled" means left the program voluntarily or graduated after meeting goals.</p> <p>** Paid using the CMS approved SFY17 base rate of \$1,541.89. SFY17 quarterly incentives amounts for performance measures met increased each quarter's rate to: Q1-\$1,588.15, Q2-\$1,618.98, Q3-\$1,626.69, Q4-\$1,580.44. An additional \$172.50 PMPM is outstanding pending CMS guidance on payment mechanism.</p> <p>*** Paid using SFY17 PMPM amount of \$1,541.89. The proposed SFY18 rate is currently with CMS for review and approval. Incentive payments for SFY18 performance measures will be calculated during the end of SFY19-Q3.</p> <p>**** "Graduated youth" is defined as those youth who have successfully transitioned from the CME program meeting all of their goals.</p> <p>(-) 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</p>										

STORY BEHIND THE PERFORMANCE

- “High Fidelity Wraparound” (HFWA) is an evidence-based, intensive care coordination process for youth who are at risk of being placed outside of their home due to complex behavioral issues. HFWA promotes a community-based solution which brings together providers, community and system partners, families, governmental services, and educational partners to help children, youth, and their families pull themselves up and move forward in positive and healthy ways.
 - Wraparound is a completely different way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. Their ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound.
 - The youth and their family members work with a Family Care Coordinator to build their Wraparound team, which can include the family’s friends and people from the wider community (informal supports), as well as providers of services and supports (formal supports). With the help of the team, the family and youth take the lead in deciding team vision and goals, and in developing creative and individualized services and supports that will help them to achieve the goals and vision. Team members collaborate to put the plan into action, monitor how well it’s working, and make changes as needed. The overall aim is to help youth stay “in home, in school, and out of trouble.”
- Magellan Healthcare Inc., began operations as the Wyoming Medicaid Care Management Entity (CME) July 1, 2015. The first youth served were Children’s Mental Health Waiver youth and participants from the CME pilot program that served the seven southeast counties of Wyoming. Magellan took the program statewide on the first day of operations.
 - Magellan was contractually required to provide additional training to certify the existing CMHW/CME pilot providers to meet the current national wraparound implementation standards of high fidelity wraparound within the first six months of operations.
 - For purposes of the CME’s network coverage mapping, the state is divided in to eight regions. All regions have at least one CME provider agency located within and serving youth in all areas of each region.
- Medicaid-covered youth who meet the 1915(b) waiver’s clinical eligibility criteria may enroll with the CME and receive the additional benefit plan. Youth who aren’t Medicaid eligible but meet the clinical and financial eligibility criteria specified in the 1915(c) waiver may also be enrolled with Medicaid and the CME and receive full Medicaid medical coverage.
- Wyoming assesses fidelity to the HFWA model using a national tool called the WFI-EZ. Wyoming averages between 72% and 75% fidelity to the model since the inception of the program. The national average is 72%.
- MY LIFE (Magellan Youth Leaders Inspiring Future Empowerment) is a free program offered to any youth in the community between the ages of 13 and 23. Cheyenne, Laramie and Rock Springs have active chapters and more communities are interested in establishing chapters.
- Wyoming’s CME program presented Wyoming’s data and use of the Child & Adolescent Needs and Strengths (CANS) and Adverse Childhood Experiences (ACE) screening tools at the annual national CANS conference and the Annual Research & Policy Conference on Child, Adolescent, and Youth Adult Behavioral Health. The CME’s use of the CANS has led to research that isolates a specific area of the tool and the significance of the score range in that area to predict which youth are more likely to admit to an inpatient program.



Wyoming Medication Donation Program

Program Description

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

Program Expenditures and People Served

	CY 2016	CY 2017	CY 2018 (Jan-June)
Total Program Cost*	\$340,132	\$306,001	\$164,760
People Served	2,967	2,866	1,706
Cost per Person	\$114	\$107	\$96.58
Non-600 Series	100%	100%	100%

* 100% State General Fund

Program Cost Notes

- Revenue Source:
 - Grants: 2015-13%, 2016-2018-0%
- Return on Investment (Value of Rxs dispensed/program cost):
 - 2015- \$10.77
 - 2016- \$6.92
 - 2017- \$8.79
 - 2018 (Jan-June)- \$7.70

Program Staffing: 3.25 FTE

- 0.75 FTE pharmacist and fill-in pharmacist up to 0.25 FTE, as needed
- 0.75 FTE pharmacy technician
- Other - 1.5 FTE contracted pharmacy technician & Volunteers
 - 2015- 368 volunteer hours
 - 2016- 390
 - 2017- 195
 - 2018- 391

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 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 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. [CRMC, Dispensary of Hope and Block Grant].
- In March 2018, the Legislature approved additional funding to support program expansion.



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 2017 Target	CY 2018 Target	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018 (Jan-June)
Total patients served by re-dispensed medication ¹	>1,500	>1,500	1,558	2,948	2,967	2,866	1,706
Total value of re-dispensed prescriptions ^{1,2}	\$1,500,000	\$1,500,000	\$1,765,148	\$2,718,536	\$2,353,926	\$2,691,470	\$1,268,125
Patient medication compliance rate on mailed prescriptions	>85%	>85%	62%	86%	88%	86%	77%
Return on Investment (ROI) to communities (value of Rx's dispensed ² / program cost)	> \$5.00	> \$5.00	\$6.09	\$10.77	\$6.92	\$8.79	\$7.70

(-) 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 2014	CY 2015	CY 2016	CY 2017	CY 2018 (Jan-June)	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Number of prescriptions filled using re-dispensed medication ¹	17,115	22,341	24,641	25,959	9,113	N/A*	N/A*	N/A*	N/A*
Rxs mailed ¹	Number	2,959	6,215	9,583	11,949	5,639	N/A*	N/A*	N/A*
	Value	\$510,022	\$1,101,064	\$1,403,106	\$2,015,763	\$1,016,526	N/A*	N/A*	N/A*
# of 30 Day Fills (mailed)	2,373	5,458	8,624	11,918	6,266	N/A*	N/A*	N/A*	N/A*
Patients served via mail	Number	255	611	713	775	522	N/A*	N/A*	N/A*
	Percent	16%	21%	24%	27%	31%	N/A*	N/A*	N/A*
Donated Medication	Pounds	12,902	15,948	14,675	14,510	3,216	N/A*	N/A*	N/A*
	AWP value	\$3,198,712	\$3,274,153	\$3,132,899	\$4,165,753	\$2,036,713	N/A*	N/A*	N/A*
Donation Sites	Number ²	25	28	28	33	33	N/A*	N/A*	N/A*
	Pounds of unacceptable medication properly disposed	3,167	4,101	3,614	4,034	1,321	N/A*	N/A*	N/A*
EFFICIENCIES									
Average program cost per prescription dispensed ³	\$16.93	\$11.30	\$13.80	\$11.79	\$18.08	N/A*	N/A*	N/A*	N/A*
Average AWP value per prescription dispensed	\$103.13	\$121.68	\$95.53	\$103.68	\$139.15	N/A*	N/A*	N/A*	N/A*
Donation usage rate (\$ dispensed/ \$ donated)	55%	83%	75%	65%	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 drugs ran out in early 2017.
- In September 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 is \$12,500. 2nd year value \$783,652 AWP (\$61.69 ROI). 3rd year (July 2017-June 2018) AWP valued dispensed \$910,785.77 (\$72.86 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 state-wide. This resulted from strategies implemented to improve coordination with hospitals and patient centered medical homes to send referrals. An online inventory, updated daily, is available to assist referrals and prescribing. The program is not actively trying to expand the number of dispensing sites at this time.
- August 2016 the Prescription Drug Assistance Program closed due to budget cuts.
- July 2017- started filling 90 day supply prescriptions on select formulary medications from the Dispensary of Hope and donations.
- January 2018- stopped accepting medical supplies and open/expired medications for disposal.



Medicaid Behavioral Health (BH) Services

Program Description

Outpatient and community-based behavioral health treatment resources are a covered benefit for Wyoming Medicaid clients who are experiencing mental health and/or substance abuse disorders.

Program Expenditures and People Served

SFY	2016	2017	2018
Total Program Cost*	\$36,205,842	\$32,062,769	\$27,296,006
People Served	15,466	16,263	16,189
Cost per Person	\$2,394	\$1,981	\$1,686
Non-600 Series	0%	0%	0%
Administrative Costs**	n/a	n/a	\$20,400

* includes claims expenditures only based on BH procedure codes and BH taxonomies, by paid date

** includes utilization management vendor costs Quarter 1 calendar year (Qualis Health)

Program Cost Notes

- 50% Federal / 50% State Funded
- Utilization Management Contractor (Qualis) Paid \$150 per Review

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The top three BH diagnoses by expenditures for all ages served in SFY2018 were:
 - Depression (\$5,639,954, 21%)
 - Adjustment Disorder (\$3,025,826, 11%)
 - Post-Traumatic Stress Disorder (\$2,603,359, 10%)

Events that have Shaped this Program

- Pursuant to W.S. § 42-4-103(a)(xx), effective July 1, 2014 Medicaid allows 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.
- Pursuant to W.S. § 42-4-103(a)(xx), effective July 1, 2015 Medicaid allows provisional license mental health professionals to enroll and practice under the supervision of a licensed mental health professional when serving Medicaid clients and 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 and was phased in throughout CY 2017, resulting in decreasing expenditures.
- January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) required Medicaid programs to provide medically necessary diagnostic and treatment services to beneficiaries with Autism Spectrum Disorder (ASD) under the age of 21 years. Applied Behavioral Analysis (ABA) treatment was implemented.



Medicaid Behavioral Health (BH) Services

PROGRAM CORE PURPOSE

Provide access to outpatient and community-based behavioral health services and ensure services are medically necessary and meet clinical criteria.

OUTCOMES

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of prior authorization requests approved* (# approved / # reviews)		N/A	N/A	N/A	N/A	N/A	N/A	56% (497/884)
% of enrolled clients w/ mental health diagnosis (adults age 18+)	Medicaid** (national***)	N/A	N/A	14.7% (18.5%)	15.3% (18.1%)	18.7% (17.9%)	20.6% (18.3%)	19.9% (-)
% of clients with mental health diagnosis who received a BH outpatient treatment (adults 18+)	Medicaid** (national***)	N/A	>70%	73.2% (24.4%)	75.3% (24.3%)	74.2% (25.4%)	73.6% (24.5%)	70.4% (-)

(-) Indicates data not yet available

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

*Qualis started reviewing for medical necessity on 11/01/2017. This target reflects ideally how often providers are requesting legitimate medically necessary services.

**By primary diagnosis and service date. Excludes substance abuse, developmental disabilities, and dementia. Used Agency for Healthcare Research and Quality (AHRQ) ICD diagnosis grouper to define mental illness.

***National Survey on Drug Use and Health. Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Online: <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm>

OUTPUTS AND EFFICIENCIES										
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4	
OUTPUTS										
Rate of BH visits per child recipient* (# of children / # of visits)	21.3 (8,308/ 177,267)	20.0 (8,602/ 171,805)	19.9 (8,847/ 175,861)	19.1 (9,271/ 177,063)	18.2 (9,344/ 166,815)	N/A*	N/A*	N/A*	N/A*	
Rate of BH visits per adult recipient* (# of adults / # of visits)	26.2 (4,600/ 120,410)	25.1 (5,209/ 130,502)	25.5 (5,710/ 145,525)	21.0 (5,896/ 123,527)	14.3 (5,198/ 74,095)	N/A*	N/A*	N/A*	N/A*	
Outpatient BH service expenditures**	Total	\$31,996,717	\$35,144,285	\$36,206,409	\$32,064,078	\$27,296,006	N/A*	N/A*	N/A*	N/A*
	Children	\$21,069,903	\$21,819,733	\$20,484,119	\$20,187,426	\$20,021,130	N/A*	N/A*	N/A*	N/A*
	Adult	\$10,925,712	\$13,324,178	\$15,721,601	\$11,875,343	\$7,274,876	N/A*	N/A*	N/A*	N/A*
# of unique BH Providers	In State	1,705	1,911	2,015	1,990	1,931	N/A*	N/A*	N/A*	N/A*
	Out of State	433	677	675	428	412	N/A*	N/A*	N/A*	N/A*
% of total Medicaid enrolled clients who received a BH service	16%	16%	17%	19%	20%	N/A*	N/A*	N/A*	N/A*	
EFFICIENCIES										
% of total BH expenditures paid to Community Mental Health Centers and/or Substance Abuse Treatment Centers	44%	42%	34%	35%	36%	N/A*	N/A*	N/A*	N/A*	
PMPM for outpatient BH services	\$37.34	\$35.41	\$42.01	\$36.79	\$31.33	N/A*	N/A*	N/A*	N/A*	
Cost per client for outpatient BH services	\$2,315	\$2,394	\$2,346	\$1,981	\$1,686	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 *BH procedure codes and service date **BH procedure codes and BH tax and paid date ***Decrease in the number of unique providers is due to final reenrollment in SFY2016.										

STORY BEHIND THE PERFORMANCE

- An initiative was started by the Medicaid Behavioral Health Manager in SFY 2012 to potentially reduce inappropriate behavioral health services being provided to the Comprehensive/Supports Waivers. There has been a significant decrease in cost per recipient receiving psychological services in SFY 2018.
- 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 was implemented.
- 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.
 - Restorative (Rehabilitative) Services – Services that help patients retain, regain, or improve skills and functioning for daily living that have been lost or impaired because the client was sick, hurt or suddenly disabled.
 - Maintenance (Habilitative) Services – Services that help clients retain, learn, or reach developmental milestones or improve skills and functioning for daily living that they have not yet acquired. Examples would include therapy for a child who isn't walking or talking at the expected age.
- Starting January 1, 2018, Wyoming Medicaid Behavioral Health program contracted with Qualis Health to provide clinical reviews 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 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

	2016	2017	2018
Total Program Cost	\$15,663,152	\$14,363,119	\$12,150,218
People Served	32,446	31,295	28,746
Cost per Person	\$485	\$451	\$412
Non-600 Series*	N/A	N/A	N/A

* 600 series is defined as direct service contracts.

Program Cost Notes

- Dental expenditures were 3% of the total Medicaid expenditures for SFY 2018
- 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 \$347,040 of dental expenditures in SFY18.

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.
- With the reductions to the adult dental benefit in 2016, close monitoring of emergency room visits will be imperative to ensure that costs are not rising in other areas due to the elimination of the restorative and tooth replacement benefit.

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.
- During the summer of 2018, provider workshops were held throughout Wyoming to educate and train dental providers on accurate billing policies for Medicaid.
- Budget reductions to the adult dental program have negatively affected access to oral health care for adults. Recipients are unable to pay for treatment that is recommended at their check-up appointments and may opt for extractions (a covered benefit). Some providers have discontinued accepting adult clients due to service limitations.



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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of practicing, licensed Wyoming dentists enrolled as a Medicaid provider	>85%	>85%	76% 215/283	78% 232/295	79% 243/307	79% 251/319	72% 229/317
% and # of Medicaid children that received a dental cleaning (0-20 years)	>50%	>50%	38% 20,856/ 54,417	39% 21,578/ 55,589	42% 21,779/ 51,282	40% 21,433/ 54,049	40% 20,142/ 50,158
% and # of children who received a dental cleaning then taken to the hospital/ASC for dental work (0-20 years)	<5%	<5%	6.5% 1,344/ 20,856	6.3% 1,361/ 21,578	5.9% 1,291/ 21,779	5.8% 1,247/ 21,433	5.8% 1,178/ 20,142
% of Medicaid Teenagers that received a preventive visit	>50%	>50%	N/A	N/A	36% 5,949/ 16,308	38% 5,922/ 15,397	39% 5,687/ 14,670
% of nursing home clients seen for a dental visit	>20%	>20%	17% 426/2,453	16% 398/2,490	21% 446/2,140	17% 402/2,433	14% 344/2,416

(-) 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4	
OUTPUTS										
% and # of unique children served (any dental service)	45% 24,311/ 54,417	45% 24,929/ 55,589	48% 25,371/ 51,282	46% 24,944/ 54,049	47% 23,394/ 50,158	N/A*	N/A*	N/A*	N/A*	
# of unique adults served (any dental service)	16% 5,395/ 33,450	16% 6,052/ 37,283	22% 7,075/ 32,171	20% 6,351/ 31,252	17% 5,352/ 30,732	N/A*	N/A*	N/A*	N/A*	
# of adult dental services	cleanings	3,026	3,988	4,292	4,014	3,873	1,935	2,079	1,950	1,923
	tooth extractions	6,577	8,156	9,236	7,004	5,240	4,369	2,635	2,610	2,630
# of ER visit with dental diagnosis codes – Adults	N/A	N/A	485	544	495	277	267	242	253	
# of orthodontic applications approved	31% 95/310	32% 128/397	48% 223/461	42% 208/499	41% 144/348	N/A*	N/A*	N/A*	N/A*	
EFFICIENCIES										
Dental Expenditures (millions)	Adult	\$3.17	\$3.77	\$4.35	\$3.16	\$1.5	N/A*	N/A*	N/A*	N/A*
	Children	\$10.53	\$10.63	\$11.25	\$11.14	\$10.6	N/A*	N/A*	N/A*	N/A*
	Total	\$13.7	\$14.4	\$15.6	\$14.3	\$12.1	N/A*	N/A*	N/A*	N/A*
Per Member Per Month	\$15.93	\$16.02	\$18.80	\$17.74	\$15.50	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

- Wyoming Medicaid continues to be among one of the highest in the nation for dentist participation at 72% (national average 40-50%).
- 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.
- Adult dental benefits were reduced to limited services in 2016 due to budget cuts. The services that were eliminated from the adult dental benefit were fillings, tobacco counseling, nerve treatments, stainless steel crowns, and dentures. Currently the benefit covers two basic cleanings per year, x-rays, repairs to existing dentures, and extractions.
- With the reductions to the adult dental benefit in 2016, close monitoring of emergency room visits will be imperative to ensure that costs are not rising in other areas due to the elimination of the restorative and tooth replacement benefit.
- Efforts have been made to educate providers and clients on the adult dental benefits that remain; many providers were telling their adult clients that Medicaid no longer had any dental benefits, causing clients to not schedule dental appointments due to costs.
- The number of orthodontic applications has decreased dramatically in SFY 2018. Referrals to the Severe Malocclusion have been closely monitored for appropriateness and provider education has been key to reducing the number of inappropriate referrals.



Medicaid Pharmacy Program

Program Description

The Medicaid Pharmacy Program provides payment to outpatient pharmacies for the provision of covered outpatient prescription drugs and specific over-the-counter drugs. The program promotes the appropriate use of medications and strives to maximize cost savings through manufacturer drug rebates, the preferred drug list, and sound reimbursement methodology.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost (Before Rebate)—All Pharmacies	\$50,905,606	\$52,229,638	\$58,178,767
Total Program Cost (Before Rebate, Excludes IHS)	\$50,905,606	\$52,229,638	\$49,716,062
Total Program Cost (Net of Rebate, Excludes IHS)	\$19,504,067	\$24,516,145	\$19,301,785
People Served	44,333	44,291	43,455
Cost per Person (Before Rebate, Excludes IHS)	\$1,148	\$1,179	\$1,144

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 except Indian Health Service (IHS) expenditures which are 100% FFP.
- Row 1: reflects reimbursement to all pharmacies for outpatient drug claims.
- Row 2: reflects the reimbursement to pharmacies that included State funds (excludes IHS claims paid by 100% federal funds).
- Row 3: reflects the program cost once collected rebate is factored in. This number is derived by subtracting rebate collected during the given fiscal year from the pharmacy reimbursement figure in the second row.

Program Staffing

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

Program Metrics

- All Medicaid enrollees are eligible for pharmacy coverage. Approximately 52% of enrollees used the pharmacy benefit in SFY 2017, while approximately 54% used the pharmacy benefit in SFY 2018.
- Pharmacy expenditures were approximately 9.4% of total expenditures in SFY 2017 and 8.8% of total expenditures in SFY 2018.

Events that have Shaped this Program

- In September of 2017, the two in-state pharmacies that are classified as Indian Health Service (IHS) or tribal pharmacies began running their pharmacy claims through the Pharmacy Point of Sale system. These pharmacies are reimbursed per prescription at the All Inclusive Rate (AIR) published annually in the Federal Register. This rate was \$391 in calendar year 2017 and is \$427 in calendar year 2018. The State program is a pass-through for these claims as they are paid at 100% federal financial participation (FFP).
- In October 2017, the state plan amendment (SPA) bringing Wyoming Medicaid into compliance with the Final Covered Outpatient Drug Rule was approved by CMS with an effective date of 4/1/2017. The SPA included moving pharmacy reimbursement to a lesser of logic based on National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee.



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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Short Term Outcomes—Cost Effective Coverage								
Rebate Savings	Mandatory	N/A	N/A	\$22,528,038	\$21,274,188	\$29,542,136	\$25,427,155	\$27,973,723
	Supplemental	N/A	N/A	\$2,242,400	\$1,686,750	\$1,859,403	\$2,286,338	\$2,440,555
	Total	N/A	N/A	\$24,770,438	\$22,960,938	\$31,402,539	\$27,713,493	\$30,414,278
Savings generated by Preferred Drug List and Prior Authorization ^{a,2}		\$11,000,662	\$11,079,029*	\$7,844,047	\$8,894,753	\$9,821,265	\$10,476,821	\$10,756,339
State Maximum Allowable Cost Savings ²		\$13,000,000	\$950,000	\$14,359,484	\$15,085,685	\$17,045,765	\$14,454,219	\$900,210 ^b
Intermediate Outcomes—Clinically Sound Treatment								
% and # of Prior Authorizations approved / # reviewed (% approved)		40-50%	40-50%	55.2% 4,693/ 8,507	47.7% 4,520/ 9,471	45.7% 4,783/ 10,472	40.8% 4,479/ 10,969	40.3% 4,757/ 11,797
% and # of prescriptions that changed due to Drug Utilization Review (DUR) edits / # that hit DUR edits (% of prescriptions changed)		15-20%	15-20%	19.5% 9,468/ 48,508	17.5% 8,572/ 49,055	16.7% 7,230/ 43,277	16.6% 7,236/ 43,498	21.3% 9,751/ 45,743

* 3% increase over actual SFY 2018 figure

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).

²Indicates that metric was reported or calculated excluding any claims from IHS or tribal pharmacies.

³Indicates that a program other than Pharmacy was responsible for PAD rebates for all or part of the time period noted.

OUTPUTS AND EFFICIENCIES										
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4	
OUTPUTS										
# of clients served	47,166	47,696	44,333	44,291	43,455	31,836	34,063	31,546	33,608	
# of prescriptions paid	571,568	578,236	542,427	523,104	515,395	255,520	267,584	251,167	264,228	
Average # of prescriptions per client per month	2.84	2.89	2.88	2.87	2.95	2.9	2.84	2.94	2.96	
# / \$ of claims recovered on by program integrity ^d	375 / \$239,247	409 / \$380,732	210 / \$80,263	302 / \$125,153	753 ^c / \$280,937	132 / \$109,208	170 / \$15,945	170 / \$27,456	583 / \$253,481	
EFFICIENCIES										
Avg. Cost	Per client served before rebate ²	\$979	\$1,088	\$1,148	\$1,179	\$1,144	\$796	\$790	\$796	\$732
	Per client served net of rebate ²	\$454	\$607	\$440	\$554	\$444	\$348	\$395	\$186	\$399
	Per Rx ²	\$74.16	\$80.81	\$93.85	\$99.85	\$100.93	\$99.19	\$100.61	\$103.31	\$98.62
Rebate Collected for Physician Administered Drugs	\$1,629,162 ³	\$1,073,083 ³	\$1,931,337 ³	\$4,819,598 ³	\$5,747,677	\$1,852,147 ³	\$2,967,451	\$3,960,037	\$1,787,640	
Program Integrity Cost Avoidance ^e	\$56,765	\$57,597	\$327,818	\$317,320	\$1,092,461	N/A*	N/A*	N/A*	N/A*	
¹ The Medicaid Pharmacy Program is governed by 42 CFR §440.120, §441.25, §447.520, §456, Subpart K, §447, Subpart I, and W.S. 42.4.103 (a)(xiii). ² Indicates that metric was reported or calculated excluding any claims from IHS or tribal pharmacies. ³ Indicates that a program other than Pharmacy was responsible for PAD rebates for all or part of the time period noted.										

STORY BEHIND THE PERFORMANCE

- a. This number reflects the difference between the projected cost of the program (if rebates were not collected and if all medications were covered equally without a preferred drug list) and the actual cost of the program (including mandatory and 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. On April 1, 2017, new pharmacy reimbursement methodology was implemented. The new methodology continues to use lesser of logic, but includes National Average Drug Acquisition Cost (NADAC) as one of the price points. NADAC prices are generally very close to SMAC prices. Consequently, though over 50% of pharmacy claims continue to pay at SMAC, the savings realized between SMAC and NADAC prices are much smaller than the differences between SMAC and FUL or SMAC and EAC, which were the price points used in reimbursement calculations under the old reimbursement methodology.
- c. Claims from the Wind River Family and Community Pharmacy and the Wind River Service Unit account for 457 of these claims.
- d. These numbers reflect money that was recovered on claims that were originally submitted incorrectly by pharmacy providers and, therefore, overpaid by the State.
- e. 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).



Medicaid 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

	SFY 2016	SFY 2017	SFY 2018
Total Program Cost	\$11,758,859	\$12,391,507	\$12,540,772
People Served	290	285	289
Cost per Person	\$40,548	\$43,479	\$43,394
Non-600 Series*	N/A	N/A	N/A

* 600 series is defined as direct service contracts

Program Cost Notes

- Medicaid youth are funded by 50% federal and 50% state general funds. Non-Medicaid youth are 100% state general funded.
- Medicaid youth Medicaid costs
 - SFY 18 - \$12,530,436
 - SFY 17 - \$12,366,081
 - SFY 16 - \$11,719,350
- Non-Medicaid youth SGF costs:
 - SFY 18 - \$10,336
 - SFY 17 - \$25,426
 - SFY 16 - \$39,509

Program Staffing

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

Program Metrics

- Number of unique clients served in SFY 2018: 288 Medicaid-funded, 1 state general funds
- Number of PRTFs currently enrolled: 3 in-state and 16 out-of-state
- Average length of stay in SFY 2018: 200 days

Events that have Shaped this Program

- Enrolled Act No. 57, House of Representatives became effective July 1, 2013. This specifies that any order regarding potential placement at a PRTF shall not specify a particular PRTF or level of care for the placement of the child.
- In SFY 2013, SGF costs were \$4,434,165 due to incorrectly worded court orders for which CMS would not reimburse the state through Medicaid.
 - The program has worked closely with the courts to ensure correctly worded court orders and payment is no longer made using 100% SGF for any clients with an incorrectly worded court order after July 1, 2013.
 - SGF-only payment is only used for clients who are court ordered, no longer meeting PRTF criteria, and awaiting discharge, resulting in a significant decrease in SGF-only expenditures.



Medicaid Psychiatric Residential Treatment Facility

PROGRAM CORE PURPOSE

This program manages psychiatric residential treatment facility (PRTF) services and treatment provided to Wyoming Medicaid eligible children under the age of 21 years.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of PRTF placements with a previous PRTF/RTC admit*	50%	50%	36% (121/332)	58% (184/317)	66% (188/285)	64% (180/283)	64% (183/288)
Average length of stay (days)**	N/A	<180	178	203	185	206	200
% of discharged recipients with 6+ month length of stay (LOS)	N/A	<50%	44%	46%	47%	50%	57%

All data is based on Medicaid Chart A client information

* Medicaid only. Regardless of how long ago. RTC (Residential Treatment Center).

** Based on individuals discharged during the SFY

N/A New Metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of new PRTF admits vs. # of PRTF continued stay reviews completed	267 2,287*	237 1,826*	218 N/A	211 1,671	213 1,316	N/A*	N/A*	N/A*	N/A*
# of recipients	Medicaid	332	317	285	283	288	N/A*	N/A*	N/A*
	SGF-only	22	14	5	2	1	N/A*	N/A*	N/A*
	Discharged w/ 6+ month LOS	78	84	74	82	98	N/A*	N/A*	N/A*
# of placements**	In-State	144	166	171	190	190	N/A*	N/A*	N/A*
	Out-of-State	212	174	129	106	114	N/A*	N/A*	N/A*
# of Medicaid covered/paid days	48,615	44,298	38,062	39,632	38,370	N/A*	N/A*	N/A*	N/A*
# of reported incidents	283*	179*	237*	36***	149****	N/A*	N/A*	N/A*	N/A*

* From CQS WYhealth Quarterly Reports based on CY

** Will not equal total served as the same client can be placed in both in-state and out-of-state in the same SFY.

*** From Optum WYHealth data Feb-June 2017 (partial year)

**** After January 1, 2018, incident reports received via new online process

EFFICIENCIES										
Performance Metric		SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
% of PRTF placements	In-State	40%	49%	57%	64%	63%	N/A*	N/A*	N/A*	N/A*
	Out-of-State	60%	51%	43%	36%	37%	N/A*	N/A*	N/A*	N/A*
Average cost per client		\$44,119	\$41,988	\$40,548	\$43,479	\$43,394	N/A*	N/A*	N/A*	N/A*

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 JCAHO 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 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. The OSCR team completes reviews on a three point maximum scale.
 - Average OSCR Score: Year 1 (SFY 2016) = **2.89 (8 visits)**
 - Average OSCR Score: Year 2 (SFY 2017) = **2.87 (6 visits)**
 - Average OSCR Score: Year 3 (SFY 2018) = **2.90 (6 visits)**
- In SFY 2018 there were 19 PRTFs enrolled with Wyoming Medicaid: 3 in-state and 16 out-of-state



Medicaid Customer Service Center (CSC)

Program Description

The Medicaid Customer Service Center determines eligibility for Modified Adjusted Gross Income (MAGI) groups, Medicare Saving Programs, Supplemental Security Income (SSI) and SSI-related programs, Employed Individuals with Disabilities (EID), Breast and Cervical Cancer (BCC), and Tuberculosis.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$5,491,115	\$4,870,906	\$4,503,380
Application or Renewals Processed	45,004	54,783	57,733
Cost per Application or Renewal	\$122.01	\$88.91	\$78.00
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 75% Federal match on the cost of staffing the Customer Service Center and State staff
- Customer Service Center Operations Cost was \$369,032 per month from July –September 2017. Per contract, this amount increased to \$377,365. per month for the remainder of the State Fiscal Year.
- Maximus can qualify for a monthly incentive payment of up to 7% of the monthly invoice amount if they meet all Service Level Agreements (SLAs) and exceed the SLA criteria in five high-priority areas.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 66 Other - Contractor (Maximus)

Program Metrics

- Average total call volume: 12,162 per month from July 1, 2017, through June 30, 2018, with January 2018 being the highest month at 13,971 calls.
- Average speed to answer in January 2018, was 11.73 minutes, but for the month of June 2018, that decreased to 1.36 minutes.
- Average application processing time has been as low as 1 day, but for the month of June 2018, the average was 13.4 days.

Events that have Shaped this Program

- Maximus took over CSC Operations on October 1, 2016, and has an average of 66 FTE per month. Although Maximus has more staff than originally estimated in the Technical Proposal, the State continues to pay the monthly cost set in the contract.



Medicaid Customer Service Center

PROGRAM CORE PURPOSE

The Medicaid Customer Service Center answers eligibility requests quickly, processes Medicaid and Kid Care CHIP applications timely, and provides excellent customer service.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Speed to Answer (Minutes)*	<10	<10 SLA <6 Incentive	N/A	22.54	10.9	9.8	4.75
Client Satisfaction Survey Results (1 to 5, with 5 Being Most Satisfactory).	>4.6	>4.0 SLA >4.8 Incentive	N/A	4	4.52	3.8**	4.62
Average Processing Time for Application (days)***	<10	<30 SLA	N/A	15.5	6.5	13	15.11
Quality-Eligibility Error Rate	>99%	>=99% SLA	N/A	N/A	N/A	N/A	12.82%
First Call Resolution	>75%	>=75% SLA	N/A	N/A	N/A	95.02%	96.46%

*Beginning Dec 2017, 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 business 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.
 **Transition period score includes three months of the Northrop Grumman and the initial months of the Maximus contract
 ***The Federal application processing guideline is 45 days. The contract SLA is 30 days when all information needed to process is initially provided by the applicant when the application is initially taken.
 N/A indicates data not available due to creation of new metric or re-definition of metric methodology.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015*	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4	
OUTPUTS										
# of Applications Processed	New Applications	N/A	8,883	22,591	23,281	18,858	12,142	11,139	10,494	8,364
	Renewals	N/A	10,740	22,413	31,502	38,875**	15,256	16,246	18,325	20,550
	Total	N/A	19,623	45,004	54,783	57,733	27,398	27,385	28,819	28,914
Total Call Volume	N/A	108,965	140,769	134,015	145,938	69,802	64,213	69,541	76,397	
EFFICIENCIES										
Average Handle Time (minutes)	N/A	11.1	12.65	14.15	13.86	15	13.3	12.2	15.53	
# of Abandoned Calls	N/A	40,317	33,785	30,689	12,740	23,384	7,834	4,256	8,671	
Abandonment Rate	N/A	37%	24%	22.9%	8.74%	35.5%	12.2%	6.12%	11.35%	

* Partial numbers reported in SFY 2015
 ** Beginning November 2017, the Application and Renewal Report was changed by the system vendor to include cases that were closed for not turning in a renewal form.
 N/A indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- The Medicaid Customer Service Center (CSC) opened on October 1, 2013.
- Normal business hours of the CSC are 7:00AM to 6:00PM (MT) Monday through Friday (excluding State holidays).
- Applications and renewals are taken via telephone, online, fax, email, walk-ins, and mailed-in hard copies.
- The majority of cases managed by the WDH Customer Service Center are modified adjusted gross income (MAGI) cases. These programs include children (Medicaid and CHIP), adults with Medicaid eligible children, and pregnant women.
- As of February 2014, all of the Medicaid and Kid Care CHIP eligibility determinations are processed through the CSC and the Medicaid Long Term Care Unit. These functions transitioned from 29 DFS field offices to centralized Medicaid eligibility processing to promote consistent policy decisions.
- On July 1, 2016, Deloitte Consulting LLP and Maximus Health Services Inc. began a three month transitional period to replace 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.
- Eligibility rules for Medicaid and Kid Care CHIP programs are built into the rules engine of the Wyoming Eligibility System (WES) which is utilized by the Customer Service Center.
- The WES is 97% functional as of June 30, 2018, but much of the missing functionality is what is needed to determine eligibility in a truly no-touch, real-time manner.
- The WES/CSC Contract Manager closely monitors both vendors to verify that deliverables are of high quality and all service level agreements (SLAs) are met or exceeded.
- Both vendors work in collaboration by attending joint Change Control Board (CCB) meetings, creating and sharing training documents, participating in system Design and Requirement sessions, as well as User Acceptance Testing (UAT) when system changes and/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 Maximus training materials before they are used in the CSC.
- State staff also give refresher training, training on WES enhancements and extra training when requested by Maximus or when the State staff identify a need.



Medicaid Long Term Care Eligibility Unit

Program Description

The Medicaid Long Term Care Eligibility Unit determines financial eligibility for the Community Choices Waiver, Comprehensive Waiver, Support Waiver, Children’s Mental Health Waiver, PACE, Nursing Home, Inpatient Hospital, and Hospice services. Applications and renewals are taken via telephone, online, fax, email, walk-ins, and mailed hard copies.

Program Administrative Costs and People Served

	2016	2017	2018
Total Yearly Cost	\$1,502,949	\$1,701,398	\$1,818,615
Average # of Cases Per Month	6,376	6,578	6,644
Cost Per Case Per Month	\$19.64	\$21.55	\$22.81
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

- In SFY 2018 the case load mix was:
 - 72% Waiver programs
 - 25% Nursing Home
 - 2% PACE clients
 - 0.5% Hospice services
 - 0.5% Inpatient Hospital services

Events that have Shaped this Program

- In August of 2012, the Department of Health assumed responsibility for Long Term Care Eligibility.
- In August of 2012, the Long Term Care Eligibility Unit began transitioning Eligibility staff positions and cases from DFS starting with Albany, Laramie, and Platte counties.
- From August 2012 through April 2013, the Department of Family Services (DFS) transferred 12 positions to WDH for the creation of the Long Term Care Eligibility Unit and WDH supplied the other positions for the unit.
- The transition was completed in May of 2013.
- Centralizing the Long Term Care Eligibility Unit has reduced case processing time and provided consistency statewide.
- The Long Term Care Eligibility Unit is co-located with other WDH entities allowing for face-to-face coordination on cases.



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 consistently, timely and accurately.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average processing time for new application approvals (days)*	<45	<45	N/A	20.98*	20.35	16.70	13.07
Average processing time for new application denials (days)*	<45	<45	N/A	22.87*	23.34	18.13	14.70
Average processing time for renewal approvals (days)	<30	<30	N/A	8.41*	4.01	2.34	3.70
Average processing time for renewal denials. (days)	<30	<30	N/A	18.24*	15.68	13.42	7.88

(-) 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Average # of new Applications processed monthly	N/A	132*	152	168	167	159	178	158	175
% of new Applications denied monthly	N/A	38%*	33%	23%	11%	27%	19%	13%	9%
Average # of Renewals processed monthly^	N/A	305*	325	358	353	342	374	323	383
% of cases closed at renewal monthly^^	N/A	N/A	N/A	N/A	21%	N/A	N/A	N/A	21%
EFFICIENCIES									
Average number of active cases per month	5,519	5,966	6,376	6,578	6,644	6,556	6,601	6,643	6,644
Average number of active cases per worker	587	597	633	548	554	546	550	554	554

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

*SFY15 data for applications and renewals are from March 2015 through June 2015

^Average # of renewals exclude SSI cases as SSI does not require renewals

^^Beginning November 2017 the application & renewal report was changed by the vendor to include cases that were closed for not turning in a renewal. Prior year's data was not accurate so only 2018 data is listed.

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 for consistent eligibility determinations.
- As of February 2014, cases were converted from the DFS EPICS eligibility system to the WDH WES eligibility system.
- Supervisors and the manager receive a weekly report of cases that were finalized so they can conduct reviews for accuracy. New workers have every case reviewed and seasoned workers have approximately 20% of decisions randomly reviewed each week. Supervisors and the manager also pull caseload reports from WES to ensure staff meet application and renewal processing timeframes. The Eligibility Review Unit also reviews cases for accuracy. The manager and supervisors address issues with staff and provide individual and group training as needed on any issues discovered on reviews.
- 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, technology systems (WES, EMWS, RIS, MMIS, AVS) and Administrative Hearings.
- Ongoing training for all staff members occurs during weekly meetings. Training is conducted for new policies and procedures, ongoing policy and procedure questions or clarifications, and areas identified through quality assurance (QA) processes that need to be addressed.
- The number of average monthly cases has increased from SFY 2015 to SFY 2018. Some of the increase is due to changes in waiver programs and an appropriation to reduce the wait list and an increase in the number of individuals on PACE, as well as the aging population and the number of people applying.
- The Long Term Care Eligibility 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 unless there is a staff meeting or it is outside of office hours. Calls are returned within 24 business hours if a message is left.

Medicaid – Third Party Liability (TPL)

Program Description

Third party liability (TPL) staff in the Client Services Unit ensure that Medicaid is the payor of last resort. TPL staff concentrate on identifying when another individual, entity, insurer, or program has the responsibility to pay part or all of the claim prior to Medicaid making payment.

Program Expenditures and Total Dollars Recovered

	SFY 2016	SFY 2017	SFY 2018
Total Program Cost*	\$863,165	\$873,821	\$898,969
Total TPL Dollars Recovered**	\$4,764,659	\$4,602,136	\$5,205,642
Non-600 Series***	100%	100%	100%

* Adjustments have been removed from total program cost and SFY 2016 and SFY 2017 re-calculated accordingly

**Includes estate recovery, TPL recovery and credit balances, but it does not include cost avoidance.

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

Program Cost Notes

- The AG's Office performs legal services for TPL and estate recovery.
- Medicaid's Fiscal Agent (contractual, Conduent) performs cost avoidance, pay and chase recoveries, pursues small personal injury recoveries involving medical payments coverage, tort recovery for criminal restitution, products liability, worker's compensation, preliminary research for estate recovery, and Medicare reclamation.
- Recoveries made by TPL are reported on the CMS-64 report. Using the current FMAP rate, federal funds are returned to CMS for TPL services.
- Costs are 50% SGF / 50% Federal Fund

Program Staffing

- 1 FTE Program Manager
- Other
 - Contractual (Conduent) Staff 10.5 FTE for TPL and credit balance services
 - 2 part-time attorneys and 1 part-time paralegal at the Attorney General's Office

Program Metrics

- Dollar amount of cost avoidance, pay and chase recoveries, estate recoveries, third party liability 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.
- Wyoming Statutes §§ 42-4-201 – 42-4-207 Medicaid Benefit Recovery.
- Wyoming Medicaid Rules Chapter 35 Benefit Recovery.
- Bipartisan Budget Act of 2018 – Prenatal services must be cost avoided beginning 02/09/2018.

Medicaid – Third Party Liability

PROGRAM CORE PURPOSE

To reduce Medicaid costs by pursuing payment from other legally obligated/responsible parties for the medical assistance costs.

OUTCOMES

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018 ***
Total TPL excluding cost avoidance*		>\$5,000,000	>\$5,000,000	\$4,097,467	\$4,297,863	\$4,764,659	\$4,602,136	\$5,205,642
Total TPL including Cost Avoidance**		>\$18,000,000	>\$18,000,000	\$16,846,865	\$17,767,706	\$19,805,345	\$16,721,211	\$16,617,957
% of Medicaid claims expenditures offset by total TPL****	Excluding Cost Avoidance	>1%	>1%	0.79%	0.81%	0.86%	0.83%	0.92%
	Including Cost Avoidance*****	>3.50%	>3.50%	3.25%	3.37%	3.57%	3.02%	2.93%
Estimated return on investment*	Excluding Cost Avoidance	>\$5 to \$1	>\$5 to \$1	\$6 to \$1	\$5 to \$1	\$6 to \$1	\$5 to \$1	\$6 to \$1
	Including Cost Avoidance*****	\$18 to \$1	\$18 to \$1	\$25 to \$1	\$22 to \$1	\$23 to \$1	\$19 to \$1	\$18 to \$1

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

** These figures include estate recovery, third party liability recoveries, credit balances and cost avoidance. By paid date.

*** SFY2018 figures are through 06/30/2018. By paid date.

**** Based on four years of paid claims history in SFY 2016 Annual Report and MMIS Report of Expenditures for SFY 2017 and for 2018.

***** Client Services- 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018**	
OUTPUTS						
Total Estate Recovery	\$2,441,084	\$2,623,778	\$2,629,995	\$3,271,222	\$3,603,406	
Total Third Party Liability – Pay and Chase	\$1,382,978	\$1,480,990	\$2,003,137	\$1,293,902	\$1,525,552	
Total Credit Balances	\$273,405	\$193,095	\$131,527	\$37,012	\$76,684	
Total Cost Avoidance*	\$12,749,398	\$13,469,843	\$15,040,686	\$12,119,075	\$11,412,314	
Number of Estate Recovery Cases	Opened***	1,123	1,396	1,054	1,574	1,391
	Closed****	965	1,198	1,353	1,486	1,189
Number of TPL Cases	Opened***	847	627	442	446	599
	Closed****	797	593	232	875	483
EFFICIENCIES						
% of recovered estate recovery cases to open cases	12.11%	10.32%	13.66%	13.87%	12.01%	
% of recovered TPL cases to open cases – Pay and Chase	47.21%	60.77%	74.21%	70.85%	52.25%	
% of Medicaid clients with other insurance coverage identified (relates to TPL recoveries and cost avoidance potential, excludes Medicare)	5.25%	5.61%	5.64%	5.38%	5.38%	
<p>* The cost avoidance figure may be inflated, as cost avoidance is currently calculated based on billed charges from providers rather than the final amount Medicaid would have paid. These numbers do not include pharmacy cost avoidance.</p> <p>**Recoveries are through 06/30/2018. By paid date. These numbers do not include pharmacy pay and chase recoveries.</p> <p>***Opened cases are cases that are not fully settled or resolved, such as a case that is referred to the AG's Office for assistance, a case that is pending settlement from a liable third party, a case pending distribution of the estate, a case pending payment from a Miller Trust, a case pending payment as Medicaid is the beneficiary of a special needs trust or pooled trust, a case that has not been opened for one year from the date of loss, so recovery cannot be made, a case where the surviving spouse has not passed away, a case pending payment from a Wyoming Medicaid provider.</p> <p>****Closed cases are fully resolved cases. Examples of closure reasons are: maximum recovered from estate, no liable third party no property or resource identified, no related claims in 1 year, not cost effective to pursue, received payment in full, and received all payment available.</p> <p>N/A indicates data not available due to creation of new metric or re-definition of metric methodology</p>						

STORY BEHIND THE PERFORMANCE

- Wyoming Medicaid released a TPL RFP on 03/15/2018 to outsource TPL requirements to a specialty vendor and received no responses to the RFP as of 05/10/2018. The TPL requirements have been incorporated into the BMS procurement. The TPL requirements are being reviewed and redrafted.
- As a part of the restructuring of the Division of Healthcare Financing, the TPL & Estate Recovery Specialist position transitioned to the Client Services Unit. The transition to the Client Services Unit has been advantageous for the TPL & Estate Recovery Specialist position.
- Wyoming Medicaid is drafting policies and procedures for the each area of TPL, including special needs trusts, pooled trusts, and estate recovery.
- Wyoming Medicaid is finalizing several change system requests (CSRs). The CSRs are for improvements to the data match with Child Support Enforcement and for improvements and changes to the data match with Blue Cross/Blue Shield of Wyoming.
- Wyoming Medicaid has been working with CIGNA and UnitedHealthcare (UHC) to establish data matches.
- Wyoming Medicaid is receiving and reviewing a monthly report from the State Data Exchange (SDX) for individuals with a TPL indicator as a lead to new health insurance.
- Wyoming Medicaid's Contractor is reviewing the quarterly PARIS data match to determine if a client has coverage through Tricare.
- Bipartisan Budget Act of 2018 mandated that prenatal services be cost avoided. The effective date of the legislation was 02/09/2018. A CSR has been drafted and submitted to comply with the federal mandate.
- **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-ordered 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.
- **Cost avoidance** recognizes the existence of other insurers' responsibility and requires the insurer to pay prior to Medicaid payment.
- **Pay and chase** involves TPL staff attempting to recover money from the liable third party when a Medicaid payment has been made, and third party liability is subsequently identified and determined.

UPCOMING EVENTS THAT WILL IMPACT PERFORMANCE

- Wyoming Medicaid is reviewing how it handles pay and chase claims for preventative pediatric care. The program may be moving away from using ICD-10 diagnoses to utilizing CPT and CDT procedure codes.
- Wyoming Medicaid is exploring options to change policies and procedures for estate recovery.
- Wyoming Medicaid will be working with the Wyoming Supreme Court to see if they will provide a monthly report of torts, probates, trusts, wills, administrative cases appealed to the district court, and circuit court cases that will be heard at the district court to discover new estate and TPL cases.

WDH | Behavioral Health Division

Information contained in this section includes:

- 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



Comprehensive Waiver

Program Description

The Comprehensive Waiver funds person-centered services for people with intellectual disabilities and acquired brain injuries in their community as a safe, cost-effective alternative to services in an institutional setting.

Program Expenditures and People Served

	2016	2017	2018
Total Medical & Waiver Cost	\$110,276,268	\$108,809,060	\$108,558,674
Total Waiver Cost	\$88,539,448	\$88,718,492	\$94,059,283
Total Medical Costs	\$21,736,820	\$20,090,568	\$14,499,391
Total People Served	1,927	1,890	1,989
Cost per Person (Medical & Waiver)	\$58,678	\$57,958	\$54,580
Non-600 Series*	2.7%	1.9%	3.2%

*600 series is defined as direct service contracts.

Program Cost Notes

- Participants receive both Medicaid medical and waiver services.
- Staffing for the Developmental Disabilities (DD) waivers is proportional to the number of participants active in the program.
- Waiver cost increases are due to rate increases implemented in the 2017-2018 biennium.
- Medical cost decreases are due to a reduction in home health expenditures.

Program Staffing

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

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of \$7,524 per person in FY18.
- The Waiver average costs per participant in FY18 was \$47,941.
- 224 participants received some self-directed waiver services in FY18.
- There were 713 providers, certified and monitored by the DD Section, that were available to provide services for this Waiver during FY18.

Events that have Shaped this Program

- **Federal HCB rules.** Under the Home and Community Based (HCB) 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 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, to ensure all provider settings are in compliance with the rule. Wyoming was the 8th state in the country to receive approval on its transition plan and 100% of providers are now in compliance with the new rules.
- **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 SFY18. This resulted in an across the board rate increase of 4.2%. The 2018 Legislative Session appropriated \$20 million for the 2019-20 biennium and directed the Department of Health to absorb an additional \$3 million in additional provider payment rate increases. The \$23 million in additional funding for the biennial budget fully funded the provider payment rates identified in the rate rebasing project completed in conjunction with Navigant Consulting.
- **Acquired Brain Injury Population.** As of April 1, 2018, the Acquired Brain Injury Waiver was closed and all participants were transitioned to the Comprehensive Waiver or the Supports Waiver.

Comprehensive Waiver

PROGRAM CORE PURPOSE

The Comprehensive Waiver funds person-centered services for people with intellectual disabilities and acquired brain injuries in their community as a safe, cost-effective alternative to services in an institutional setting.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
The number and % of participants ages 18+ living independently or semi-independently	25.1%	26.7%	N/A	24.4% (351/ 1,441)	23.0% 375/ 1,632	23.4% 380/ 1,623	25.4% 432/ 1,695
The number and % of participants ages 18+ working in competitive and community integrated settings earning at least minimum wage	17.2%	18.19%	N/A	17.2% (258/ 1,469)	18.6% (296/ 1,593)	14.4% (206/ 1,435)	17.7% (298/ 1,683)
The number of physical, mechanical, and chemical restraints used	1,200	N/A	N/A	1,166	1,647	1,201	92*
The number and % of individualized plans of care that pass quality review**	N/A	72%	N/A	N/A	N/A	N/A	72% (327/ 457)
The number & % of reported incidents found to be a result of a provider's failure to meet criteria established in statute, rule, or policy	N/A	30%	N/A	N/A	N/A	N/A	39% (318/ 802)

(-) Indicates data not yet available
 N/A indicates data not available due to the creation of a new metric
 *Drop in figure due to restraints definition change. See Story Behind the Performance.
 **Quality review is used to improve the quality of information provided by the case manager, beyond the minimum requirements, and to target technical assistance efforts.

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of participants	38	1,832	1,927	1,890	1,989	1,887	1,871	1,836	1,956
# of waiver participants ages 18+ living in residential services or with family	N/A	1,090	1,257	1,224	1,249	1,186	1,180	1,114	1,196
# of participants ages 18+ using waiver supported employment services	N/A	165	176	188	229	179	185	200	225
EFFICIENCIES									
Average cost per participant (waiver and medical)	N/A	\$39,391	\$58,678	\$57,958	\$54,580	\$28,756	\$29,153	\$28,908	\$28,366
Average cost per participant (waiver only)	N/A	\$36,380	\$45,863	\$47,513	\$47,941	\$22,963	\$24,773	\$25,390	\$24,872
(-) 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

- Federal HCB rules.** Under the Home and Community Based (HCB) 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 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, to ensure all provider settings are in compliance with the rule. Wyoming was the 8th state in the country to receive approval on its transition plan and 100% of providers are now in compliance with the new rules.
- Drop in Restraints.** The significant drop in restraints is a result of the Behavioral Health Division’s DD section redefining chemical restraints. After researching the high number of restraints, the DD Section found that providers were reporting a chemical restraint use every time they issued a prescribed medication such as anti-depressants and other mood altering medication. The Division has made changes to redefine a chemical restraint as any medication given involuntarily, or against the participant’s wishes.
- Provider Payment Rate Increases.** As approved by the Wyoming State Legislature, provider payment rates were increased by 3.3% for SFY2017 and an additional 4.2% for SFY2018. These rate increases were applied equally across all services for the Comprehensive and Supports Waiver programs.
- Acquired Brain Injury Population.** As of April 1, 2018, the Acquired Brain Injury Waiver was closed and all participants were transitioned to the Comprehensive Waiver or the Supports Waiver.



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 supervision, probation, and substance use treatment to individuals who have committed crimes stemming from their addiction to drugs and/or alcohol. These individuals are at high risk for reoffending and in high need of substance use treatment services.

Program Expenditures and People Served

	SFY 2016	SFY 2017	SFY 2018
Total Program Cost	\$3,729,593**	\$3,422,539**	\$3,220,374.03**
People Served	610	596	572
Cost per Person	\$6,114**	\$5,743**	\$5,630**
Non-600 Series*	7%	10%	4%

* 600 series is defined as direct service contracts

**These amounts were originally reported as paid within fiscal year; they are now reported by service dates July 01- June 30

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 included \$600,000 reduction from the previous year due to budget cuts.
- Surcharge account from July 1, 2016 through June 30, 2018 is \$309,970.54

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- There were 19 funded CST Programs in FY18 (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. These services support completion of treatment services, reduce recidivism, and increase the duration of sobriety.
- Supervision services: CST program probation officers including those from the Wyoming Department of Corrections, Department of Family Services, and County officers who conduct home visits, verify that a participant is on their agreed upon program schedule, and assure that participants are spending time with program approved contacts only. These services monitor compliance and identify any violations 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 governing CST Programs were promulgated in January of 2010 and repealed previous CST Program Rules.
- The CST Funding Panel makes all funding decisions for the programs. The Panel consists of the Attorney General, Directors of the Department of Health, Department of Family Services and Department of Corrections, the Chairman of the Governor’s Advisory Board on Substance Abuse and Violent Crimes, and the State Public Defender, or their designees, per Wyo. Stat. Ann. § 7-13-1605(d).
- The surcharge account was created per Wyo. Stat. Ann. § 7-13-1616 and is a surcharge in addition to any fine or other penalty prescribed by law.

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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of participants who graduate (retention rate) Adult (A) Juvenile (J)	A: 59% J: 59%	A: 59% J: 59%	A: 63%* J: 52%*	A: 49%* J: 58%*	A: 38%* J: 66%*	A: 2%* J: 14%*	A: 0%* J: 4%*
% of participants having at least 120 days sobriety prior to graduation	A: 100% J: 100%	**	A: 99% J: 100%	A: 99% J: 97%	A: 98% J: 100%	A: 100% J: 92%	A: 99% J: 100%
% of participants having re-arrest during their program participation (In-Program Recidivism Rate)	A: <5% J: <10%	A: <5% J: <10%	A: 8% J: 12%	A: 7% J: 18%	A: 5% J: 11%	A: 6% J: 24%	A: 4% J: 16%
% of participants having re-arrest within three years after their program participation (Post-Program Recidivism)	A: <3% J: <15%	A: <3% J: <15%	A: 10% J: 19%	A: 8% J: 20%	A: 4% J: 19%	A: 4% J: 24%	A: 4% J: 24%

* Metrics are broken out by year cohort. In the past they were broken out by point in time. Numbers are subject to change as the cohorts progress.

** Metric will be removed and replaced in SFY2019.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
# of unique participants Adults (A) Juveniles (J)	636 A: 539 J: 97	635 A: 551 J: 84	610 A: 545 J: 65	596 A: 542 J: 54	572 A: 515 J: 57	464 A: 418 J: 46	444 A: 409 J: 35	437 A: 401 J: 36	436 A: 393 J: 43
# of ancillary services per month, per participant	A: 5 J: 2	A: 5 J: 2	A: 4 J: 2	A: 4 J: 2	A: 4 J: 1	A: 5 J: 3	A: 5 J: 3	A: 5 J: 1	A: 6 J: 1
# of supervision contacts per month, per participant	A: 5 J: 6	A: 5 J: 6	A: 5 J: 10	A: 5 J: 8	A: 5 J: 7	A: 6 J: 11	A: 6 J: 11	A: 6 J: 9	A: 6 J: 10
# of substance abuse tests per month, per participant	A: 5 J: 4	A: 5 J: 4	A: 4 J: 5	A: 4 J: 4	A: 5 J: 3	A: 6 J: 5	A: 6 J: 7	A: 6 J: 4	A: 6 J: 4
Units of service per month, per participant	A: 20 J: 16	A: 19 J: 16	A: 17 J: 22	A: 17 J: 19	A: 18 J: 14	A: 22 J: 25	A: 22 J: 26	A: 23 J: 20	A: 24 J: 19

EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
Cost per unit of service (ancillary, treatment, supervision, drug test) A: Adult J: Juvenile	A: \$25.63 J: \$32.03	A: \$26.08 J: \$30.97	A: \$30.23 J: \$23.36	A: \$28.15 J: \$28.19	A: \$26.06 J: \$33.51	N/A*	N/A*	N/A*	N/A*
Annual program cost per participant (cost per day per participant)	\$6,150 (\$16.85)	\$6,083** (\$16.67)	\$6,114** (\$16.75)	\$5,743** (\$15.73)	\$5,630** (\$9.84)	N/A*	N/A*	N/A*	N/A*

* Indicates data not available on a quarterly basis

** These amounts were originally reported by paid within fiscal year; they are now reported by service dates for July 01 – June 30.

STORY BEHIND THE PERFORMANCE

- In SFY18, a Request for Proposal was completed for a new CST data system to meet the changing needs of the CST Program. The new data system will provide more accurate and reliable data on program performance.
- CST created statewide guidelines that align with Adult Drug Court Best Practice Standards. To gain stakeholder input on the new guidelines, the CST Program developed a stakeholder committee. The committee included state employees, county coordinators, as well as National Drug Court Institute staff. The new guidelines were including in the SFY2019 contracts.
- CST continues the program tune-up project to align with national standards, in order to successfully compare with other states and to provide more consistency among Wyoming state courts. With the rollout of the standards, CST is evaluating effectiveness and will update the standards, rules, and data formulas to better align with national best practice standards.
- Since SFY2017, retention rates have been collected as cohorts, which are defined as any participant who begins court supervised treatment between July 1 and June 30 of that state fiscal year. Because reported numbers have been impacted, CST is working to determine how courts can best meet unique participant contract deliverable requirements.
- Due to budget cuts, the most recent court reviews were completed through self-evaluations, as an FY2019 contract requirement.
- The CST Program continued to work with Albany County Court as a national Mentor Court to learn any best practices that could benefit other state courts.
- In June 2018, CST held a meeting for all county coordinators to review data methodology and collection, as well as the guidelines that were added to the SFY2019 contracts. Coordinators were able to successfully assist each other in solving common issues.

Early Intervention & Education Program - Part B/619

Program Description

The Early Intervention and Education Program (EIEP) Part B/619 provides oversight of fourteen (14) Regional Child Development Centers (CDCs) who are contracted to provide preschool, special education, and related services to children from three to five years of age who are identified with developmental delays and/or disabilities. Part B/619 is a federally mandated program.

Program Expenditures and People Served**

	2016	2017	2018
Total State Program Cost*	\$11,534,204	\$11,294,519	\$10,997,872
Children Served	1,266	1,289	1,254
State per child amount	\$9,067	\$8,743	\$8,750
Non-600 Series***	0.2%	0.2%	0.3%

*Total program cost includes Part B/619 state funds for contracts and 0.25 FTE for the state-funded Unit Manager

**Reflects only Part B/619, not all of EIEP

***600 series is defined as direct service contracts

Program Cost Notes*

- State Part B: \$10,997,872
- Federal Part B funds: \$1,709,488
- Total Part B federal and state funding: \$12,707,360

*Contract amounts for CDCs only

Program Staffing

- 2 FTE (0.25 SGF, 1.75 FF)
- 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 and Results Driven Accountability.
- Child Outcomes Summary data, which indicates growth a child shows from receiving preschool, special education, and related 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.
- WDE is the State Education Agency who receives federal grants for Part B Section(s) 611 & 619; WDE grants a portion of 611 and 619 funds to the Wyoming Department of Health.
- Part B/619 completed on-site monitoring of one Child Developmental Center in 2018.
- In SFY2017, EIEP piloted new Child Outcome Summary reporting with three CDCs using a standardized assessment tool for entry and exit of a child in Part B/619 services. This pilot was analyzed after a year of reporting and implemented statewide in SFY2018.
- Training was provided to all regions on the proper administration of the assessment tool during SFY2018.



Early Intervention & Education Program – Part B/619

PROGRAM CORE PURPOSE

The Part B/619 program provides oversight to fourteen (14) Regional Child Development Centers (CDCs) 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.

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of children who substantially increased their rate of growth in Social-Emotional skills	89.50%	90%	88.5%	91.2%	90.9%	88.33%*	87.79%**
% of children who substantially increased their rate of growth in skills Acquiring and Using Knowledge and Skills	91.27%	75%	89.9%	92.1%	92.7%	84.71%*	70.34%**
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Needs	89.58%	82%	90.4%	92.77%	91.5%	86.3%*	78.50%**
% of children receiving special education in inclusive settings	N/A	60%	N/A	N/A	N/A	N/A	58.96%
% of students with a speech language disability with occupational or physical therapy	N/A	34%	N/A	N/A	N/A	N/A	37.25%

N/A indicates data not available due to the creation of a new metric
 *Does not include child outcome summary scores from the three pilot regions
 **Includes all 14 child development center child outcome performance measurements

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Number of children served based on annual child count**	2,804	2,730	2,695	2,612	2,635	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)**	3,621	3,972	3,548	3,493	3,338	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted**	\$8,643	\$8,812	\$8,659	\$8,319	\$8,238	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually**	\$6,644	\$5,875	\$6,124	\$6,214	\$6,988	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis
 **For SFY2018, W.S. § 21-2-701-706 implemented a change in child count from November 1 to December 1, leading to slight data changes in previous years.

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). The act 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 provides funding specific to children ages three through five.
- The Department of Health, through a Memorandum of Understanding with the Department of Education, administers the Part B/619 program.
- All children ages three through five who are suspected of having a 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 piloted a new process for determining child outcomes based on a standardized assessment tool in SFY2017. This pilot included three of the fourteen regional centers from July 1, 2016 to June 30, 2017. EIEP rolled out the new Child Outcomes process to all fourteen regions in phases throughout SFY2018.
- In 2017, the Wyoming State Legislature approved an update to W.S. § 21-2-701-706 that requires a child ages three through five to be placed on an Individualized Education Program (IEP) as of December 1 in order to be included in the child count.
- The SFY2018 metric related to the percentage of children increasing their rate of growth in Acquiring and Using Knowledge and Skills was significantly lower than the target due to a combination of utilizing two different processes for Child Outcome Reporting while the new process was rolled out to all regions. The SFY2019 Target for Acquiring and Using Knowledge and Skills has been reduced to more closely align with reasonable expectations for growth of children.
- SFY2019 is the last year for the current Child Outcome targets. Through work with the Wyoming Department of Education, Part B/619 will be developing new targets for Child Outcomes.
- Child Outcomes metrics are monitored annually and difficult to monitor in shorter increments. In addition to these annual metrics, Part B/619 will monitor two additional metrics in the upcoming year. Improvement in these two areas may improve the annual Child Outcomes metric.
 - Percent of children receiving special education in inclusive settings, defined as a preschool with at least 50% of children that are typically developing. - All states are working toward inclusiveness in their EIEP programs.
 - Number of students with a speech language disability who are also receiving occupational therapy and/or physical therapy. – Students in this category should only be receiving speech therapy, however a large number are also receiving OT/PT, indicating a need for technical assistance and training to the CDCs to ensure appropriate service delivery.

Early Intervention & Education Program – Part C

Program Description

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

Program Expenditures and People Served**

	2016	2017	2018
Total Program Cost*	\$11,534,206	\$11,294,513	\$10,997,872
Children Served	1,289	1,254	1,215
Cost per Person	\$8,743	\$8,751	\$8,751
Non-600 Series***	0.2%	0.2%	0.3%

* Total program cost includes Part C state funds and 0.25 FTE for the state-funded Unit Manager

**Reflects only Part C, not all of EIEP

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

Program Cost Notes*

- State Part C: \$10,973,666
- Federal Part C funds: \$1,656,590
- Total Part C federal and state funding: \$12,630,256

*Contract amounts for CDCs only

Program Staffing

- 2 FTE (0.25 SGF, 1.75 FF)
- 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 the 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.
- 2018 on-site monitoring of four Part C regional service providers for children ages birth through two.
- State Performance Plan and Annual Performance Report for Part C.
- Department of Health continues to be the Lead Agency for the Part C federal grant.
- In SFY2017, EIEP piloted new Child Outcome Summary reporting with three CDCs using a standardized assessment tool for entry and exit of a child in Part C services. This pilot was analyzed after a year of reporting and implemented statewide in SFY2018.
- Training was provided to all regions on the proper administration of the assessment tool during SFY2018.

Early Intervention & Education Program – Part C

PROGRAM CORE PURPOSE

The Part C program provides oversight of fourteen (14) Regional Child Developmental Centers (CDCs) that are contracted to provide Individual Family Service Plan (IFSP) services to children from birth through age two who meet the state's criteria for early intervention IDEA Part C services.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of children who substantially increased their rate of growth in Positive Social-Emotional skills.	88%	88%**	81.9%	80.3%	86.4%	78.83%*	80.68%***
% of children who substantially increased their rate of growth in Acquiring and Using Knowledge and Skills	85%	85%**	80.7%	79.7%	83.8%	71.92%*	72.59%***
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Their Needs	88%	88%**	81.6%	81.8%	86.8%	78.67%*	85.34%***
Median hours of planned IFSP services per month	N/A	2	N/A	N/A	N/A	N/A	1

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

*Does not include COS scores from the three pilot regions

**Targets are the same for SFY 2018 and SFY 2019 as the targets were not met

***Includes all 14 CDC child outcome performance measurements

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
Number of children served based on annual count**	1,210	1,207	1,266	1,289	1,254	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)**	***	***	2,231	2,125	2,097	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted**	\$8,643	\$8,812	\$9,068	\$8,743	\$8,751	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually**	***	***	\$5,052	\$5,164	\$5,070	N/A*	N/A*	N/A*	N/A*

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

**For SFY18, W.S. § 21-2-701-706 implemented a change in child count from November 1 to December 1, leading to slight data changes in previous years.

***Data not available. Previous information was provided, but upon further review, data cannot be validated.

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 by a parent, guardian, or doctor are evaluated through a series of research-based and professionally recognized assessment instruments.
- Part C piloted a new process for determining child outcomes based on a standardized assessment tool in SFY2017. This pilot included three of the fourteen regional centers from July 1, 2016 to June 30, 2017. EIEP rolled out the new Child Outcomes process to all fourteen regions in phases in SFY2018.
- As of July 1, 2018, all children are evaluated using the piloted standardized assessment tool to measure a child's skill level when entering the Part C program and again when exiting the program; the assessment summarizes into a progress category for that child's participation in services.
- With all 14 regions utilizing the new child outcomes process, the data trends have changed for Wyoming Part C Child Outcome reporting. Implementation of the new child outcomes monitoring process was phased in by center throughout SFY 2018, with all regions on-boarded by July 1, 2018. Due to the meaningful changes in the data collection, Part C targets were not met for SFY2018.
- A new metric, "Increase the median amount of planned IFSP services per month" has been added for SFY2018. This metric captures the amount of services a child receives, which is correlated with a child's rate of growth in the various skill areas. Unlike rate of growth, which is only measured on an annual basis, this metric can be gathered quarterly to monitor progress on a more regular basis.
- Due to a change in W.S. § 21-2-701 through 706, the annual child count will take place on December 1 of each year, as opposed to November 1, as seen in recent years. There have been slight changes to the data to reflect the date of the child count.

Mental Health Outpatient Treatment

Program Description

The Mental Health Outpatient Treatment program provides access to effective outpatient treatment services to improve the levels of functioning for persons with mental illness.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$20,733,470	\$20,400,451**	\$20,048,387 ***
People Served	18,107	17,851	16,269
Cost per Person	\$1,145	\$1,143	\$1,232
Non-600 Series*	4.2%	3.6%	2.1%

* 600 series is defined as direct service contracts.

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

*** Includes year 2 of the Assisted Outpatient Treatment federal grant totaling \$617,703

Program Cost Notes

SFY 2018 Funding

- 95.48% State General Funds (\$19,342,696)
- 3.52% Federal Funds (\$705,691)

Program Staffing

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

Program Metrics

- A total of 275,239 hours of mental health outpatient services were delivered in SFY2018 with an average of 16.92 hours of service per client.
- Populations served: 47.01% adults with Serious Mental Illness (SMI); 7.70% youth with Severe Emotional Disturbance (SED), and 45.29% not diagnosed as 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 Mental Health Outpatient Treatment program provides access to effective outpatient treatment services to improve the level of functioning for persons with mental illness or Serious Mental Illness (SMI).

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	SFY 2018
Wait time for services (days) (12 of 14 providers met this target)	≤ 2 days	≤ 2 days	5.32	2.79	2.24	2.19	1.86
Treatment completion	72%	75%	51%	65%	66%	68%	75%
% of clients with SMI who left treatment against medical advice (AMA) or were “no shows” for appointments and were discharged	15%	15%	27%	22%	21%	23%	16%
Number of statewide Involuntary Hospitalizations	N/A	237	271	341	357	259	245
% of SMI clients with an improvement of functioning of 5 points or more as measured by the Daily Living Activities-20 functional assessment and translated into a GAF score	65%	65%	67%	60%	59%	57%	61%

(-) 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 2014	SFY 2015	SFY* 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Number of persons served	17,477	17,934	18,107	17,851	16,269	12,582	12,704	11,839	11,735
Number of persons with SMI served	6,756	7,619	8,003	7,679	7,648	5,888	5,975	5,770	5,870
Number of hours of outpatient services delivered	370,948	349,426	342,632	299,490	275,239	150,123	149,368	136,460	138,779
EFFICIENCIES									
Average cost per client	\$1,251	\$1,209	\$1,145	\$1,143	\$1,232	N/A*	N/A*	N/A*	N/A*
Average cost per service hour	\$60**	\$62**	\$61	\$68	\$73	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

- The Mental Health and Substance Abuse (MHSA) Section continues to refine processes for contract management and monitoring of provider performance.
 - Behavioral Health Division staff developed a mechanism within our data system to automate reporting of contract deliverables and provider performance in 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 fragmented deliverables tracking and consistency in approaches to noncompliance, quality improvement, and outcomes development,
 - A mechanism for providers to determine contract compliance at any time during the contract cycle.
 - Processes providing performance feedback to providers on a quarterly basis were instituted.
 - A semi-annual contract and performance review was conducted, resulting in three providers placed on Corrective Action Plans for consistently not meeting performance metrics. Training and technical assistance was provided through monthly meetings with the providers.
 - On-site visits were conducted, which included review of federal block grant requirements.
- Nine (9) University of Wyoming ECHO sessions behavioral health were held in SFY 2018 with 214 participants. Unlike traditional training, ECHO brings together diverse rural and frontier professionals in a didactic adult learning forum that quickly advances utilization of best and promising practices. ECHO has especially helped in the understanding and utilization of best practices related to opioid use disorders in Wyoming.
- The MHSA Section has identified specific challenges to each treatment provider and developed individual targets in provider contracts. Individual targets were identified using data submitted by providers in SFY 2014 through SFY 2017 and the specific target metrics were then negotiated with each provider. Progress on achieving the targets is monitored monthly and issues identified are addressed with the individual provider.
- The Assisted Outpatient Treatment Grant continued through SFY 2018. The grant supported the development of infrastructure and implementation of services under Wyo. Stat. Ann. § 25-10-110.1, the Wyoming Directed Outpatient Commitment Statute. A statewide training was held for community partners to highlight accomplishments and to problem solve issues.
- This program area was also given the responsibility of implementing the Gatekeeping Wyo. Stat. Ann. 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.
- Budget cuts beginning in SFY 2017 have resulted in a reduction in the number of people served and the number of hours of service provided. Overall funding (see Program Snapshot) remained steady due to the receipt of several targeted federal grants that were distributed to only a few community mental health centers. The federal funding targeted very specific populations, served only a small number of individuals, and could not make up for the loss incurred with the budget cuts.



Mental Health Residential Treatment

Program Description

The Mental Health Residential Treatment program is 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.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$7,212,807	\$7,138,277	\$7,082,079
People Served	482	434	550
Cost per Person	\$14,964	\$16,447	\$12,877
Non-600 Series*	4.0%	3.7%	2.0%

* 600 series is defined as direct service contracts.

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

- 233 individuals resided in Community Housing (group homes and supervised living environments) in SFY 2018.
- 317 persons received Crisis Stabilization services in SFY 2018.
- The program focused on turning over housing beds, increasing crisis stabilization utilization, and implemented use of the LOCUS tool to determine placement, resulting in an increase in the number of persons served in SFY 2018.

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 Mental Health Residential Treatment program is 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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	SFY 2018
Utilization rate for crisis stabilization beds	85%	55%	9.20%	30.47%	55.61%	50.72%	47.71%
Utilization rate for group homes	95%	95%	83.26%	83.99%	92.57%	92.42%	89.08%
Utilization rate for supervised living	95%	95%	96.18%	100.07%**	103.99%**	98.23%	86.44%
Length of stay in group homes (days)	300	300	352.49	404.46	452.90	422.22	425.40
Length of stay in supported living environments (days)	400	400	607.11	621.08	546.06	531.10	575.95

(-) 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

** 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Number of persons served – crisis stabilization	156	50	232	231	317	N/A*	N/A*	N/A*	N/A*
Number of persons served – group homes	77	80	118	104	121	N/A*	N/A*	N/A*	N/A*
Number of persons served – supervised living	77	84	132	99	139	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average cost per client for crisis stabilization	\$11,353	\$35,422	\$8,075	\$9,722	\$7,775	N/A*	N/A*	N/A*	N/A*
Average cost per client for group home and supervised living***	\$28,128	\$27,119	\$19,367	\$24,593	\$19,817	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

*** Funding for group homes and supervised living is bundled together

STORY BEHIND THE PERFORMANCE

- The Mental Health and Substance Abuse (MHSA) Section continues to refine processes for contract management and monitoring of provider performance.
 - Behavioral Health Division staff developed a mechanism within our data system to automate reporting of contract deliverables and provider performance in 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 fragmented deliverables tracking and consistency in approaches to noncompliance, quality improvement and outcomes development,
 - A mechanism for providers to determine contract compliance at any time during the contract cycle.
 - Processes providing performance feedback to providers on a quarterly basis were instituted.
 - A semi-annual contract and performance review was conducted, resulting in three providers placed on Corrective Action Plans for consistently not meeting performance metrics. Training and technical assistance was provided through monthly meetings with the providers.
 - On-site visits were conducted, which included review of federal block grant requirements.
- Nine (9) University of Wyoming ECHO sessions in behavioral health were held with 214 participants in SFY 2018. Unlike traditional training, ECHO brings together diverse rural and frontier professionals in a didactic adult learning forum that quickly advances utilization of best and promising practices. ECHO has especially helped in understanding and utilization of best practices related to opioid use disorders in Wyoming.
- The MHSA Section has identified specific challenges to each treatment provider and developed individual targets in provider contracts. Individual targets were identified using data submitted by providers during SFY 2014 through 2017 and the specific target metrics were then negotiated with each provider. Progress on achieving the targets are monitored monthly and issues identified are addressed with the individual provider.

Substance Use Outpatient Treatment

Program Description

Funding is contracted to community substance use treatment centers for outpatient treatment services that assist Wyoming residents in achieving and maintaining recovery from alcohol and drug dependency. The program is authorized by Wyo. Stat. Ann. § 9-2-102 *et. seq.* and Wyo. Stat. Ann. § 9-2-2701 *et. seq.*

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$10,514,963**	\$10,503,615***	11,348,303****
People Served	6,680	6,012	6,255
Cost per Person	\$1,574	\$1,747	\$1,814
Non-600 Series*	4.0%	3.6%	2.7%

* 600 series is defined as direct service contracts.

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

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

**** Includes STR grant, year 1 totaling \$1,830,421

Program Cost Notes

SFY 2018 Funding:

- 42% State Tobacco Funds (\$4,824,917)
- 27% State General Funds (\$3,047,011)
- 31% Federal Funds (\$3,476,375)

Federal funds increased due to the STR grant

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 165,006 hours of outpatient services were delivered by community substance use providers, with an average of 26.38 hours of service per client in SFY 2018.
- 48.34% of persons served in SFY 2018 were admitted with a primary problem of alcohol, 19.13% for marijuana/hashish, 19.33% for methamphetamine, 10.11% for opiates (including heroin), and 3.09% 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, and 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 Use Outpatient Treatment

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	SFY 2018
% of clients completing treatment	72%	75%	59%	66%	66.04%	71.13%	73.56%
% of clients with an improvement of functioning of 5 points or more as measured by the Daily Living Activities-20 functional assessment and translated into a GAF score	70%	70%	65%	61%	66%	62%	67.87%
Average wait time for services (days)	≤ 2	≤ 2	5.69	2.46	1.98	2.75	1.90

(-) 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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Number of persons served	6,560	6,672	6,680	6,012	6,255	3,988	3,881	4,008	4,188
Number of persons admitted	4,372	5,314	4,421	4,496	5,438	2,270	2,226	2,731	2,707
Number of persons discharged	5,236	5,923	4,846	5,012	4,924	2,580	2,432	2,243	2,681
Hours of outpatient services delivered	209,729	199,863	193,942	165,977	165,006	83,805	82,172	80,014	84,992
EFFICIENCIES									
Average cost per client	\$1,509**	\$1,424	\$1,574	\$1,747	\$1,814	N/A*	N/A*	N/A*	N/A*
Average service cost per hour	\$47**	\$48**	\$52	\$63	\$69	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

**These calculations do not include administrative costs

STORY BEHIND THE PERFORMANCE

- The Mental Health and Substance Abuse (MHSA) Section continues to refine processes for contract management and monitoring of provider performance.
 - Behavioral Health Division staff developed a mechanism within our data system to automate reporting of contract deliverables and provider performance in 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 fragmented deliverables tracking and consistency in approaches to noncompliance, quality improvement and outcomes development,
 - A mechanism for providers to determine contract compliance at any time during the contract cycle.
 - Processes providing performance feedback to providers on a quarterly basis were instituted.
 - A semi-annual contract and performance review was conducted, resulting in three providers placed on Corrective Action Plans for consistently not meeting performance metrics. Training and technical assistance was provided through monthly meetings with the providers.
 - On-site visits were conducted, which included review of federal block grant requirements.
- Nine (9) University of Wyoming ECHO sessions in behavioral health were held with 214 participants in SFY 2018. Unlike traditional training, ECHO brings together diverse rural and frontier professionals in a didactic adult learning forum that quickly advances utilization of best and promising practices. ECHO has especially helped in understanding and utilization of best practices related to opioid use disorders.
- During SFY 2018, staff managed two (2) federal grants targeted at increasing access to treatment and medication assisted treatment for persons with opioid use disorder, resulting in an increase in the number of persons served from SFY 2017 to SFY 2018. The Medication Assisted Treatment Grant ended in July, 2018. The State Targeted Response Grant is in its second year and will expire at the end of April, 2019.
- The MHSA Section has identified specific challenges to each treatment provider and developed individual targets in provider contracts. Individual targets were identified using data submitted by providers during SFY 2014 through 2017 and the specific target metrics were then negotiated with each provider. Progress on achieving the targets are monitored monthly and issues identified are addressed with the individual provider.



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

	2016	2017	2018
Total Program Cost	\$13,428,946	\$13,206,817	\$13,550,539
People Served**	1,794	1,051	962
Cost per Person	\$7,485	\$12,566	\$14,086
Non-600 Series*	4.2%	3.6%	2.0%

* 600 series is defined as direct service contracts.

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

Program Cost Notes

- SFY 2018 Funding:
 - 74% State General Funds (\$10,066,800)
 - 15% Federal Funds (\$1,968,359)
 - 11% Tobacco Settlement Funds (\$1,515,380)

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 65,604 days of residential treatment were delivered statewide with an average of 68.2 days of service per client in SFY 2018.
- People served decreased due to a decrease in the number of treatment beds available and an increase in both the number of treatment episodes and the average length of stay in SFY 2018.
- 40.33% of persons served in SFY 2018 were admitted with a primary problem of methamphetamine, 35.34% for alcohol, 15.70% for opiates (including heroin), 6.55% for marijuana/hashish, and 2.08% 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, and 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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016*	SFY 2017	SFY 2018
Utilization rate	95%	96%	87%	88%	90%	92%	96%
Treatment completion rate	80%	80%	64%	73%	74%	76%	74%
% 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.	90%	90%	84%	91%	85%	82%	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Number of persons served	1,117	1,174	1,794	1,051	962	629	615	576	595
Number of persons admitted	921	1,044	1,090	895	835	458	437	412	423
Number of persons discharged	930	1,033	1,108	892	886	459	433	407	479
Number of days of residential services provided	81,057	81,795	80,468	65,565	65,604	32,681	32,884	34,486	31,118
EFFICIENCIES									
Average cost per client	\$11,574**	\$11,973	\$7,485	\$12,566	\$14,086	N/A*	N/A*	N/A*	N/A*
Average cost per day	\$189**	\$172**	\$167	\$201	\$207	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

**These calculations do not include administrative costs.

STORY BEHIND THE PERFORMANCE

- The Mental Health and Substance Abuse (MHSA) Section continues to refine processes for contract management and monitoring of provider performance.
 - Behavioral Health Division staff developed a mechanism within our data system to automate reporting of contract deliverables and provider performance in 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 fragmented deliverables tracking and consistency in approaches to noncompliance, quality improvement and outcomes development,
 - A mechanism for providers to determine contract compliance at any time during the contract cycle.
 - Processes providing performance feedback to providers on a quarterly basis were instituted.
 - A semi-annual contract and performance review was conducted, resulting in three providers placed on Corrective Action Plans for consistently not meeting performance metrics. Training and technical assistance was provided through monthly meetings with the providers.
 - On-site visits were conducted, which included review of federal block grant requirements.
- Nine (9) University of Wyoming ECHO sessions in behavioral health were held with 214 participants in SFY 2018. Unlike traditional training, ECHO brings together diverse rural and frontier professionals in a didactic adult learning forum that quickly advances utilization of best and promising practices. ECHO has especially helped in understanding and utilization of best practices related to opioid use disorders.
- The average length of stay increased from 62 days per person in SFY 2017 to 68 days per person in SFY 2018, resulting in a decrease in the number of persons served and increase in the cost per client.
- The MHSA Section has identified specific challenges to each treatment provider and developed individual targets in provider contracts. Individual targets were identified using data submitted by providers during SFY 2014 through 2017 and the specific target metrics were then negotiated with each provider. Progress on achieving the targets are monitored monthly and issues identified are addressed with the individual provider.

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. 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

	2016	2017	2018
Total Medical & Waiver Cost	\$4,821,928	\$7,712,009	\$9,555,008
Total Waiver Cost	\$2,783,016	\$4,387,059	\$5,889,330
Total Medical Costs	\$2,038,912	\$3,324,950	\$3,665,678
Total People Served	425	556	580
Cost per Person (Medical & Waiver)	\$11,629	\$14,105	\$16,474
Non-600 Series*	12.5%	6.8%	7.4%

*600 series is defined as direct service contracts

Program Cost Notes

- Participants receive Medicaid medical services in addition to Waiver services.
- Program staffing for the Developmental Disabilities (DD) waivers is proportional to the number of participants active in the program.
- Increases to provider rates have increased the cost per participant.

Program Staffing

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

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of \$6,751 per person in SFY2018.
- The Waiver average costs per participant in SFY2018 was \$10,424.
- 65 participants self-directed some of their waiver services in SFY2018.
- 279 eligible individuals were on the waiting list for the Supports Waiver as of June 30, 2018.
- There were 679 certified providers monitored by the DD Section during SFY2018.

Events that have Shaped this Program

- **Wait list funding.** The 2014 legislature appropriated \$9.7 million (50% State General Funds and 50% Federal Funds) to reduce the waiting list for the Adult DD Waiver, \$5.9 million to reduce the waiting list for the Child DD Waiver, and \$4.6 million for the Acquired Brain Injury Waiver, for a total of \$20.2 million.
- **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 SFY18. This resulted in an across the board rate increase of 4.2%. The 2018 Legislative Session appropriated \$20 million for the 2019-20 biennium and directed the Department of Health to absorb an additional \$3 million in additional provider payment rate increases. The \$23 million in additional funding for the biennial budget fully funded the provider payment rates identified in the rate rebasing project completed in conjunction with Navigant Consulting.
- **Acquired Brain Injury Population.** As of April 1, 2018, the Acquired Brain Injury Waiver was closed and all participants were transitioned to the Comprehensive Waiver or the Supports Waiver.
- **Federal HCB rules.** Under the Home and Community Based (HCB) 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 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, to ensure all provider settings are in compliance with the rule. Wyoming was the 8th state in the country to receive approval on its transition plan and 100% of providers are now in compliance with the rules.



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. 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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average utilization of Individual Budget Amount (IBA) for child and adult Supports Waiver participants	55.0%	55.0%	N/A	21.8%	37.3%	46.5%	50.68%

(-) 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Total # of participants	47	203	425	556	580	448	546	531	544
# of participants, all ages, using community integration services	0	2	38	44	51	38	43	47	45
# of participants, of all ages, using supported living services	1	3	107	133	179	113	128	164	171
# of participants, ages 18+, using waiver supported employment services	0	3	7	16	21	12	16	16	19
EFFICIENCIES									
Average cost per participant (waiver and medical)	N/A	\$6,097	\$11,629	\$14,105	\$16,474	\$7,720	\$7,789	\$8,840	\$8,872
Average cost per participant (waiver only)	N/A	\$4,302	\$6,542	\$8,093	\$10,424	\$4,508	\$4,575	\$5,498	\$5,459

(-) 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

- **Federal HCB rules.** Under the Home and Community Based (HCB) 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 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, to ensure all provider settings are in compliance with the rule. Wyoming was the 8th state in the country to receive approval on its transition plan and 100% of providers are now in compliance with the 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. DD is working with an interagency taskforce to implement the legislation statewide.
- **Provider Payment Rate Increases.** As approved by the Wyoming State Legislature, provider payment rates were increased by 3.3% for SFY17 and an additional 4.2% for SFY18. These rate increases were applied equally across all services for the Comprehensive and Supports Waiver programs.
- **Acquired Brain Injury Population.** As of April 1, 2018, the Acquired Brain Injury Waiver was closed and all participants were transitioned to the Comprehensive or Supports Waiver.

WDH | Public Health Division

Information contained in this section includes:

- Community Health Section
 - Child Health
 - Chronic Disease Prevention
 - Immunization Program
 - Injury Prevention Program
 - Public Health Nursing
 - Healthy Baby Home Visitation Program
 - Substance Abuse Prevention Program
 - Tobacco Prevention and Control Program
 - Women and Infant Health Program
 - Women, Infants, and Children (WIC) Program
 - Wyoming Cancer Program
 - Youth & Young Adult Health Program
- Health Readiness & Response Section
 - Community Medical Access and Capacity (CMAC) Program
 - Community Services Program
 - Healthcare Preparedness Program (HPP)
 - Healthcare Workforce Recruitment, Retention and Development (HWRRD)
 - Office of Emergency Medical Services (OEMS)

- Office of Health Equity
- Public Health Emergency Preparedness (PHEP)
- Trauma Program
- Public Health Sciences Section
 - Communicable Disease Prevention Program
 - Communicable Disease Treatment Program
 - Infectious Disease Epidemiology
 - Public Health State Laboratory

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 to address the health, safety, and development of children (ages 1-11 years), including children with special healthcare needs. The Child Health Program also strives to foster the engagement of parents and other caregivers across the state.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$402,515	\$388,973	\$380,547
People Served*	N/A	N/A	22,651
Cost per Person	N/A	N/A	\$16.80
Non-600 Series**	40%	55%	47%

*People Served is defined as those children in Wyoming ages 1-11 impacted by services supported through the Child Health Program.

Previous reports included all children in Wyoming ages 1-11 years.

** 600 series is defined as direct service contracts.

Program Cost Notes

- The Child Health Program is federally funded through Title V Maternal & Child Health Block Grant.

Program Staffing

- 1.0 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Motor Vehicle Crashes are the leading cause of injury mortality for Wyoming children, ages 1-18 years. (Wyoming Vital Statistics Mortality data—state fiscal year 2007 through 2017)
- 40.1% of Wyoming children 6-11 years old are physically active 60 minutes per day (four to six days per week), compared to 29.3% nationally. (2016 National Survey of Children's Health)
- 62.3% of Medicaid-enrolled children ages 1 to 9 years received an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen in the past 12 months. (Medicaid 416 Report 2017)

Events that have Shaped this Program

- The Maternal and Child Health Unit completes a needs assessment every 5 years to determine Unit priorities. Three of the priorities identified in the 2015 needs assessment directly applied to the Child Health Program for 2016-2020: 1) Promoting Preventive and Quality Care for Children, 2) Reducing and Preventing Childhood Obesity, and 3) Preventing Injury in Children.
- The Wyoming child injury mortality rates remain consistently higher than the U.S. rate.
- Department-wide focus on increasing EPSDT screening rates.
- In June of 2018, a new Program Manager moved into the Child Health Program.
- The Child Health Program continues to build upon partnerships with other state agencies and external partners to address program priorities.

Child Health

PROGRAM CORE PURPOSE

The purpose of the Child Health Program is to ensure that all Wyoming children, including children with special healthcare needs, have access to early developmental services, healthy and safe communities to grow, and engaged caregivers.

OUTCOMES

Performance Metric	CY2018 Target	CY2019 Target	CY2014	CY2015	CY2016	CY2017	CY2018
% of eligible children (1-9 years) that received at least one EPSDT screen in the past 12 months ¹	68.5%	68.5%	54.7% (11,356/ 21,082)	53.6% (11,207/ 20,890)	59.6% (11,144/ 18,693)	62.3% (10,824/ 17,374)	(-)
% of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year ²	31.1%	31.1%	N/A*	N/A*	27% WY 31.1% US	N/A*	(-)
% of children ages 6-11 who are physically active at least 60 minutes per day ² (New measure)	44.1%	44.1%	N/A*	N/A*	40.1% WY 29.3% US	N/A*	(-)
Injury Mortality Rates (per 100,000) 0 - 18 years ³	13.5	13.5	WY: 23.5 US: 13.3	WY: 23.1 US: 13.4	WY: 21.5 US: 13.9	WY: 22.5 US: N/A	(-)
% of Parents who felt like a partner in their child with special healthcare needs care ²	75%	75%	N/A*	N/A*	75% WY 69.5% US	N/A*	(-)

¹ Medicaid 416 Report, Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) – calendar year, 2018 data available in 2019

² National Survey of Children's Health

³ Wyoming Vital Statistics, CDC WISQARS Mortality data– three year rolling rates.

N/A* indicates data not available on an annual basis

(-) indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of Ages and Stages Developmental Screenings Completed by Public Health Nursing (ASQ3+SE2) ⁴	N/A	722	1,018	1,241	943 as of 8/2018	565	676	681	262 (Q3)
# of Wyoming Educators trained in Comprehensive School Physical Activity Program (CSPAP)	N/A*	N/A*	N/A*	N/A*	118	N/A*	N/A*	N/A*	N/A*
# of car seats distributed (D) & inspected (I) through Safe Kids Wyoming ⁵	D:646 I:1,501	D:675 I:1,293	D:521 I:1,184	D:774 I: 1,689	D:543 I:987 as of 8/2018	D:406 I:1,023	D:368 I:666	D:393 I:726	D:150 I:261 as of 8/2018
# of unique families served by Wyoming Parent Partner ⁶	N/A	N/A	N/A	217	205 as of 9/2018	N/A	N/A	N/A	N/A
EFFICIENCIES									
Cost per family served by Parent Partner	N/A	N/A	N/A	\$284.79 (\$61,800/ 217)	\$301.46 (\$61,800 /205) as of 8/2018	N/A	N/A	N/A	N/A
<p>⁴ ASQ3/SE – Ages & Stages Developmental Questionnaire, Third Edition (ASQ3)/Ages & Stages Questionnaire: Social-Emotional Second Edition (ASQ:SE2)</p> <p>⁵ Safe Kids USA</p> <p>⁶ Wyoming Parent Partner Project by HALI</p> <p>N/A indicates data not available due to the creation of a new metric</p> <p>N/A* indicates data not available on an annual basis</p> <p>(-) indicates data not yet available</p>									

STORY BEHIND THE PERFORMANCE

- The Child Health Program provides leadership and support for the design, implementation, and evaluation of state and local policies and programs to address the health, safety, and development of children (ages 1-11 years), including children with special health care needs. The Child Health Program also strives to foster the engagement of parents and other caregivers across the state.
 - Examples of MCH activities directly supporting the child population include the Help Me Grow Program, Parent Partner Program, Safe Kids Wyoming, and the Wyoming Vision Collaborative.
 - The Parent Partner Program serves as a central access point in primary care practices for coordination of health services and family support to ensure that all available services are fully integrated into a patient's primary preventive health care program.
 - The Child Health Program Manager also participates in the Wyoming Early Intervention Council and Wyoming Home Visiting Network.
 - MCH undertakes a Title V Needs Assessment every (5) five years in which population specific priorities are adopted. In 2015, the 2016-2020 MCH priorities were selected. The (3) three priorities which directly relate to the Child Health Program include:
 - Reduce and prevent childhood obesity
 - Promote preventive and quality care for children
 - Prevent injury in children

Chronic Disease Prevention Program

Program Description

The Chronic Disease Prevention Program (CDPP) 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 the 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 2016	SFY 2017	SFY 2018
Total Program Cost	\$665,509	\$943,393	\$1,041,198
People Served	585,501	585,501	579,315
Cost per Person	\$1.14	\$1.61	\$1.80
Non-600 Series*	99%	99%	92%

* 600 series is defined as direct service contracts.

Program Cost Notes

- 100% federally funded from the Centers for Disease Control and Prevention (CDC).
- In FY 2017, the program 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.

Program Staffing

- 2.15 FTE
- 1 AWEC
- 0 Other

Program Metrics

- At the end of SFY18, Wyoming had 22 Diabetes Self-Management Education (DSME) program sites and 5 CDC-recognized Diabetes Prevention Programs (DPP), an increase of 3 and 2 from SFY17, respectively.
- The CDPP contracts with 2 Certified Diabetes Educators to provide professional development to providers, nurses, and other health workers in chronic disease self-management as well as to provide technical assistance and support to DSME and DPP sites.
- In SFY18, 537 Early Childhood Education (ECE) providers were 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 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 SFY17, which significantly increased program capacity and improved outcomes.
- In SFY18, the final year of the federal grant, the program shifted efforts to focus on sustainability.



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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
# of Early Childhood Education sites (ECEs) that report adopting 100% of best practice strategies to increase physical activity ¹	40	N/A	0	3	6	25	9 YTD
% of schools that do not sell less healthy foods and beverages ^{2,3}	N/A	N/A	37.4%	N/A*	45.8%	-	-
% of people with diabetes in targeted settings who have had at least one encounter with Diabetes Self-Management Education (DSME) ⁴	5.0%	5.3%	4.0%	4.4%	4.3%	4.9%	-
% of people with self-reported hypertension ⁵ (national average)	30.0%	30.0%	N/A*	29.9% (30.9%)	N/A*	30.8% (-)	N/A*
% of people with self-reported diabetes ⁵ (national average)	8.2%	8.8%	8.4% (10.1%)	8.4% (10.0%)	8.3% (10.5%)	9.0% (-)	-

¹ Data Source: WY Let's Move Childcare Checklist Dataset (data collected on a calendar year)
² Data Source: School Health Profiles. Note: Wyoming participated in the Youth Risk Behavior Surveillance System (YRBSS) from 1995-2015. Due to Legislative action in the 2016 Session (Footnote 3 to Section 206 of Senate Enrolled Act No. 19), the state was restricted from conducting the YRBSS, which also impacted the collection of School Health Profiles, so this data is no longer collected in Wyoming.
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 Data Source: Wyoming Behavioral Risk Factor Surveillance System; data is weighted.
 N/A* indicates data not available annually
 (-) indicates data not yet available
 (N/A) indicates data no longer being collected
 YTD covers January 1st, 2018 through July 31st, 2018.

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of healthcare professionals trained on diabetes and hypertension self-management strategies ⁶	N/A	N/A	357	831	410	421	410	162	248
# of ECE providers that received professional development to adopt policies to increase physical activity ⁶	N/A	N/A	166	537	302	350	187	121	181
# of local education agencies that received professional development or technical assistance on strategies to create a healthy school nutrition environment ⁶	N/A	15	19	15	16	9	6	6	10
EFFICIENCIES									
Cost per healthcare professional trained in hypertension and diabetes management	N/A	N/A	\$309.50 (\$110,492/ 357)	\$225.84 (\$187,677/ 831)	\$295.85 (\$121,299/ 410)	\$200.32 (\$84,333/ 421)	\$315.08 (\$129,181/ 410)	\$298.95 (\$48,430/ 162)	\$343.13 (\$85,095/ 248)
N/A indicates data not available due to the creation of a new metric									
⁶ Data Source: Count of attendees at CDPP sponsored trainings and technical assistance session.									

STORY BEHIND THE PERFORMANCE

The Chronic Disease Prevention Program is funded by a federal grant, 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 reducing 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.



Immunization Unit

Program Description

The Immunization Unit promotes the immunization of children and adults. The Unit provides education to healthcare providers and the public, reports immunization coverage rates, and oversees the mandatory immunizations for children attending schools and child care facilities. The Unit manages 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 for administration to eligible patients. The Immunization Unit also manages the Wyoming Immunization Registry (WyIR).

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$5,365,174.60	\$4,508,668.27	\$3,367,550.79
People Served	117,811	141,910	146,480
Cost per Person	\$45.54	\$31.77	\$22.99
Non-600 Series*	33%	33%	32%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Operational funding consists of 71% federal and 29% state.
- Number of people served per the WyIR.
- Standard budget was reduced by \$356k in SFY 2017.
- Total Program Cost in SFY 18 was less than SFY 17 to accommodate an agency-wide shortfall. The Immunization Unit was able to contribute a one-time \$1,143,726 by using an existing credit with the CDC's advance purchase program to order vaccine doses in SFY 2018; the program will need to continue making advance purchases to maintain vaccine supply in the next SFY.

Program Staffing

- 8 FTE: 1 state-funded, 7 federally-funded
- 2 AWEC: Both federally-funded
- 0 Other

Program Metrics

- As of June 30, 2018, 119 public and private healthcare providers receive state and/or federally-purchased vaccines from Public Vaccine Programs operated by the Immunization Unit.
- More than 144,609 doses of pediatric and 6,917 adult vaccines were distributed to enrolled providers through the Public Vaccine Programs during SFY 2017.
- As of July 10, 2018, the WyIR contained information for 7,995,063 vaccinations.

Events that have Shaped this Program

- In 2006, Wyo. Stat. § 35-4-139 established a program to provide all recommended vaccines for all children of Wyoming residents who are not eligible for the federal Vaccines for Children (VFC) 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. §33-24-157 required pharmacies to report immunizations to the WyIR significantly increasing the number of adult immunizations recorded in the WyIR.
- In February 2018, with the approval of the Immunization Unit Administrative Rules, reporting of all immunization information became required and pneumococcal and rotavirus vaccination became mandatory for children attending schools and child caring facilities.



Immunization Unit

PROGRAM CORE PURPOSE

Reduce the risk of contracting vaccine-preventable diseases (VPDs) in Wyoming.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
7-Vaccine Series Coverage Estimate (19-35 mos.) ¹	80%	65%	44%	57%	61%	57%	61%
Kindergarten Coverage Estimate ²	98%	90%	N/A	96.8%	96.8%	98%	85.5%
Missed Opportunity Rate ³	2%	5%	16%	19%	2%	3%	18%
Number of VPD Cases ⁴	N/A	45	85 (CY 2013)	74 (CY 2014)	46 (CY 2015)	35 (CY 2016)	47 (CY 2017)
HPV Up-To-Date Coverage Estimate (15-18 yrs.) ⁵	N/A	40%	19%	21%	22%	23%	31%

(-) 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of AFIX Visits ⁶	N/A	71	56	47	73	N/A*	N/A*	N/A*	N/A*
# of Pediatric Doses Shipped ⁷	147,833	150,392	147,070	144,147	132,359	77,565	66,582	72,982	59,377
# of Facilities Active within the WyIR ⁸	137	174	195	200	375	N/A*	N/A*	N/A*	N/A*
# of VFC/WyVIP Program Providers ⁹	127	127	126	123	123	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per AFIX Visit	N/A	N/A	N/A	\$25	\$35.72	N/A*	N/A*	N/A*	N/A*
Cost of Pediatric Vaccine Distributed ¹⁰	\$7,928,504	\$8,387,962	\$8,623,774	\$8,857,524	\$8,414,873	\$4,802,350	\$4,055,174	\$4,634,785	\$3,780,88
WyIR Cost per Facility ¹¹	N/A	N/A	\$1,586 (\$333,345/ 195)	\$1,546 (\$309,208/ 200)	\$952 (\$357,147/ 375)	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

Coverage estimates reported here are from the Wyoming Immunization Registry (WyIR).

¹ The 7-vaccine series (4:3:1:3:3:1:4) among children 19 to 35 months consists of: 4 DTAP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, and 4 Pneumococcal vaccines. According to the National Immunization Survey (NIS), the national coverage for 2016 was 70.7%. The target for this goal was changed from 80%, the Healthy People 2020 goal to 65% which is much more attainable.

² The Immunization Status Report allows schools to self-report immunization status for enrolled children. This report is submitted by November 1 of each year and is not a measure for the entire school year or state fiscal year. Average percentage includes 2 doses of MMR, 4 doses DTP/DTaP/DT, 2 doses Varicella, 3 doses Hepatitis B, and 3 doses Polio. Activities have begun to increase the use of the WyIR for completing this report as it will utilize data directly from the WyIR rather than self-reported data. The decrease in coverage is attributed to more accurate data and improved assessment tools.

³ This measure evaluates missed opportunities for the 7-dose series for children ages 19 to 35 months. Missed opportunities are when a child receives a vaccine and was eligible to receive another vaccine but did not. The notable reduction from SFY 2015 to SFY 2016 is a result of stronger education and intervention. The increase from SFY 17 to SFY 18, based on feedback from the Assessment, Feedback, Incentive and Exchange (AFIX) Visits, is due to increased parent request for and provider acceptance of alternative schedules. The providers who saw the most significant increase attributed it to difficulty absorbing patients who were not up-to-date from other clinics that had closed.

⁴ The number of cases of vaccine-preventable diseases (VPDs) is obtained from the Annual Reports provided by the WDH Infectious Disease Epidemiology Unit. Because not all VPDs are required to be reported in Wyoming, this measure only includes cases of Diphtheria, Hib, Hepatitis A and B, Measles, Meningitis, Meningococcal, Mumps, Pertussis, Polio, Rubella, Tetanus and Varicella.

⁵ The HPV vaccination series changed in 2017 from 3 doses to 2-3 doses based on when the series was initiated. This measure is reported here at 15-18 years; however, is measured nationally at 13-17 years. Note that HPV is not provided by the WyVIP Program, nor mandatory for school entry. According to the NIS 2016-2017, Wyoming's estimated vaccination coverage for adolescents aged 13-17 years for ≥ 1 HPV is 46.9%. This is less than the national average as well as the HHS Region VIII average. This is also 13.8% lower than ≥ 1 meningococcal and 39.5% lower than ≥ 1 Tdap. Both Tdap and Meningococcal are recommended at approximately the same age as HPV.

⁶ An AFIX Visit is conducted for no less than 50% of providers enrolled in the Vaccines for Children (VFC) Program. This visit includes a review of coverage estimates for the clinic as well as ways to improve practices. The decrease from SFY 15 to SFY 16 was due to a reduction to one (1) site visitor from two (2). Staff vacancy and new hires occurred in SFY 17.

⁷ The number of pediatric doses shipped consists of doses shipped to healthcare providers enrolled in the state-funded Wyoming Vaccinated Important People (WyVIP) and federally-funded VFC Program.

⁸ Facilities considered as active in the WyIR consist of those that have a valid WyIR Information Sharing Agreement and have either manually entered or electronically sent immunization information in the past 3 months.

⁹ The number of providers enrolled in a pediatric Public Vaccine Program (PVP).

¹⁰ The cost of pediatric vaccine distributed include vaccines distributed the WyVIP Program and VFC Program excluding influenza vaccines. The VFC Program is federally-funded and accounts for approximately 56% of the vaccine distributed while the WyVIP Program is state-funded and accounts for 44% of vaccine distributed. Note that funding for the federal VFC Program is not included in Total Program Cost.

¹¹ WyIR Cost per Facility is calculated by taking the costs associated with the WyIR (maintenance and annual technical assistance) and dividing it by the number of facilities active in the WyIR. The decrease in SFY 18 is attributed to the significant increase in the number of facilities reporting electronically.



Wyoming Injury and Violence Prevention Program

Program Description

To coordinate state and local efforts to prevent unintentional and intentional injury and violence by promoting public awareness and providing training.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$112,308	\$118,082	\$357,057
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 CDC Preventive Health and Health Services Block Grant, the National Highway Traffic Safety Administration (NHTSA) Highway Safety Federal 402 Grant, and Tobacco Settlement Funds.

Program Staffing

- 3.0 FTE
- 0.5 AWEC
- 0 Other

Program Metrics

- Injury is the leading cause of death for Wyoming residents aged 1-54 years and the third leading cause of death for all ages (WY VSS).
- Wyoming has one of the top five highest injury mortality rates in the US.
- The leading causes of injury in Wyoming are suicide attempts, motor vehicle crashes, poisoning, and falls. These top four causes accounted for 76% of fatal injuries (2004-2016) and 60% of non-fatal injury hospitalizations (2009-2015) (WY VSS).
- In Wyoming, the unintentional injury mortality rates are over two times higher than suicide rates and eighteen times higher than homicide rates (WY VSS).
- In 2016, the Wyoming suicide rate was almost twice the national average and the third highest suicide rate behind only Montana and Alaska (WISQARS 2017).
- On average, one Wyoming resident dies by suicide every two days.

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 2017, suicide prevention was moved to the WIPP and the programs name was changed to the Wyoming Injury and Violence Prevention Program (WIVPP).
- In 2017, the WIVPP was reorganized to 3 FTE and 0.5 AWEC.
- Funding for community prevention grants for substance abuse, tobacco, and suicide prevention will go directly to Wyoming counties beginning in SFY 2019, pursuant to Footnote 7 of the 2018 Budget Bill.



Wyoming Injury and Violence Prevention Program

PROGRAM CORE PURPOSE

The purpose of the Wyoming Injury and Violence Prevention Program is to reduce unintentional and intentional injury and violence in Wyoming.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Crude injury mortality rate per 100,000 population (National Rate) ¹	90	90	85.7 (62.7)	96.8 (66.7)	90.5 (71.8)	89.8 (-)	-
Older adult unintentional injury mortality rate per 100,000 population age 65+ (National Rate)	128	128	133.9 (104.5)	141.5 (107.7)	132.1 (107.9)	-	-
% of participants completing a fall prevention course with an improved Timed Up & Go score ²	85%	85%	N/A	N/A	85% (28/33)	89% (85/96)	62% (73/118)
Crude suicide Rate per 100,000 population (National Rate) ¹	24	24	20.6 (13.4)	26.4 (13.7)	24.3 (13.9)	26.6 (-)	-

(-) Indicates data not yet available

N/A indicates data not available

¹ Crude rates are not age-adjusted, e.g. they do not account for differences in rates by age nor the age structure of the population.

² The Timed Up & Go (TUG) test assesses the functional mobility of the participant. Assessments are given to older adult participants at the beginning and completion of fall prevention programs supported by WIVPP. TUG times of greater than 12 seconds are associated with low functional mobility and a higher fall risk.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of WY older adults who participated in a fall prevention course ²	N/A*	N/A*	53	131	235	66	65	165	70
# of people attending AARP Smart Driver Course	N/A*	N/A*	N/A*	N/A*	650	N/A*	N/A*	200	450
# of people trained in suicide prevention supported by WDH	N/A*	N/A*	N/A*	1,799	996	1,707	92	649	347
# of personal safety devices distributed	N/A*	N/A*	369	990	4,160	517	473	0	4,160
EFFICIENCIES									
Falls prevention training cost per participant	N/A*	N/A*	\$34.66 (\$1,837/ 53)	\$79.39 (\$10,400/ 131)	\$44.26 (\$10,400/ 235)	N/A	N/A	N/A	N/A

*Measures reported in Calendar Year

(-) indicates data not yet available

N/A* indicates development of new metric

² Includes individuals who participated in some off the course but did not complete the full course.

STORY BEHIND THE PERFORMANCE

Trends

Injuries affect every Wyoming resident directly or indirectly. Injuries cause death, disability, disruption of daily routines, loss of productivity, and millions of dollars in work loss and medical costs. Injury is the leading cause of death among Wyoming residents between the ages of 1 and 54 and the third leading cause of death among Wyoming residents of all ages. Wyoming injury mortality rates are consistently higher than the U.S.; in 2016 the Age Adjusted Injury Death Rate was 91.7 deaths per 100,000 population compared to the U.S. rate of 68.8 (CDC WISQARS). The Wyoming suicide rate has significantly increased from 17 per 100,000 in 2004 to 25.23 per 100,000 in 2016 almost twice the national rate and the third highest suicide rate behind only Montana and Alaska. (CDC WISQARS).

Several outcome measures used to track progress for the program including Older Adult Unintentional Injury Rates and Suicide Rates are increasing. If the rates can be maintained and further increases slowed or stalled this would be a success for the program.

Challenges

Wyoming Hospital Discharge Data is a valuable dataset that is used to inform programmatic efforts, monitor emerging issues, and evaluate program impacts. Conversion from ICD-9-CM coding to ICD-10-CM coding occurred in October 2015 and changes related to the conversion have made injury hospitalization data incomplete. Efforts to increase data quality and reporting for injury hospitalizations are currently underway.

Public Health Nursing

Program Description

Public Health Nursing (PHN) is a partnership between the state and county governments for the provision of public health services in 20 counties; in 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

	2016	2017	2018
Total Program Cost	\$8,636,577	\$7,860,744	\$7,667,616
People Served	107,088	94,299	88,137
Cost per Person	\$80.64	\$83.36	\$87.00
Non-600 Series*	85%	92%	88.5%

*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 counties' contracts in 2017 and 2018.
- Number of participants represents both direct care services, classes, and outreach provided through PHN.

Program Staffing

- 88 State PHN positions in 20 counties and PHN administration (71 FTE, 15 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 PHN, and locally through county PHN offices.
- In SFY18, PHN provided services to 10,380 people in 44,912 visits. Classes and outreach efforts were provided to 77,757 participants (some class participant numbers may be repeat participants). Clinic numbers are included in direct care service numbers. Further refinement of definitions and tracking methods, including use of the Total Health Record system, should continue to increase accuracy of these numbers and improvement of total program evaluation.
- In SFY 2019 the redesign of the Public Health Nursing Informatics (PHNI) system will improve data collection and program evaluation capabilities and will lead to increased efficiency and use of public health nursing time.
- Each \$1 spent on public health programming generally returns \$5.06 in savings (APHA, 2013). Approximately \$43,260,991 in future savings to the State of Wyoming's social and health care systems may be realized from 2018 Public Health Nursing services alone.

Events that have Shaped this Program

- State statutes pertaining to Public Health Nursing are Wyo. Stat § 35-1-240; 35-1-305, 35-1-306; 35-27-101 through 104 and § 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

To 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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
# of Wyoming adult residents reached through outreach activities ¹	4,472	12,820	5,703	4,937	3,456	4,065	11,702
% of eligible Children's Special Health receiving case management services through PHN	100%	100%	N/A	N/A	100% (643/643)	100% (655/655)	100% (704/704)
# of communicable disease screens conducted by PHN ²	7715	7,828	7,866	6,376	7,783	7,639	7,116
% of Ryan White-enrolled, HIV-infected Wyoming residents receiving PHN case management	85%	85%	N/A	N/A	100% (186/186)	75% (137/183)	100% (174/174)
% of long-term care Medicaid waivers completed within 7 days or within granted extension ³	95%	95%	N/A	N/A	N/A	N/A	99.2% (7,264/7,320)

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

¹Increase in adults reached through outreach activities is likely due to improved tracking; previously this was not well-defined or tracked.

²Screenings include STI tests and TB screening.

³"Completion" of an LT101 is measured as the time from completion of the in-person patient assessment to submission of the LT101 by PHN to the Medicaid system.

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
% of Wyoming PHNs involved in community partnerships and coalitions	N/A	N/A	N/A	65% (51/78)	65% (51/78)	N/A	65% (51/78)	N/A*	65% (51/78)
# of outreach events and classes delivered by PHN	2,845	3,110	3,464	3,200	1,151	1,391	1,809	580	571
% and # of Wyoming adult immunizations administered by a PHN office	48% (41,483/86,226)	43.6% (37,096/84,879)	34.6% (36,902/106,829)	26.8% (32,091/119,513)	24.7% (30,086/121,742)	N/A	26.8% (32,091/119,513)	23.8% (23,269/97,435)	28% (6,817/24,307)
EFFICIENCIES									
Nursing time in dollars spent completing data entry tasks ³ (# of hours)	N/A	N/A	\$413,764 (14,064)	\$354,453 (12,048)	\$306,674 (10,424)	\$185,721 (6,312)	\$168,733 (5,735)	\$163,722 (5,565)	\$142,952 (4,859)
% of PHN hours spent on Maternal Child Health services for TANF clients	60.2%	58%	60.3%	60.1%	60.0%	60.1%	60.1%	59.4%	60.1%
Vaccine wastage costs for all PHN offices ⁴	\$8,734	\$6,913	\$4,892	\$669	\$7,659	\$599	\$70	\$1,273	\$6,386
<p>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 ³Based on PHN average salary of \$29.42/hour does not include program materials. ⁴Most 2018 vaccine wastage costs were due to power outages and inability of transport coolers to adequately store vaccine at consistent temperatures until power restoration; this problem is currently being addressed.</p>									

STORY BEHIND THE PERFORMANCE

- One additional county (Laramie) opted to move to the independent model beginning in SFY2019.
- 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, work with WDH programs 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 Wyo. Stat § 35-1-240; 35-1-305; 35-1-306; 35-27-101 through 104 and § 35-1-243.
- Performance of independent counties is included in the PHN outputs and efficiencies.
- A client satisfaction survey will be conducted in November 2018.



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 ages birth to two years of age.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost (SFY)	\$1.2M	\$971,483	\$838,596 ¹
People Served (CY)*	2,336	1,745	1,810 ¹
Cost per Person	\$513	\$557	\$463
Non-600 Series**	6.3%	7.4%	10.2%

* People served may vary slightly from past reports due to a new methodology for tracking clients.

** 600 series is defined as direct service contracts.

¹Indicates years to date cost and people served up to 11-7-2018

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*
- 0 AWEC
- 0 Other

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

Program Metrics

- HBHV goals are to improve maternal and birth outcomes, increase child health outcomes, and decreasing infant mortality.
- In FY 2017, PHN visited 1,355 pregnant women and new mothers. This represents 19.4% of all Wyoming births that year.
- In FY 2017, 87.1% of women enrolled in BB were breastfeeding at their first postpartum visit. Higher than the Healthy People 2020 goal (81.9%).
- In FY 2017, 9.7 of prenatal women and 13.0% of postnatal women enrolled in BB quit smoking.

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.
- In 1990, MCH began providing grants to counties to implement maternal and child health services.
- In 1996, NFP, an evidence-based home visiting model for first-time mothers, was implemented in Wyoming, in addition to the already existing (BB) home visiting model.
- In 2000, State Legislation (Wyo. Stat. §§ 35-27-101 to 104) provided TANF funding for PHN Home Visiting Programs.
- 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-three (23) counties deliver BB.
- In 2013, 2015, and 2018 training on the Partners for a Healthy Baby home visiting curriculum was provided to public health nurses who deliver the BB model of home visitation.



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 2015	CY 2016	CY 2017	CY 2018
% and # of WY resident births contacted ¹	75%	75%	71.3% 5,465/ 7,669	62.4% 4,607/ 7,384	58.6% 4,049/ 6,904	3,828*
% and # of WY resident Medicaid births contacted ¹	95%	95%	76.5% 1,828/ 2,389	74.0% 1,772/ 2,393	65.1% 1,429/ 2,192	1,403*
% of women enrolled in Nurse Family Partnership (NFP) who quit smoking during pregnancy (national %) ²	25%	25%	22.0% (16.0%)	23.0% (16.0%)	23.0% (16.0%)	23.0%* (16.0%)
% of infants enrolled in NFP born premature (<37 weeks gestation) (national %) ²	9.5%	9.5%	9.7% (9.6%)	9.9% (9.6%)	9.9% (9.7%)	9.3%* (13.6%)
% of women enrolled in NFP who initiated breastfeeding (national %) ²	90%	90%	87.4% (81.4%)	87.8% (83.5%)	88.0% (84.1%)	88%* (84.3%)

(-) indicates data not yet available

* indicates year-to-date through 9-23-18; final percentages not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2015	CY 2016	CY 2017	CY 2018	2017 Q1+ Q2	2017 Q3+ Q4	2018 Q1+ Q2	2018 Q3+ Q4
# of NFP clients Served ³	239	159	152	66*	69	83	66	66*
# of Best Beginning (BB) clients ⁴	2,067	1,586	1,383	1,744*	1,039	705	1,577	N/A
# of NFP clients graduated from the program ⁵	31	23	14	3	7	3	3	NA
Cost ⁺ to Healthy Baby Home Visitation (HBHV) program per client ⁶	\$513 (\$1.2M/ 2,336)	\$557 (\$971,483/ 1,745)	\$586 \$898,999/ 1,535)	\$416 (\$753,737/ 1,810*)	NA*	NA*	NA*	NA*

(-) indicates data not yet available

* indicates year-to-date through 9-23-2018

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

⁺SFY costs/CY people served (Ex. \$/CY2014/ FY2015 people)

STORY BEHIND THE PERFORMANCE

Wyoming State Statute (Wyo. Stat. § 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 have partner to implement the Healthy Baby Home Visitation Program.

A contact is defined as a two-way conversation between a nurse and a potential client where home visiting is explained and offered in person or by phone.

Healthy Baby Home Visitation is delivered by Public Health Nurses using one of two models. Nurse Family Partnership (NFP) is an evidence-based home visiting model, which 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 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.

A third Partners for a Healthy Baby Curriculum Training will be held in Casper September 11, 12, 13, 2018.

Footnotes:

¹ 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 reported from Nurse Family Partnership Efforts to Outcomes (ETO) data system; the time period from program initiation through end of most recent quarter 3 (as of 9-23-18) CY 2018).

³ Quarterly and CY 2018 figures include duplicates as clients are enrolled longer than a quarter.

⁴ A BB client is defined as a client who is not enrolled in NFP and who received at least one BB home visit.

⁵ NFP clients graduate from the program when their child is 2 years old.

⁶ 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

Substance Abuse Prevention Program

Program Description

The Substance Abuse Prevention Program uses an environmental approach to prevent alcohol abuse, opioid abuse, and other drug abuse.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$3,256,311	\$3,060,784	\$2,163,804
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	10%	13%	26%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funded by Federal and Tobacco Settlement Funds.
- Federal Funds include the following grants and cooperative agreements: Substance Abuse Prevention and Treatment Block Grant, Strategic Prevention Framework Partnership for Success, and Prescription Drug Opioid Overdose Prevention.
- Funding reductions and expenditure limits on 600 series passed in the 2017 legislative session resulted in an increase in the percentage of non-600 series funds within this unit.

Program Staffing

- 2.5 FTE positions
- 0 AWEC
- 0 Other

Program Metrics

- 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 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 Fiscal Year 2018, suicide prevention efforts were moved to the Injury Prevention Program.
- The Substance Abuse Prevention Services are authorized by the Substance Abuse Control Plan, Wyo. Stat. § 9-2-2701 as part of a comprehensive, integrated plan.
- Funding for community prevention grants for substance abuse, tobacco, and suicide prevention will go directly to Wyoming counties beginning in SFY 2019, pursuant to Footnote 7 of the 2018 Budget Bill.

Substance Abuse and Suicide Prevention Program

PROGRAM CORE PURPOSE

To reduce adult binge drinking, underage alcohol use, and other drug abuse.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
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%	17.2% (561/5,966) (16%)	16% (511/5,211) (16.3%)	18.4% (486/4,336) (-)	17.7% (653/4,363) (-)	-
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%	27%	32% (48/150) (31%)	38% (56/145) (29%)	29% (29/100) (28%)	-	-
Opioid and Other Drug # of overdose deaths from prescription, illicit, and unspecified drugs ⁴	N/A	45	107	95	94	58	-

(-) Indicates data not yet available

¹ Data from the Behavioral Risk Factors Surveillance System (BRFSS)

² Data from the Prevention Needs Assessment (PNA)

³ Data from the National Highway Traffic Safety Administration (NHTSA)

⁴ Data from Wyoming Vital Statistics Services (VSS)

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Beverage Server Trainings ⁵	3,234	3,547	3,158	2,668	3,496	1,069	1,599	1,411	2,085
Alcohol Compliance Checks No Infractions	85% 1,033/ 1,215	86.5% 1,073/ 1,240	86% 1,213/ 1,410	85.4% 1,050/ 1,230	-	N/A*	N/A*	N/A*	N/A*
# of naloxone (Narcan®) doses distributed	N/A	N/A	N/A	N/A	727	N/A	N/A	190	537
# of individuals trained in opioid overdose response	N/A	N/A	N/A	N/A	733	N/A	N/A	400	333
EFFICIENCIES									
Prevention Needs Assessment Survey, cost per school district	\$6,353.62 (\$285,913/ 45)	-	\$7,266.67 (\$283,400/ 39)	-	\$6,912.20 (\$283,400 / 41)	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

⁵ Data from the Prevention Intervention Planning and Reporting (PIPR) system

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)

Efficiency

- Monitoring the cost per school district participating in the Prevention Needs Assessment Survey. Participation in the survey began decreasing, resulting in a loss of some county data. Since the 2016 survey, to increase school districts participation, the SAPP modified the survey to better accommodate school schedules resulting in an increase of six districts participating and a decrease in cost per school district.

Current Efforts

- The SAPP 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 SAPP 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
- Wyoming participated in the Youth Risk Behavior Surveillance System (YRBSS) from 1995-2015. Due to Legislative action in the 2016 Session (Footnote 3 to Section 206 of Senate Enrolled Act No. 19), the state was restricted from conducting the YRBSS so this data is no longer collected in Wyoming. Underage alcohol use percentages will be taken from the PNA, which is Wyoming specific, for which there is no national comparison.

Tobacco Prevention & Control Program

Program Description

The Tobacco Prevention and Control Program utilizes a science-based approach to develop comprehensive tobacco prevention and tobacco cessation treatment programs in Wyoming.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$5,234,969	\$4,670,579	\$3,822,073
People Served	586,102	584,910	579,315
Cost per Person	NA	NA	NA
Non-600 Series*	45%	45%	81%

* 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: 6% State General Funds; 22% Federal Funds, 72% State Tobacco Funds.
- Amounts above do not reflect administrative costs (100-500 series)
- During the 2017 legislative session, funding reductions and expenditure limits on 600 series were passed resulting in an increase in the percentage of non-600 series funds within this unit.

Program Staffing

- 2.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Adult smoking rates (18.7 %, 2017 Behavioral Risk Factor Surveillance System (BRFSS))
- Youth smoking rates (12%, 2016 Prevention Needs Assessment (PNA))
- Exposure to secondhand smoke in workplaces (93% of employed adults report smoking is never allowed in indoor areas of their workplace, 2017 Adult Tobacco Survey (ATS))
- In FY2018, there were 3,815 enrollments in the Wyoming Quit Tobacco Program with a quit rate of 31% for Nicotine Replacement Therapies (NRT) and 44% for Chantix.

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.
- Wyo. Stat. § 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.
- Funding for community prevention grants for substance abuse, tobacco, and suicide prevention will go directly to Wyoming counties beginning in SFY 2019, pursuant to Footnote 7 of the 2018 Budget Bill.



Tobacco Prevention & Control Program

PROGRAM CORE PURPOSE
To reduce tobacco use in Wyoming.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of Wyoming employed adults surveyed who report that smoking is never allowed in indoor areas of their workplace ¹	92%	94%	91%	91%	*	93% (preliminary)	*
% of Wyoming adults surveyed who currently smoke ² (national average)	18.5%	17.1%	19.5% (18.1%)	19.1% (17.8%)	18.9% (17.1%)	18.7% (-)	-
% of Wyoming high school students surveyed who smoked cigarettes on one or more of the past 30 days ^{3,4} (national average)	11%	11%	16% ⁶ (-)	15.7% ² (11%)	12% ⁶ (-)	*	-

(-) Indicates data not yet available

* Intervening years between survey dates, for which there is no data

¹ Data from the Adult Tobacco Survey (ATS)

² Data from the Behavioral Risk Factor Surveillance System (BRFSS)

³ Data for SFY 2015 and before are from the Youth Risk Behavior Surveillance System (YRBSS)

⁴ Data for SFY 2016 forward are from the Prevention Needs Assessment (PNA), which does not have a national comparison.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4	
OUTPUTS										
WQTP Enrollment ⁵ (Wyoming Quit Tobacco Program)	Total	2,552	2,571	4,734	3,779	3,815	1,663	2,116	1,397	2,418
	Pregnant women	36	32	27	17	24	7	10	8	16
	American Indian Commercial Tobacco Program	-	-	8	28	16	10	18	7	9
# of PHN Referrals ⁵	20	46	44	51	27	23	28	21	6	
Media Impressions ⁶ (mass, digital, social)	15,707	7383	32.3M	27.5M	48.7M	*	27.5M	34.6M	14.1M	
# of policies implemented in communities	22	17	16	11	5	8	3	3	2	
EFFICIENCIES										
Average cost per WQTP enrollee	\$357 (913,273/2,552)	\$355 (913,273/2,571)	\$193 (\$913,273/4,743)	\$242 (\$913,273/3,779)	\$239 (\$913,273/3,815)	NA*	NA*	NA*	NA*	

* Intervening years between survey dates, or periods for which there is no data

(-) Data is currently unavailable

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

⁵ Data from National Jewish Health, WQTP enrollment reports

⁶ Data from Warehouse Twenty-One, media analytics and metrics reports

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 2017 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 (83%) and restaurants (79%). Additionally, 54% of adults support smoke free laws for casinos & clubs and 52% support smoke free bars. (Data from the 2017 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.
- Wyoming participated in the Youth Risk Behavior Surveillance System (YRBSS) from 1995-2015. Due to Legislative action in the 2016 Session (Footnote 3 to Section 206 of Senate Enrolled Act No. 19), the state was restricted from conducting the YRBSS so this data is no longer 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:

- The WQTP has been able to sustain offering Chantix for free since February 2016. The quit rate for enrollees who used Chantix is 44%, and for those who use NRT the quit rate is 31%.
- Protocols specific to Native Americans, pregnant women, and those with behavioral health issues (anxiety, depression) to address disparities in smoking rates in these populations.

Current Efforts:

- The significant increase in media impressions in 2016-2018 is due to strategic marketing utilizing digital, radio, and newspaper media to promote the WQTP and free Chantix. Media has been successful in increasing utilization of the WQTP.
- 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. Medicaid is currently referring newly enrolled Medicaid recipients who use tobacco to the WQTP.
- 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.
- The Stay Fresh media campaign began in March 2018. This is a youth centered campaign that focuses primarily on e-cigarette use and vaping, but also addresses other tobacco products.
- A secondhand smoke campaign to focus on parents who smoke in front of their children began in October of 2018.



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 healthcare 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

	2016	2017	2018
Total Program Cost	\$2,189,710**	\$1,764,517**	\$1,696,105**
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	12.4%	14%	12%

*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.

Program Cost Notes

- The 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 V Block Grant (\$3 for every \$4 of grant funds); state match must remain at 1989 levels or higher.
- The program partners with Public Health Nursing (PHN) to jointly implement the Healthy Baby Home Visitation (HBHV) Program.

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 participated in the NewSTEPS 360 quality improvement initiative from 2016-2018 to improve timeliness in newborn screening, and continues to collaborate with Colorado.
- Through an ongoing partnership with the Women, Infants and Children (WIC) and Chronic Disease Prevention programs, the program is committed to sustaining Wyoming's breastfeeding success through implementation of the Wyoming 5-Steps to Breastfeeding Success program, a program designed for Wyoming hospitals to promote and improve breastfeeding initiation and duration.
- In December of 2017, the WIHP and a group of stakeholders voted to establish the Wyoming Perinatal Quality Collaborative, which will implement quality improvement projects focused on perinatal health across the state.
- The Newborn Screening Program revised the rules under Wyo. Stat. §§ 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	CY 2017
% and # of births that occur in Wyoming 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	97.8% 6,135/ 6,273
% 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	61.3% 4,232/ 6,904
% 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	13.6% 939/ 6,904
% 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	81% 51/63
% 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	8.9% 616/ 6,904

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2017 Q1+Q2	SFY 2017 Q3+Q4	SFY 2018 Q1+Q2	SFY 2018 Q3+Q4
OUTPUTS									
# of pregnant women enrolled in the Wyoming Tobacco Quit Line	36	32	27	17	36	6	11	14	22
# of individuals attending Certified Lactation Counselor training sponsored by MCH ²	20	6	19	25	12	0	25	2	10
# of women enrolled in Maternal High Risk (MHR) ³ Program	28	22	28	20	18	14	7	9	9
# of infants enrolled in Newborn Intensive Care (NBIC) ³ Program	37	54	62	49	68	31	18	27	41
EFFICIENCIES									
Cost per first newborn screen (# of first screens completed) ⁴	\$70.57 (6,868)	\$74.21 (6,932)	\$81.90 (6,786)	\$84.20 (6,298)	\$95.34 (5,978)	N/A*	N/A*	N/A*	N/A*
Cost per first & second newborn screens (# of first and second screens completed) ⁴	\$37.63 (12,879)	\$39.50 (13,018)	\$43.40 (12,812)	\$43.99 (12,055)	\$50.48 (11,291)	N/A*	N/A*	N/A*	N/A*

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

STORY BEHIND THE PERFORMANCE

- The Women & Infant Health Program (WIHP) provides leadership and support for the design, implementation and evaluation of state and local policies and programs that address the health needs of women and infants; promotes healthy development within the women and infant populations, including mothers and infants with special health care needs; and promotes all MCH 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 In August 2017, MCH sponsored CLC training for 15 public health nurses who had no previous CLC training. Ongoing support of CLC training for public health nurses remains a priority in MCH, as it increases access to vital breastfeeding support for new mothers in all 23 Wyoming Counties.
- ³ SFY Totals are unduplicated. Duplicates may be present between quarters, as individuals can be enrolled more than one quarter.
- ⁴ A second screen between 7-14 days of life is highly recommended and does not incur any additional costs to the program when performed. The amount the WDH charges providers for the transport and processing of newborn screens increased 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 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

	2016	2017	2018
Total Program Cost	\$10,336,967	\$9,590,893	\$8,830,942
People Served**	16,974	15,938	13,517
Cost per Person	\$608.99	\$601.76	\$653.32
Non-600 Series*	16.1%	17.4%	17.2%

** People served is an unduplicated count of individuals served in the federal fiscal year; current number only through June 2018.

* 600 series is defined as direct service contracts

Program Cost Notes

- Additional direct service expenditures not included in the 600 series equal \$4,644,863 for 2016-2018 combined.
- Total FY19-20 Budget of \$24,268,397 includes 6% GF, 73% FF, and 21% infant formula rebates.

Program Staffing

- 44.4 Total FTE (7.9 state office, 36.5 local agencies)
 - 38 state positions: 14 FT; 12 PT; 12 AWEC
 - 12 county positions: 1 FT; 11 PT
 - 9 hospital positions: 4 FT; 5 PT

Program Metrics

- From 2016-2018, an average of 9,644 pregnant, postpartum, and breastfeeding women, infants, and young children were served each month by WIC.
- In federal fiscal year 2018 (through June 2018), 13,517 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.
- Seventy-nine 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 Program Name

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 (up to age 5) by providing nutritious supplemental food, nutrition education, breastfeeding support, and healthcare referrals.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of survey respondents who met with a breastfeeding peer counselor and found it helpful	93%	92%	91.7% (309/ 337)	91.6% (1,024/ 1,118)	91.3% (1,220/ 1,336)	92.8% (1,106/ 1,192)	90.9% (1,129/ 1,241)
% and # of survey respondents who indicate that WIC helped them eat more vegetables and fruits	83%	80%	87.7% (615/ 701)	82% (1,790/ 2,184)	80% (2,121/ 2,652)	84% (1,949/ 2,320)	73.4% (1,830/ 2,493)
% of cash value benefits spent on fresh fruits and vegetables by WIC participants	71%	73%	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)	73.6% (\$546,154/ \$741,778)
% of WIC infants who were ever breastfed (initiation) ¹	81.9%	81.9%	N/A	N/A	79%	80%	81%
% of WIC infants who are exclusively breastfeeding at 3 months ²	46.2%	46.2%	N/A	N/A	33%	34%	33%

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Average # of women served/month ³	2,774	2,620	2,590	2,363	2,120	2,440	2,287	2,203	2,037
Average # of children (ages 1-5) served/month ³	5,775	5,449	5,162	5,036	4,671	5,076	4,996	4,803	4,540
Average # of infants (ages 0-1) served/month ³	2,620	2,462	2,498	2,396	2,097	2,485	2,307	2,158	2,036
Average # of nutrition education contacts/month ⁴	2,502	3,050	3,071	3,171	2,874	3,166	3,176	2,998	2,751
Average # of referrals documented/month ⁵	758	973	1,303	2,835	2,891	2,855	2,815	3,028	2,754
EFFICIENCIES									
Average monthly food cost/participant/month	\$49.29 (\$550,528/ 11,169)	\$47.93 (\$504,844/ 10,531)	\$48.24 (\$494,488/ 10,249)	\$47.16 (\$461,985/ 9,795)	\$47.91 (\$425,798/ 8,888)	\$47.26 (\$472,703/ 10,001)	\$47.06 (\$451,266/ 9,589)	\$48.12 (\$440,876/ 9,163)	\$47.69 (\$410,721/ 8,613)
Average nutrition education cost/participant/month ⁶	\$5.72 (\$63,008/ 11,016)	\$5.49 (\$57,178/ 10,420)	\$5.51 (\$56,216/ 10,197)	\$5.39 (\$51,697/ 9,599)	\$5.24 (\$45,287/ 8,645) {through 8/31/18}	\$4.90 (\$48,141/ 9,820)	\$5.89 (\$55,254/ 9,378)	\$4.36 (\$38,783/ 8,885)	\$6.16 (\$51,791/ 8,404) {through 8/31/18}

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 and then stabilize 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 and then stabilize over time as WIC staff utilizes new data system reporting.

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.



Wyoming Cancer Program

Program Description

The Wyoming Cancer Program provides screenings, advocacy, and education to Wyoming residents. 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 outreach and education efforts across the state and promotes the screening programs.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$3,461,627	\$2,994,968	\$2,533,901
People Served	1,733	1,872	2,016
Cost per Person	\$1,997	\$1,600	\$1,257
Non-600 Series*	62%	51%	59%

* 600 series is defined as direct service contracts.

Program Cost Notes

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

Program Staffing

- 10 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The WBCCEDP began in 1997. Since then, over 9,277 women have received clinical services and 389 breast cancers, 46 cervical cancers, and 650 high-grade cervical pre-cancers have been detected.
- WCCSP began in 2007. Since then, 4,481 Wyoming residents have received colonoscopies; 43.5% had polyps removed, 24.0% had pre-cancerous polyps, and 80 had colon cancer.
- 2011/12 was the first year of the colorectal 10-year/re-screen policy. Since 2011, 601 clients have been re-screened; 60.0% had polyps removed; 32.5% had pre-cancerous polyps; and 2% had colon cancers.

Events that have Shaped this Program

- The Program works under the Wyoming Cancer Control Act, Wyo. Stat. § 35-25-203 through 35-25-205.
- Wyoming's cancer screening rates are low: 61.0% for breast cancer screening (U.S. 72.5%); 70.2% for cervical cancer screening (U.S. 75.2%); and 65.2% for colorectal cancer screening (U.S. 70.4%) (Behavioral Risk Factor Surveillance System [BRFSS] 2016).
- WBCCEDP must comply with certain Centers for Disease Control (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.



Wyoming Cancer Program

PROGRAM CORE PURPOSE

The core purpose of the Wyoming Cancer Program is to provide eligible Wyoming residents with screening assistance through the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP) and the Wyoming Colorectal Cancer Screening Program (WCCSP), and education and outreach to all Wyoming residents through the Wyoming Comprehensive Cancer Control Program (WCCCP).

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% of women aged 40 years and older who received a mammogram in the last two years statewide ² (national median)	78.1%	x	65.2% ¹ (73.0%)	x	61% ¹ (72.5%)	x	-
% of women who have received a Pap test in the last 3 years aged 21 and older statewide ² (national median)	78.5%	x	77.2% ¹ (78.5%)	x	70.2% ¹ (75.2%)	x	-
% of people ever having an endoscopy aged 50 and above statewide ² (national median)	69.3%	x	61.8% ¹ (69.3%)	x	65.2% ¹ (70.4%)	x	-
% of first time screening through the program with positive adenoma tissue	25%	20%	37.1% (136/367)	36.6% (110/300)	30.1% (102/339)	25.8% (55/213)	20.9% (70/334)
% of positive Fecal Immunochemical Tests	7%	7%	N/A	9.6% (9/94)	26.9% (24/89)	26.9% (60/223)	15.0% (56/373)

(x) Indicates data not collected as data is available every two years through BRFSS

(-) Indicates data not yet available

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

¹ Data is a weighted measure and therefore the numerator and denominator do not equal the percentage.

² Data from the Behavioral Risk Factor Surveillance Survey (BRFSS) is on a calendar year and available every other year.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of women served through the program	724	390	391	534	545	255	279	260	285
# of clients who received a colonoscopy through the program	370	305	345	348	355	193	155	198	157
# of Fecal Immunochemical Tests distributed through program	N/A	97	153	350	628	137	213	361	267
EFFICIENCIES									
% of clients whose time from breast cancer screening to diagnosis > 60 days	9.7% (10/103)	7.9% (6/76)	5.1% (4/79)	10.1% (7/69)	-	N/A*	N/A*	N/A*	N/A*
% of clients whose time from cervical cancer screening to diagnosis > 90 days	13% (3/23)	18.2% (2/11)	12.5% (1/8)	9.1% (1/11)	-	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

- All numbers for testing are state fiscal year-to-date as of June 30, 2018. Providers have one year from the date of service to bill the program, as per federal rule. Therefore, the data for the screening programs will continue to increase over the next year.
- The program reimburses for screening services at the Medicaid/Medicare rates.
- In 2011, amendment to Wyo. Stat. § 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 \$4,000,000 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.
- WBCEDP 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 the FITs.

Youth and Young Adult Health

Program Description

The Youth and Young Adult Health Program (YAYAHP) ensures 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, to increase access to quality and preventive health care, and to promote healthy development within the youth and young adult population, including adolescents with special healthcare needs.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$268,135.55	\$232,883.60	\$252,483.99
People Served*	3,133	2,781	9,776
Cost per Person	\$85.59	\$83.74	\$25.83
Non-600 Series**	41.8%	52.3%	90.8%

* People served are those who received direct services from the program and was previously reported as the total population ages 12-24.

**600 series is defined as direct service contracts.

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)
- The increase in people served is due to the Title V work with pilot clinics and expanding the PREP program.

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.
- The Wyoming Teen Birth Rate has significantly decreased from 46.1 births per 1,000 females in 2006 to 24.8 births per 1,000 in 2017. However, the Wyoming teen birth rate still remains higher than the U.S. rate of 18.8 births per 1,000 in 2017.
- Medicaid Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) data indicates that only 29.6% of Medicaid eligible adolescents (10-20 years old) received a recommended EPSDT screening in 2017.
- In 2016, 2,425 high school and college students participated in evidence-based, sexual violence prevention programming through the RPE Program; this was an increase from 622 high school and college students in 2015.

Events that have Shaped this Program

- Maternal and Child Health (MCH) Unit priorities for 2016-2020 were identified by the MCH Health Needs Assessment and include adolescent-specific priorities of Healthy and Safe Relationships, Preventive and Quality Care, and Promoting Healthy Development within the youth and young adult population.
- The Youth and Young Adult Health Program has established collaborations with several local and state partners.



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	CY2013	CY2014	CY2015	CY2016	CY2017
% middle and high school students reporting no alcohol use in last 30 days ¹ (PNA)+	N/A	79%	N/A	78.6%	N/A	80.2%	N/A
% and # of Wyoming Personal Responsibility Education Program (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 (WyPREP post-assessment)*	75%	78%	N/A	N/A	70% (262/376)	75% (340/473)	67% (382/571)
Rate of births (per 1,000) among 15 - 19 year old girls ³ (WY & National Vital Statistics Service) (national rate)	28	25	29.8 (26.6)	30.3 (24.2)	29.0 (22.3)	26.2 (20.6)	24.8 (18.8)
% and # of Medicaid eligible adolescents (10-20 years) who received at least one ESPDT screen ⁴ (Medicaid)** (national average)	32%	32%	26.3% (5,448/ 18,586) (49.1%)	27.3% (5,380/ 19,689) (45.6%)	26.3% (5,310/ 20,218) (46.1%)	30.5% (5,546/ 18,163) (45.1%)	29.6% (5,008/ 16,914) (46.1%)
% 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	16.5% (17.9%)	N/A

(-) indicates data not yet available
 N/A indicates data not available
 N/A* indicates data not available due to new metric

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of youth and young adults participating in evidence-based programming through the Rape Prevention Education (RPE) grant ⁶	N/A	622	2,425	2,080	-	N/A*	N/A*	N/A*	N/A*
# of communities (city/town) participating in comprehensive reproductive health education (WyPREP) ²	N/A	N/A	6	8	10	N/A*	N/A*	N/A*	N/A*
# of clinics serving adolescents participating in quality improvement projects	N/A	N/A	N/A	0	4	N/A	N/A	4	4
EFFICIENCIES									
Dollars spent / Youth receiving comprehensive reproductive health education ²	N/A	N/A	N/A	\$829.00 \$483,830 /538	\$74.79 \$73,296/ 980	N/A*	N/A*	N/A*	N/A*
(-) Indicates data not yet available N/A indicates data not available N/A* indicates data not available due to new metric									

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 Maternal and Child Health (MCH) Unit 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 related 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) in Wyoming. WyPREP 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. This measure is only among participants that had parental consent and student assent to completing the WyPREP Post Survey.

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 to improve EPSDT rates for Wyoming youth and young adults. The YAYAHP is currently working with pilot clinics across the state on quality improvement efforts in increase youth friendliness in clinics.

⁵From the National Survey of Children's Health. This measure was changed in 2016 and will now be completed 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 communities to implement primary prevention activities.

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 2016	SFY 2017	SFY 2018
Total Program Cost	\$818,516	\$876,034	\$624,940
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	17%	14%	24%

*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 (\$512,373)
- Small Rural Hospital Improvement Program (SHIP) Grant, 100% FF (\$131,789)
- Community Assessment, 100% SGF (\$227,732)
- Primary Care Support Act (PCSA), 100% SGF (\$1.2M) total received for program to date
- Reduction in expenditures from SFY 2017 to SFY 2018 is due to primary care support payouts, FLEX grant carry-over, and the timing of payments made by each funding source.

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 2018 Target	FFY 2019 Target	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017
% and # of CAHs meeting minimum requirement in the Medicare Beneficiary Quality Improvement Program (MBQIP) ¹	100% 16/16	100% 16/16	87.5% 14/16	93.75% 15/16	93.75% 15/16	93.75% 15/16	100% 16/16
% of CAHs reporting Emergency Department Transfer Communication measures (EDTC) ^{1,2}	100% 16/16	100% 16/16	N/A	62.5% 10/16	37.5% 3/16	81.25% 11/16	100% 16/16
% of CAHs reporting HCAHPS ^{1,2}	100% 16/16	100% 16/16	N/A	81% 13/16	75% 12/16	86.7% 13/16	86.7% 13/16
% of CAHs reporting Patient Safety ^{1,2}	100% 16/16	100% 16/16	N/A	N/A	75% 12/16	75% 12/16	86.7% 13/16
% of CAHs reporting Out Patient ^{1,2}	100% 16/16	100% 16/16	N/A	N/A	38% 6/16	44% 7/16	86.7% 13/16
% of CAHs reporting financial data to QHi ^{1,2}	87.5% 14/16	100% 16/16	N/A	N/A	18.75% 3/16	18.75% 3/16	37.5% 6/16

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)	7 (64)	3 (33)	3 (38)	6 (58)	1 (6)
# of CAHs participating in annual Learning and Planning event ^{3,4}	5	6	4	5	1 (7)	5	0	0	1 (7)
WYQIM website # of resources (# of visitors) ^{3,4}	N/A	N/A	N/A	18 (185)	18 (139)	N/A	18 (185)	18 (139)	49 (185)
# of CAHs participating in Patient Safety Culture Survey ^{3,4}	N/A	N/A	5	9	9	5	0	9	9
# of CAHs utilizing QHi benchmarking database ^{3,4}	6	6	5	7	12	7	0	7	12
# of CAHs participating in financial improvement projects ^{3,4}	N/A	N/A	6	6	7	6	0	7	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*	\$16,256	N/A*	N/A*	\$5,750	-
Average cost per CAH participating in QI initiatives ^{3,4}	N/A	\$4,889	\$7,206*	\$4,725*	\$5,830	N/A*	N/A*	\$5,830	-
Cost per CAH to participate in QHi ^{3,4}	\$2,267	\$2,200	\$1,500*	\$1,500*	\$2,100	N/A*	N/A*	\$2,100	-
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 17 for Flex began September 1, 2017 and will end August 31, 2018. For FFY18, HRSA is extending funds for a fourth year. 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. Sublette County is pursuing building a small rural hospital in the next two years that will be designate a CAH. 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 three 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. Wyoming's 16 CAHs have a signed Memorandum of Understanding (MOU). The percentage is based on the number of CAHs reporting in all four quarters.
3. In the area of quality improvement for FFY 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 FFY 16 WY Flex funds were used to assist seven CAHs with QHi, four with HCAHPS, and nine CAHs with PSC. In FFY17 7 CAHs utilized funds for quality improvement activities. In FFY 15 six CAHs received Flex reimbursement for financial improvement and in FFY 16 eight CAHs were reimbursed for financial improvement initiatives. Wipfli, LLP conducted a statewide financial assessment of Wyoming's 16 CAHs in 2017 and in FFY17 7 CAHs are utilizing funds for financial improvement activities.
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 individual technical assistance for reporting and developing QI and F/OI projects, and hosts an annual WY Flex stakeholder meeting.

Community Services Program

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.

Program Expenditures and People Served

	FFY 2016	FFY 2017	FFY 2018**
Total Program Cost	\$2,955,969	\$3,198,938	-
People Served	22,606	31,949	-
Cost per Person	\$130.76	\$100.13	-
Non-600 Series*	6%	8%	-

* 600 series is defined as direct service contracts.

** Data for FFY2018 not available until 03/2019

Program Cost Notes

- 100% federal funding
- Funding changes annually due to federal formula

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 the CSP.
- The CSP acquired a statewide CSBG case management and data system in FFY18 that captures data that is outcome driven and can be validated for accuracy.

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, and other factors.
- Each county makes funding decisions through a Tripartite Board which consists of one-third elected officials, one-third members of the local community, and one-third representatives of the low-income population. Comprehensive Community Needs Assessments are conducted once every 3 years and public hearings are held annually regarding CSBG funding.
- Recipients of services funded by CSBG must meet financial eligibility of 125% of the Health and Human Services Federal Poverty Rate.



Community Services Program

PROGRAM CORE PURPOSE

The purpose of CSP is to support services for individuals with low incomes that alleviate conditions of poverty.

OUTCOMES

Performance Metric	FFY 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018 ²
% of emergency rent/ mortgage assistance provided (# of individuals helped / # who requested assistance) ¹	>30%	>85%	26% (2,002/ 7,797)	33% (1,537/ 4,647)	44% (753/ 1,708)	57% (1,400/ 2,472)	N/A
% of emergency medical care provided (# of individuals helped / # who requested assistance) ¹	>80%	>95%	78% (1,341/ 1,726)	77% (1,941/ 2,531)	73% (1,880/ 2,599)	96% (910/ 951)	N/A
% of emergency food provided (# of individuals helped / # who requested assistance) ¹	≥99%	≥99%	99% (14,313/ 14,526)	99% (6,002/ 6,047)	94% (6,213/ 6,673)	94% (11,424/ 12,265)	N/A
% of Wyoming's eligible families receiving CSBG services ¹	>30%	>60%	28% (7,141/ 25,120)	61% (12,578/ 20,803)	53% (10,972/ 20,803)	40% (6,339/ 15,677)	N/A

N/A indicates finalized data not available until March 2019

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
% of persons served who were homeless ¹	N/A**	N/A**	0.07% (1,476/ 22,606)	0.06% (1,771/ 31,949)	N/A	N/A*	N/A*	N/A*	N/A*
% of Tripartite Boards meeting 75% or more of the CSBG Organizational Standards ³	63% (10/16)	56% (9/16)	63% (10/16)	0% (0/15)	N/A	N/A*	NA*	N/A*	N/A*
% of service providers conducting activities in top 3 areas of greatest need according to Needs Assessment ⁴	N/A**	N/A**	56% (38/68)	68% (42/61)	N/A	N/A*	N/A*	NA*	N/A*
EFFICIENCIES									
Cost per person	\$128.20 (\$3,882,241 /30,282)	\$131.50 (\$3,271,112 /23,402)	\$130.76 (\$2,955,969 /22,606)	\$100.13 (\$3,198,938 /31,949)	N/A	N/A*	N/A*	N/A*	N/A*

N/A indicates finalized data not available until March 2019

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

N/A** indicates data not available due to the creation of 2 new metrics

STORY BEHIND THE PERFORMANCE

1. The Community Services Block Grant (CSBG) services and activities are conducted in all 23 counties and on the Wind River Reservation to address emergency services, employment, health, housing, and income management, linkages among service providers, nutrition, and self-sufficiency. Ninety percent of CSBG funding is distributed directly to communities to assist low-income individuals and families and to empower them to move towards self-sufficiency.

Employment Example: In FFY17, there were 7,123 participants with low-incomes who received services in the CSBG Network through employment initiatives which reduced or eliminated barriers to initial or continuous employment, acquired a job, obtained an increase in employment income, or achieved “living wage” employment and benefits.

Independent Living Example: In FFY17, there were 6,368 individuals with low-incomes who received services from the CSBG Network and secured or maintained an independent living situation as a result.

Emergency Assistance Example: In FFY17, there were 26,589 persons/families with low-income who received emergency assistance that included emergency food, medical, and housing.

On performance metric % of emergency rent/mortgage assistance, there was an increase from 44% to 80% due to an increase in requests for assistance.

While the data is also showing a decrease in the number of people with of low-income and/or homeless receiving services throughout the state. This could be due to the state office working more with the eligible entities on having more accurate data than the year before.

2. All metrics are reported on a FFY starting October 1st and ending September 30th. CSP data is not finalized and reported to the Office of Community Services (OCS) until the March following the end of the previous FFY.
3. In 2015, OCS developed CSBG Organizational Standards for Tripartite Boards to provide a foundation of organizational capacity for all CSBG Eligible Entities across the nation. In FFY 2015 an Organizational Standard Self-Assessment Survey was sent out to the eligible entities in Wyoming. They were not required to provide documentation supporting that the standard was met. In FFY 2017, the eligible entities were required to provide documentation via uploading supporting documents for review by the state office. The reviews showed that the Tripartite Boards were not meeting the minimally required standards and feedback of the review was provided to each grantee. This why there is a significant difference between 2016 data and 2017 data. Technical assistance is being offered to the Tripartite Boards in order meet the minimally required standards.
4. Eligible entities are required to have a CSBG Community Needs Assessment (CNA) completed every three years. These CNAs are used by the Tripartite Boards to determine what community needs can and will be addressed through the use of CSBG funds. The Tripartite Board then puts out a request for application from community agencies who provide services that would meet the identified needs.

Healthcare Preparedness Program

Program Description

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

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$836,173*	\$843,452	\$837,538
People Served	586,102	584,910	579,315
Cost per Person	\$1.43	\$1.44	\$1.46
Non-600 Series**	100%	100%	100%

* SFY 2016 updated to include carry-over funds expended in SFY 2017

** 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, Assistant Secretary for Preparedness & Response (ASPR) for FY18
- 10% match requirement primarily from State General Fund positions and hospital and EMS personnel

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- HPP supports five healthcare coalitions which, in turn, assist over 180 healthcare facilities throughout Wyoming.
- All five healthcare coalitions met all contract deliverables during SFY18.
- HPP oversees the Hospital Available Beds for Emergencies and Disasters (HAVBED) and the Wyoming Activation of Volunteer in Emergencies (WAVE) programs.
- ASPR 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

- 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 was enacted in November 2017.



Healthcare Preparedness Program (HPP)

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of essential member agencies participating in a healthcare coalition (HCC) ¹	75%	75%	52% (80/154)	58% (84/144)	62% (84/136)	74% (95/129)	74% (99/133)
% and # of other potential member agencies participating in a HCC ²	25%	30%	6% (9/157)	9% (15/171)	17% (31/180)	17% (31/181)	22% (55/255)
% and # of hospital member agencies which achieve full NIMS compliance ^{3,4}	75%	95%	N/A	11% (3/27)	26% (6/23)	58% (15/26)	88% (23/26)
% and # of hospital and EMS member agencies that exercised their medical surge plan	50%	75%	N/A	N/A	N/A	68% (36/53)	72% (41/57)

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY17 Q1 & Q2	SFY17 Q3 & Q4	SFY18 Q1 & Q2	SFY18 Q3 & Q4
OUTPUTS									
Awardee-Level Direct Cost ^{5,6}	N/A	N/A	\$91,263	\$109,558	\$96,260	\$54,757	\$54,802	\$60,728	\$35,532
EFFICIENCIES									
Awardee-Level Direct Cost Ratio ^{5,6}	N/A	N/A	10.9%	13.0%	12.8%	23.3%	9.4%	19.0%	8.1%
Percent of Grant Funds Expended ⁷	N/A	N/A	99.97%	99.75%	92.3%	27.8%	69.0%	38.2%	52.6%

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

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.
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. Awardee-Level Direct Cost (ALDC) is defined by the Assistant Secretary for Preparedness and Response as personnel, fringe benefits, and travel. The maximum amount allowed for ALDC is 18% of the award. Awardee-Level Direct Cost ratio is the percentage of Administrative Costs divided by the Total Expense. ALDC ratio must be no more than 15% of the award (calculated at the end of the grant year.)
6. The Healthcare Preparedness Program Coordinator position was vacant three months during SFY 2016. The EMS Supervisor position (0.25 FTE) was removed from the HPP budget during SFY 2018.
7. Percent of grant expended includes any amount expended that was carried over to the following SFY. Unexpended funds from SFY2018 will carry-over and be expended in SFY2019.

Healthcare Workforce Recruitment, Retention, and Development

Program Description

Healthcare Workforce Recruitment, Retention, and Development (HWRRD) supports the recruitment, retention, and development of the healthcare workforce in Wyoming's underserved communities.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$751,497	\$1,009,806	\$980,487
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	16%	14.24%	13.95%

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY18: 67% SGF and 33% FF
- SFY2017 increase in expenditures is 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 Wyoming Healthcare Professional Loan Repayment Program (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 for this program was eliminated for SFY17-18 and 19-20.
- The Research and Explore Awesome Careers in Healthcare (REACH) Program provides grants for hosting educational programs to expose students in grades 5-8 to healthcare careers. Two were hosted in 2018 with 26 participants.
- 2015 was the Wyoming State Loan Repayment Program's (WY-SLRP) first year. Seventeen awards have been issued since 2015 (six physicians, seven physician assistants, and four nurse practitioners).

Events that have Shaped this Program

- Wyo. Stat. § 9-2-118 and 9-2-119 created the WHPLRP in 2005, and Wyo. Stat. § 35-1-1101 created the Wyoming Provider Recruitment Grant Program (PRGP) in 2008. House Bill 88, passed during the 2015 General Legislative Session, increased the maximum allied healthcare professional award under Wyo. Stat. § 9-2-119 and expanded eligibility under PRGP (Wyo. Stat. § 35-1-1101) to non-physicians.
- As a result of agency-wide budget reductions, funding for WHPLRP (100% tobacco settlement funds) was eliminated for SFY17-18 and 19-20, resulting in the loss of approximately 30 awards; funding for PRGP (\$400,000 SGF) was reduced to \$244,000 for SFY17-18 and 19-20, resulting in a reduction of approximately six 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 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. Funding is 50% federal and 50% state matching funds.



Healthcare Workforce Recruitment, Retention, and Development

PROGRAM CORE PURPOSE

To assist Wyoming's medically-underserved communities and safety-net facilities with the recruitment and retention of healthcare professionals.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of loan repayment (LRP) awardees completing obligation (# / # total awards by cohort) ²	≥80%	≥80%	72.7% (8/11)	87.5% (7/8)	90% (9/10)	84.6% (11/13)	81.8% (9/11)
LRP 3-year retention rate (# retained / # respondents by cohort) ³	≥80%	≥80%	89.65% (78/87)	83.33% (15/18)	92.3% (12/13)	66.67% (2/3)	N/A
% and # of retained LRP awardees still accepting Medicare/Medicaid/CHIP (# accepting/ # retained) ³	≥85%	≥85%	98.72% (77/78)	100% (15/15)	91.67% (11/12)	100% (2/2)	N/A
% and # of Provider Recruitment Grant (PRGP) awardees successfully recruited (# recruited/ # awards by cohort) ⁴	60%	60%	50% (2/4)	0% (0/4)	60% (3/5)	60% (3/5)	N/A (- /4)

N/A indicates data not available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Amount awarded (# LRP awards) ¹	\$504,297 (13)	\$670,000 (11)	\$678,000 (12)	\$140,000 (5)	\$160,000 (4)	0	\$140,000 (5)	0	\$160,000 (4)
Amount awarded (# PRGP awards) ⁴	\$200,000 (4)	\$200,000 (4)	\$238,520 (5)	\$235,000 (5)	\$132,447 (4)	0	\$235,000 (5)	0	\$132,447 (4)
# of new candidates sourced ⁵	0	378	686	686	609	441	245	N/A	609
# of candidates placed ⁵	0	4	9	6	15	3	3	8	7
# of new J-1 Visa Waivers ⁶	10	4	10	5	7	N/A	5	N/A	7
EFFICIENCIES									
Average PRGP Reimbursement ⁴	\$42,342	\$42,342	\$47,020	\$46,808	\$41,485	N/A	N/A	N/A	N/A
Average cost per new candidate sourced ⁵	0	\$62.81 (\$23,740 /378)	\$39.25 (\$26,928 /686)	\$45.43 (\$31,165 /686)	\$28.71 (\$17,486 /609)	\$34.60 (\$15,258 /441)	\$64.93 (\$15,907 /245)	N/A	N/A
Average cost per placement ⁵	0	\$8,000 (\$32,000 /4)	\$7,111 (\$64,000 /9)	\$5,333 (\$32,000 /6)	\$5,600 (\$84,000 /15)	\$5,333 (\$16,000 /3)	\$5,333 (\$16,000 /3)	\$6,500 (\$52,000 /8)	\$4,571 (\$32,000 /7)

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 and 2019-2020.

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, 303 loan repayment awards have been issued through both WHPLRP and WY-SLRP. As of the 4th quarter of SFY2018, 273 have either successfully completed or are currently completing their service obligation and requirements. To date, 30 awardees have withdrawn from program participation prior to the first payment or have defaulted on their service obligation or other requirements. 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 to determine the rate of prior awardees still practicing in Wyoming three years after the end of their service obligation. Surveys were not conducted in 2018 due to joining a multi-state retention collaborative that includes a survey function which will allow WY to compare retention to other states and will occur annually for all awardees with a set questionnaire. Numbers reported under outcomes are for each survey year cohort versus overall as stated above. 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, 35 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. Sixteen have been successful at recruiting and the SFY2018 awardees have through February 2019 (SFY2019) 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.

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. This includes two key tasks: ensuring compliance within existing infrastructure and developing new components. To this end, the OEMS oversees various activities, to include the EMS educational system, compliance, investigations, the EMS for children program, the collection of data, and the provision of technical and other assistance to local communities throughout the state.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$1,066,263	\$1,019,384	\$1,067,827
People Served	586,102	584,910	579,315
Cost per Person	\$1.82	\$1.74	\$1.84
Non-600 Series*	100%	100%	98%

* 600 series is defined as direct service contracts

Program Cost Notes

- 90% General Funds
- 10% Federal Funds

Program Staffing

- 7 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. 45 EMT courses were provided in SFY2018.
- 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 2017 recorded approximately 76,177 requests for service statewide (46,444 were from 911) (approximately nine 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. 33-36-101 and 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 Emergency Medical Services program works to enhance Wyoming's EMS system through programmatic and regulatory activities, including data collection, rule development/enforcement, and technical assistance, all aimed at ensuring properly equipped ambulances and competent staff are available statewide to respond to and appropriately transport patients when needed.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of services reporting in WATRS ¹	90%	90%	82% (63/77)	91% (77/85)	89% (91/102)	89% (92/103)	93% (95/102)
% and # of services submitting complete data ²	90%	90%	86% (54/63)	84% (65/77)	76% (69/91)	87% (78/92)	81% (77/95)
% of chute times <10 minutes ³	>95%	>95%	90% (22,564/ 24,945)	84% (42,542/ 50,919)	91% (41,992/ 46,145)	92% (40,949/ 44,510)	96% (43,518/ 45,444)
% of response times ≤ 8:59 minutes ⁴	60%	60%	52% (13,095/ 24,945)	43% (22,068/ 50,919)	52% (23,995/ 46,145)	51% (22,700/ 44,510)	64% (29,027/ 45,444)

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Supported EMT classes	27	19	31	34	45	9	25	13	32
WATRS records (911 only)	45,897	50,952	50,437	47,611	49,580	23,897	23,714	25,224	24,356
Completed records (911 only)	35,989	47,436	46,145	44,510	45,444	22,556	21,954	23,568	22,876
WATRS trainings	9	16	20	16	4	7	9	2	2
WATRS customer support (minutes)	9,466	11,758	24,744	16,620	13,878	8,940	7,680	7,206	6,672
EFFICIENCIES									
Cost per successful student	\$184 (\$33,525/ 182)	\$122 (\$32,988/ 270)	\$218 (\$55,755/ 255)	\$77 (\$21,100/ 273)	\$85 (\$27,081/ 318)	\$43 (\$4,800/ 111)	\$100 (\$16,300/ 162)	\$35 (\$5,597/ 124)	\$111 (\$21,484/ 194)
Class completion rate	69% (182/262)	87% (270/322)	87% (255/294)	82% (273/334)	87% (318/367)	89% (111/125)	78% (162/209)	86% (124/145)	87% (194/222)

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 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, maintain 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 the WATRS and began tracking the completeness of reporting within the system. This validity report does not measure the accuracy of the data that is entered; only whether or not data was entered into a field. The accuracy of reporting will continue to be a goal of the OEMS.

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

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

Office of Health Equity

Program Description

The Office of Health Equity (OHE) serves as the Public Health Division's (PHD) central point for the assistance, expertise, and exchange of information related to health equity.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$137,420	\$90,072	\$90,072
People Served	1,666*	1,306*	629*
Cost per Person	\$82	\$69	\$143
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 2018

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Priorities for 2018: (1) Education on health equity for PHD staff and (2) Education and implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.
- 100% 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, and 27 in 2017-2018.
- Program utilization of interpreting services increased from 79 calls in SFY 2016 to 143 calls in SFY 2017 and 569 calls in SFY 2018.

Events that have Shaped this Program

- 2013: PHD Strategic Map listed "Promote Health Equity and Health Literacy" as a foundational element.
- 2014: Focus for program altered from engagement with external partners to training of internal PHD staff and programmatic support for PHD programs. Change occurred in reaction to the loss of a former grant focused on external efforts; Wyoming no longer receives the federal State Partnership Grant.
- 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 began.
- 2017: Health Equity course required for all PHD staff.
- 2017: PHD staff required to have a health equity goal performance measure.
- 2018: Optional health equity special provision clause introduced for use in PHD contracts.



Office of Health Equity

PROGRAM CORE PURPOSE

Promotes health equity via training, evaluation, and consultation with Public Health Division (PHD) programs and partnerships across the state.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of PHD staff trained on health equity ¹	100%	100%	N/A	88% (204/ 231)	16% (38/ 231)	99% (241/ 242)	100% (242/ 242)
% of HEWTalks participants intending to use content in work ²	N/A	90%	N/A	N/A	N/A	N/A	87% 86/99
% and # of PHD programs consulted regarding HEAT ³	40%	50%	N/A	7% (2/26)	19% (5/26)	25% (6/24)	46% (11/24)
% and # of PHD programs utilizing Telelanguage services ⁴	25%	55%	N/A	N/A	N/A	29% (7/24)	50% (12/24)
% and # of PHD programs utilizing interpreter services ⁵	20%	27%	N/A	N/A	N/A	17% (4/24)	25% (6/24)

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of Health Equity trainings offered	8	44	41	30	38	10	20	17	21
# of HEWTalks Offered	N/A	N/A	N/A	12	11	6	6	6	5
# of people trained ⁶	201	1,120	1,666	1,306	629	662	644	300	329
# of interpreted calls ⁷	N/A	N/A	79	143	569	22	121	282	287
EFFICIENCIES									
Cost per training attendee ⁸	\$58 \$11,600 /201	\$24.07 \$26,960 /1120	\$3.07 \$5,120. 82/1,666	\$2.45 \$3,204. 44/1,306	\$6.46 \$4,064. 29/629	\$.83 \$552/ 662	\$4.12 \$2,652. 44/644	\$6.28 \$1,883. 82/300	\$6.63 \$2,180. 47/329

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

STORY BEHIND THE PERFORMANCE

¹ Public Health Division (PHD) staff were offered varied training options in SFY 2018 to include webinars, the Unnatural Causes video series, and cultural competency. A course is mandated for all PHD employees and is built into the onboarding process for new PHD staff. Starting in 2017, numbers reflect only the mandated PHD health equity training.

² The HEWTalks are short, informative presentations organized to educate on health equity topics affecting people in Wyoming. After each presentation a short evaluation is sent to each participant; one of the questions measures participant's intent to use the content in their work.

³ In 2015, the Health Equity Workgroup (HEW) created a program survey on health equity called Health Equity Assessment Tool (HEAT). The purpose of the survey is to identify opportunities or needs for education and training related to advancing health equity. The results drove language changes to the contracts, 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 national culturally and linguistically appropriate services (CLAS) standards and the importance of social determinants of health in population health. In 2018, an optional special provision was created for inclusion in contracts to promote health equity. The Office of Health Equity (OHE) manager has been meeting one on one with program managers in the PHD to assist programs in advancing health equity.

⁴ This reflects PHD programs utilizing the language access services provided by the Telelanguage services contract. The OHE has contracted with Telelanguage, Inc. since July 2016 for Language Access Services. Services include telephonic, face-to-face, and video remote interpretation (including sign language), translation, and phone tree. Nine programs contributed financially to the contract and 12 programs utilized the services in the contract; the OHE also supports non-contributing programs in the contract.

⁵ This reflects PHD programs utilizing the interpretation services provided by the Telelanguage 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 on behalf of PHD programs.

⁸ This reflects 900 and 200 series expenditures and internal staff time for organization and prep. Trainings included for 2018: interpreter training, HEWTalks, and Workshops.



Public Health Emergency Preparedness

Program Description

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

Program Expenditures and People Served

	SFY 2016	SFY 2017	SFY 2018
Total Program Cost	\$4,749,210	\$3,993,826	\$3,644,004
People Served	586,102	584,910	579,315
Cost per Person	\$8.10	\$6.83	\$6.29
Non-600 Series*	53%	59%	49%

*600 series is defined as direct service contracts.

Program Cost Notes

- 100% federal funding cooperative agreement with the Centers for Disease Control and Prevention (CDC) for July 1, 2017 - June 30, 2018 for SFY 2018
- 10% match requirement met by Public Health Nursing match contributions (27%), County match contributions (49%) and state match contributions (24%)

Program Staffing

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

Program Metrics

- PHEP maintains contracts that support 20 county public health nursing offices, three county health departments, and two tribal health departments with preparedness contract deliverables.
- 23/25 counties and tribal nations met all contract deliverables.
- PHEP funds and manages a 24/7/365 emergency notification and disease reporting hotline for the Wyoming Department of Health with on-call epidemiologists, laboratorians, and public health professionals.
- In SFY2018 there were 142 calls, comparable to SFY2017 with 167 total calls. The CDC's ability to reach WDH through a 24/7/365 phone line is a CDC metric. In SFY2018, two test calls have been completed successfully for a 100% success rate.
- CDC has five separate requirements that states must meet annually or have funding penalized by 10 to 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), preparation for disease outbreaks such as the Ebola Virus and Zika virus, and pandemics (H1N1 influenza pandemic).
- CDC developed 15 public health planning capabilities that PHEP used in spring 2011 to develop a Blueprint for Action which defined PHEP's five-year strategy; the blueprint was updated in October 2017.
- For SFY 2018, federal funding remained at a reduced amount (down 17% from SFY 2011)
- 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 and medical needs (including behavioral health), public health surveillance, and distribution and dispensing of Strategic National Stockpile and other countermeasure assets. PHEP is designated by WDH to be the ESF #8 lead for the state.
- WDH activated the Incident Management Team for the Great American Eclipse in August 2017.

Public Health Emergency Preparedness (PHEP)

PROGRAM CORE PURPOSE

Develop and maintain public health emergency response capability within the Wyoming Department of Health and local public health agencies through planning, training, exercise, evaluation, resource identification, and quality improvement.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Time, in minutes, for Immediate After Hours Assembly of WDH Incident Management Team in person or virtually ¹	<60*	<60*	10	15	23	41	6
Wyoming (state) score for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency ²	Established (3.0/4.0)	Established (3.0/4.0)	100% (US avg. 99%)	100% (US avg. 99%)	Established (3.3)	Established (3.3)	Established (3.3)
Average county scores for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency ²	Established 3.0/4.0	Established 3.0/4.0	92.5% (22 counties)	93.3% (21 counties)	96.9% (21 counties)	Established 3.5 (23 counties)	Established 3.5 (23 counties)
State, county, and tribal public health responders completing respirator fit testing ³	95%	95%	93.8% (242/258)	83.9% (256/305)	86.1% (223/259)	87.9% (227/258)	975 (249/256)
WDH Jurisdictional Risk Assessment (JRA) Score (updated every 5 years) ⁴	85%	85%	N/A	N/A	76%	N/A	N/A

*CDC and Healthy People 2020 target

N/A indicates data not available

(-) indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
% of WDH Improvement Plan recommendations associated with full scale exercise or real event addressed within 1 year of After Action Report ⁵	100% (12/12)	N/A	N/A	N/A	91% (48/53)	N/A	N/A	N/A	91% (48/53)
% of WDH Incident Management Team trained to role requirements for WDH response management	72% (18/25)	77% (21/27)	87.5% (14/16)	71.4% (20/28)	82% (23/28)	64% 16/25	71% 20/28	82% (23/28)	82% (23/28)
# of CDC 24/7 no notice bidirectional contact drill for epidemiology and lab staff	2/2	4/4	2/2	2/2	2/2	1/1	1/1	0/0	2/2
# of courses of antibiotics compared to estimated number of key personnel identified ⁶	0/ 5,060	3,313/ 5,060	3,313/ 5,060	5,644/ 5,060	5,644/ 5,060	3,313/ 5,060	5,644/ 5,060	5,644/ 5,060	5,644/ 5,060
EFFICIENCIES									
Cost per Wyoming Alert and Response Network message recipient	N/A	N/A	N/A	N/A	\$1.74 (\$12,995/ 7,479)	N/A	N/A	N/A	\$1.74 (\$12,995/ 7,479)
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.
2. The Technical Assistance Review was a measurement tool utilized by the CDC's Division of Strategic National Stockpile (DSNS) to determine a state's level of planning to receive, stage, store, distribute, and dispense DSNS provided materiel. It was utilized at state and local levels to assess plans to receive, stage, store, and distribute SNS assets during a public health emergency. In 2015, the Cities Readiness Initiative (CRI) jurisdictions (Laramie and Natrona counties) and the state were evaluated utilizing the Medical Countermeasures Operational Readiness Review (MCM ORR) which did not result in a percentage score. The MCM ORR evaluates not only the plans, but also the ability to operationalize 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 is for states to have an Established status by 2022.
3. 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. This is a proxy measure for Responder Health and Safety program effectiveness.
4. The public health Jurisdictional Risk Assessment (JRA) is a required activity for public health jurisdictions nationwide to complete under the Community Preparedness capability of the CDC *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. In Wyoming, the JRA process requires each county, tribe, and the state public health division to score and document their unique hazards, risks, and public health capabilities, as measured against specific elements. Each jurisdiction determined 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. The JRA score represents, of the 109 Priority Resource Elements, do we have or have access to this resource element (Yes/No/Partial), and a score: Mostly in place (75-100%), Substantially in place (50-75%), Partially in place (25-50%), Less than partially in place (0-25%). This is an input into the final matrix of residual risk and gap analyses graphs.
5. An After Action Report (AAR) and Improvement Plan (IP) are the main products of the evaluation and improvement planning process. The IP identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion.
6. 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 when indicated. PHEP estimates we will need 5,060 courses. In 2014, our cache of antibiotics expired. 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.

Trauma Program

Program Description

The Wyoming Trauma Program serves Wyoming residents by maintaining and improving the Wyoming Trauma System infrastructure and the clinical care of the trauma patient through education, support, and regulatory activities.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$216,838	\$177,833	\$190,243
People Served	586,102	584,910	579,315
Cost per Person	\$0.36	\$0.30	\$0.33
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts

Program Cost Notes

- 88% General Funds
- 12% Federal Funds (Wyoming Trauma Registry \$22,800)

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 every three years for continued compliance to ensure quality patient care in each facility.
- Provides the mandatory Trauma Patient Registry for all acute care facilities.
- Provides support to Trauma Regions through travel reimbursement and technical support.
- Provided technical registry & programmatic support to facilities on 75 documented occasions in CY2016, 55 in CY2017, and 33 as of 7/1/2018. Provided 35 documented data report requests or assistance with writing reports for stakeholders in CY2016, 55 in CY2017 and 42 as of 10/2018.

Events that have Shaped this Program

- This is a mandated state program per Wyo. Stat. § 35-1-801 et seq.
- Unintentional injury is the #1 killer of Wyoming residents ages 1-44 years (CDC WISQARS).
- Traumatic injury results in more years of potential life lost than any other disease, including cancer and heart disease (NIH Fact Sheet, Burns & Traumatic Injury, 2013).
- There is a low workforce retention of Trauma Coordinators (TC) in acute care facilities. In July 2015, 47% of the TCs had been in their role one year or less. This increased in July 2016 to 54%, decreased to 25% in 2017, and has decreased to 21% in 2018 as of 7/1/2018.
- The trauma registry was completely redesigned and upgraded in 2017 to accommodate American College of Surgeons (ACS) verified sites; the ACS requires additional registry data.
- In response to increased requirements by the ACS for Level II Trauma Center verification, one Regional Trauma Center (RTC) opted to undergo State verification rather than ACS verification and one requested ACS verification as a Level III Center and State verification as a RTC. This change by the ACS may require rule changes; the change has increased program costs, and has affected programmatic activities.

Trauma Program

PROGRAM CORE PURPOSE

Designate acute care facilities in accordance with Wyoming Trauma Rules & Regulations, maintain the State Trauma Patient Registry, provide training, performance improvement guidance, and supporting data to trauma system participants in order to promote a trauma system prepared to provide optimal care to the injured patient.

OUTCOMES							
Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
% and # of facilities actively contributing to the Trauma Patient Registry ²	96%	96%	89% 25/28	93% 26/28	100% 28/28	100% 28/28	100% 28/28
% of facilities with full designation status (2-3 year status) running total ¹	68%	68%	64% 18/28	54% 13/28	61% 17/28	61% 17/28	75% 22/28
% of rural facilities with full designation status (2-3 year status) running total ⁵	70%	70%	N/A	58% 15/26	61% 16/26	64% 17/26	77% 20/26
% ED trauma patient overall dwell times ≤2 hours; calendar year ⁴	22%	22%	20.9%	20.2%	19.2%	19.4%	-
% of ED trauma patient dwell times ≤2 hours for injured patients requiring transfer to definitive care; calendar year ⁴	28%	28%	N/A	N/A	28.2%	25.2%	-

(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of facility site reviews conducted	12	11	14	14	15	1	13	1	14
# of Regional Trauma Councils meeting quarterly (5 total) ³	5	5	3	4	5	4	4	5	3
# of formal educational opportunities sponsored to improve facility compliance	2	2	2	2	1	2	0	1	0
% and # of facilities sending representation to at least one sponsored educational opportunity per year	89% 25/28	96% 27/28	96% 27/28	93% 26/28	75% 21/28	N/A	N/A	N/A	N/A
# of trauma records in Trauma Registry by WY acute care facilities	3,369	3,906	4,295	4,209	4,030* **	2,270	1,939	2,285* **	1,745* **
EFFICIENCIES									
Cost per trauma registry record (\$22,800/# records)**	\$6.77 (\$22,800/ 3,369)	\$5.84 (\$22,800/ 3,906)	\$5.31 (\$22,800/ 4,295)	\$5.42 (\$22,800/ 4,209)	\$5.66 (\$22,800/ 4,030)**	\$5.02 (\$11,400/ 2,270)	\$5.87 (\$11,400/ 1,939)	\$4.99 (\$11,400/ 2,285)**	\$6.53 (\$11,400/ 1,745)**

(-) Indicates data not yet available

* indicates year-to-date as of 6/30/2018

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

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 (Jurkovich & Mock, 1999).
- Trauma programs work toward the prevention of mortality & morbidity associated with medical and surgical care after an injury is sustained by a patient.
- Wyoming injury mortality rates are consistently higher than the U.S., in 2016 the Age Adjusted Injury Death Rate was 91.7 deaths per 100,000 population compared to the U.S. rate of 68.8 (CDC WISQARS)
- 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" (Trauma System Agenda for the Future).

Robust trauma systems are effective. "An inclusive regional trauma system is an independent predictor for survival and is associated with mortality reduction" (He, Schechtman, Allen, et al, 2017). A significant decrease of preventable deaths among the seriously injured has been identified in states with an established and functioning trauma system (Nathans, Jurkovic, Rivara, Maier, 2000).

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 Facility:* A Wyoming hospital or acute care facility not designated as a Regional Trauma Center. Acute care facility for this program is defined as a hospital or clinic that receives emergency patients.

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

	2016	2017	2018
Total Program Cost	\$1,681,960	\$1,955,573	\$1,544,311
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	56%	48%	66%

* 600 series is defined as direct service contracts.

Program Cost Notes

- CY17 HIV Prevention Grant – CDC Federal
- CY17 STD Prevention Grant – CDC Federal
- CY17 Hepatitis Prevention Grant – CDC Federal
- CY17 TB Prevention & Control Grant – CDC Federal
- CY17 Personal Responsibility Education Program – HHS Federal
- Adult Hepatitis A/B vaccination – General Fund

Program Staffing

- 7.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- 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 Corrections, Department of Family Services, Primary Care Association, and the Wyoming Health Council.
- 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.
- Deliver and evaluate the community health education campaign: knowyo.org.
- Work with Department of Corrections and Public Health Nursing to provide adult hepatitis A and B vaccinations to high-risk adults over the age of 19.

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



Communicable Disease Prevention Program

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	CY 2018 Target	CY 2019 Target	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
% 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	97%	91%	(-)
% of WyPREP participants correctly identifying effective methods of protection from STDs, HIV, and pregnancy in the Reducing the Risk (RTR) Knowledge Survey ²	82%	82%	N/A	N/A	69%** (214/308)	78%** (365/486)	(-)
Rates of gonorrhea infections per 100,000 persons ³ (National rate)	45.0	50.0	19.9 (111)	29.7 (124)	47.8 (145.8)	71.2 (171.9)	(-)
Active TB case rate of <1 per 100,000 statewide (National rate)	<1	<1	0.4 (2.9)	0.7 (3.0)	0.2 (2.9)	0.3 (2.8)	(-)
Rates of hepatitis C infection per 100,000 persons ⁴	80.0	80.0	99.7	82.1	84.7	65.5 ⁵	(-)

(-) 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 2014	CY 2015	CY 2016	CY 2017	CY 2018	2016 Q1+Q2	2016 Q3+Q4	2017 Q1+Q2	2017 Q3+Q4
OUTPUTS									
# condoms provided to high risk populations ⁶	362,987	275,448	242,733	339,659	292,411*	137,465	105,268	132,930	206,729
# of condom dispenser sites ⁷	77	102	107	209	380*	89	102	126	209
# of WyPREP participants**	N/A	90	587	739	(-)	258	329	264	475
EFFICIENCIES									
Cost per voucher – knowyo.org ⁸	\$31.16 \$115,000 /3,691	\$33.04 \$115,000 /3,481	\$25.12 \$115,000 /4,674	\$21.79 \$115,000 /5,277	\$33.23* \$115,000 /3,461	\$24.85 \$57,500 /2,314	\$24.36 \$57,500 /2,360	\$21.61 \$57,500 /2,661	\$22.00 \$57,500 /2,614

(-) Indicates data not yet available

*Calendar Year-to-Date (January – September)

**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.

⁴Approximately 3.5 million persons in the United States have chronic hepatitis C 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.

⁵Hepatitis 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.

⁶According 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.

⁷For the quarterly data, the numbers represent the sum total of condom dispensers at that time.

⁸The 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

	2016	2017	2018
Total Program Cost	\$1,540,350	\$1,797,199	\$1,569,534
People Served¹	2,608	2,086	1,262
Cost per Person	\$591	\$862	\$1,244
Non-600 Series	16%	14%	14%

¹ The number of people served fluctuates based on disease burden and access to health insurance across Wyoming.

Program Cost Notes

- Grant Fiscal Year (GFY) 17 - Ryan White Part B/AIDS Drug Assistance Program (ADAP) Grant—HRSA, Federal
- GFY 17 - Ryan White Part C Grant—HRSA, Federal
- GFY 17 - Housing Opportunities for Persons with AIDS Grant, HUD
- CY 17 - TB Prevention & Control Grant—CDC, Federal
- FFY 17 - Substance Abuse Block Grant Dollars—SAMSHA, Federal
- FFY 17 - Preventative Health and Human Services—CDC, Federal
- SFY 17 - 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

- 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)
- 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
- 2018: Program moved to an open formulary, thereby removing barriers for patient access to medications.



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 2018 Target	CY 2019 Target	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
% of gonorrhea cases receiving the recommended dual therapy medication ¹	90%	90%	47% (70/150)	88% (151/171)	88% (243/277)	90% (374/415)	-
% and # of Latent TB (LTBI) clients starting treatment in TB Program completing LTBI treatment ²	80%	80%	67% 69/103	77% 54/70	79% 45/57	90% 66/73	-
% of newly identified HIV positive clients linked into primary care within 3 months of diagnosis ³	95%	95%	70% 9/13	73% 11/15	80% 16/20	91% 10/11	-
% of clients enrolled in HIV Services Program with suppressed HIV Viral load ⁴	90%	92%	65% 106/164	61% 94/153	84% 184/219	90% 197/219	-
% of new HIV infections considered a late diagnosis ⁵	25%	37%	67% 8/12	31% 5/16	35% 7/20	-	-
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	210	174	168	177	167
# of HIV clients enrolled in HIV Services Program ⁶	168	174	179	208	218	182	182	192	189
# of individuals in the TB Program enrolled for LTBI/active TB disease treatment	114	127	93	98	83	47	51	41	42
EFFICIENCIES									
Average cost of HIV client enrolled in HIV Service Program ⁷	-	\$2,594	\$3,247	\$3,799	\$2,489	\$2,279	\$1,520	\$1,828	\$965
(-) 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 Wyo. Stat. § 35-4-101 through 113.

¹CDC 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.

²According 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.

³According 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.

⁴An 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.

⁵A 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.

⁶Quarterly 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.

⁷Based 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.

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.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$776,992	\$761,108	\$761,108
People Served	586,102	584,910	579,315
Cost per Person	\$1.33	\$1.30	\$1.31
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- FY18 federal funding through the CDC Epidemiology and Laboratory Capacity Grant is \$639,500
- FY18 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 was higher than the national incidence (0.17/100,000 vs. 0.06/100,000) during the 2017-2018 influenza season.
- Wyoming incidence of Pertussis, Measles, and Mumps was below the national incidence (3.1/100,000 vs. 6.6/100,000) in 2017.
- Wyoming incidence of Salmonellosis, Shigellosis, and *E. coli* was above the national incidence (22.61/100,000 vs. 19.05/100,000) in 2017.

Events that have Shaped this Program

- The Program operates under Wyo. Stat. § 35-1-223, 35-1-240 and 35-7-123.
- 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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average # of days to complete case investigations*	3	3	2.7 (CY 2014)	2.3 (CY 2015)	2.6 (CY 2016)	2.7 (CY 2017)	3.0** (CY 2018)
# of enteric disease outbreaks detected and investigated by the program and # of other outbreaks investigated	>5 (>8/1M population)	>5 (>8/1M population)	16 enteric 10 other	16 enteric 17 other	8 enteric 11 other	5 enteric 16 other	16 enteric 13 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 (0.05)	0.17 (0.05)	0.0 (0.02)	0.0 (0.03)	0.17 (0.06)
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	10.6 (9.54)	5.8 (6.03)	3.6 (6.53)	3.1 (6.6)	-
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	35.43 (21.8)	29.40 (23.9)	15.37 (22.64)	22.61 (19.05)	-

* Data for this metric is for a calendar year

**Data thru 7/31/2018

(-) Indicates data collected by calendar year and not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of initial case reports detected by Program through surveillance	2,806	5,396	2,924	5,585	9,099	677	4,908	1,092	8,007
# of influenza surveillance weekly reports created by Program	40	40	40	40	19	20	20	13	6
EFFICIENCIES									
Cost per case investigated	\$243	\$135	\$265	\$136	\$83	N/A*	N/A*	N/A*	N/A*
N/A* indicates data not calculated 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 program investigated a large outbreak of salmonellosis in Fremont County associated with daycare attendance in November 2017. The outbreak investigation utilized social network analysis for the first time in Wyoming that helped clearly demonstrate the outbreak was propagated by person-to-person transmission.
- The state incidence of enteric diseases is above the national incidence. Contact with farm and ranch animals continues to be common risk factor for enteric diseases in Wyoming. The salmonellosis outbreak in Fremont County contributed to the higher incidence.
- The incidence of vaccine-preventable diseases continues to decline as the Wyoming incidence of pertussis decreases. The Program investigated an outbreak of Hepatitis A in Natrona County in late 2017 and early 2018.
- The large increase in initial case reports from SFY 2017 to SFY 2018 was due to a particularly bad influenza season; the 17-18 season was one of the worst Wyoming has seen in many years.
- 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.

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 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

	2016	2017	2018
Total Program Cost	\$3,733,937	\$3,566,647	\$3,383,658
People Served	586,102	584,910	579,315
Cost per Person	\$6.57	\$6.10	\$5.84
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Program cost for FY18 decreased due to a decline in chemical testing volume. Revenues increased due to increased microbiology volume, while federal funding decreased by a third.
- In FY18 total expenditures were broken down as follows:
 - General Funds - 51%
 - Revenues from lab fees-24%
 - Federal grants-25%

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 Wyo. Stat. § 35-1-240; 35-4-133,221,501; 35-7-123 and chemical testing program under Wyo. Stat. § 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 Wyoming Public Health Laboratory (WPHL) supports public health, public safety, and emergency response by providing Wyoming communities, agencies, and private healthcare providers with timely, cost effective, and quality assured public health laboratory services and technical support.

OUTCOMES

Performance Metric	SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Accuracy of competency/proficiency tests performed ¹	98%	98%	99.7% 194.5/195	99.1% 315/318	99.2% 395/398	99.8% 468/469	98.5% 445/452
Average time (in days) from specimen receipt to result reporting in Microbiology and Preparedness (Tb culture excluded) ²	1.30	1.30	1.31	1.29	1.22	1.26	1.04
% and # of Microbiology clients receiving real-time laboratory results ³	80%	80%	0%	36.3%	58.6% 337/575	70.2% 501/714	67.9% 582/857
# of non-WPHL employees trained ⁴	200	100	N/A	246	207	487	76
# of newly validated tests ⁵	≥ 5	≥ 5	0	5	7	5	6

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
# of Chemistry samples tested (# confirmed)	30,460 (N/A)	33,527 (12,095)	34,726 (12,418)	17,398 (8,507)	14,017 (4,368)	9,073 (4,594)	8,325 (3,913)	7,595 (2,301)	6,422 (2,067)
# of Microbiology tests performed	36,033	37,018	39,224	40,180	43,627	19,959	20,221	22,100	21,527
# of trainings provided	N/A	13	11	22	6	7	15	2	4
# of Litigation Support Packages provided	N/A	132	154	125	120	69	56	70	50
# of times court testimony provided	N/A	77	42	36	50	20	16	23	27
Cost per test ⁶	\$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	\$54.56 <u>3,383,658</u> 62,0125	\$51.59 <u>1,734,636</u> 33,626	\$56.44 <u>1,832,010</u> 32,459	\$49.96 <u>1,598,553</u> 31,996	\$59.47 <u>1,785,105</u> 30,016
% of expenses from revenues ⁷	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	24.0% <u>811,422</u> 3,383,658	5.9% <u>102,217</u> 1,734,636	10.2% <u>186,767</u> 1,832,010	21.4% <u>342,755</u> 1,598,553	26.3% <u>468,667</u> 1,785,105
% of expenses from Federal Grant (no match)	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	24.9% <u>841,714</u> 3,383,658	35.8% <u>621,285</u> 1,734,636	33.9% <u>621,285</u> 1,832,010	22.9% <u>366,656</u> 1,598,553	26.6% <u>475,057</u> 1,785,105

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 rule out/refer for Select Agents, biosafety and risk assessment, and county coroners, law enforcement, DFS and DOC officers involved with drug and alcohol testing. There were no large trainings held on site at the Law Enforcement Academy and DFS and Probation and Parole offices as were in SFY17. In SFY18 the lab was named as a Regional Training Lead Laboratory for Whole Genome Sequencing (WGS). The training continued on a smaller scale reaching less participants. Training was severely impacted by the cut in federal funds.

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 added 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), Blood Drug Screen (10 analytes), Blood and Urine confirmation for alcohol (ETOH), and Blood Amphetamine Confirmation.

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 and continued in SFY18.

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 increase in this percent for SFY18 is due to an increase in Microbiology Testing Program revenues.

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 for affordable legal services. The state provides matching state funds for maintenance of effort to allow seniors to continue to receive this legal help.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$71,506	\$71,506	\$71,506
People Served	204	218	246
Cost per Person	\$350.52	\$328.01	\$290.67
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 FFY 2018, 246 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 FFY 2018, total client hours performed by the provider equaled 1,040.
- In FFY 2018, the average number of hours spent per client was 4.23 hours.
- The average cost per client in FFY 2018 (Federal and State funds) was \$290.67. The average cost (Federal & State fund) per hour was \$68.76.
- The average cost savings per client in FFY 2018, based on an average cost of \$250.00 per hour for private legal assistance, was \$1,056.91.
- 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 22.25 hours of outreach and public education was provided by the Legal Services grantee in FFY 2018.

Events that Have Shaped this Program

- The Legal Services and Legal Developer Program served all eligible clients with no waiting list.
- 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

Provide legal assistance and counseling services to older individuals in order to protect older adults against direct challenges to their independence, choice, and financial security. Priority should be given to individuals with the greatest social and economic need.

OUTCOMES

Performance Metric	FFY 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
Percent of cases resolved within 3 months	75%	75%	N/A	78%	91%	77%	56%
Percent of respondents who claimed improved quality of life	100%	100%	N/A	67%	56%	73%	68%
Percent of respondents who would have restricted their expenses if legal services were not received	50%	50%	N/A	67%	38%	38%	56%

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

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Total number of cases*	552	653	441	528	616	272	256	289	327
Total number of hours of service provided	955.5	1,030.25	881.25	1,110.5	1,040	668.5	442	432.5	607.5
Number of financial assistance/estate planning cases	160	161	111	203	287	93	110	153	134
Number of power of attorney and advance directives cases	12	17	14	14	20	2	12	7	13
Number of real estate/housing cases	25	44	9	66	69	17	49	26	43
EFFICIENCIES									
Average cost per unduplicated client	\$305.99	\$214.69	\$366.70	\$350.52	\$290.67	\$322.11	\$384.43	\$281.85	\$298.94
Average cost at the market rate (\$250/hour)	\$788	\$698	\$1,130	\$1,361	\$1,057	\$1,506	\$1,188	\$909	\$1,196

*Cases were redefined in FFY 2018 to include all cases, including multiple cases for the same client. Previous years reported the total number of cases as the unduplicated client caseload. All FFYs have been re-calculated for comparability and numbers will be higher than what was reported in past years.

STORY BEHIND THE PERFORMANCE

- The case priorities of Legal Aid are: domestic law, public benefits, consumer, housing, Native American rights, senior services, involuntary commitment defense, tax payer assistance, and emergency assistance.
- Clients are screened for income, conflicts, emergencies, and whether their case is within the program priorities. Advice only and brief service cases receive immediate assistance, an advice letter, a survey, and the case is closed. Possible litigation cases go to case review. Cases are reviewed a second time by Legal Aid and partner organizations during case review. Accepted cases are placed with staff attorneys, pro bono attorneys, and contract attorneys for litigation assistance. Rejected cases receive an advice letter, a survey, and the case is closed.

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

	FFY2016	FFY2017	FFY2018
Total Program Cost	\$267,281	\$258,842	\$323,327
People Served	2,056	1,542	1,599
Cost per Person	\$130	\$168	\$202
Non-600 Series**	5.26%	1.80%	3.56%

** 600 series is defined as direct service contracts.

Program Cost Notes

- 57% federal funds
- 43% state funds
- 0% local funds (not required; local contractor will supply additional funds as available)

Program Staffing

- 1 FTE
- 0 AWEC
- 3.42 Other FTE (contractor)

Program Metrics

- Evaluate caseloads (151 in 2018) and activity level (1,448 activities completed in 2018), 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 the 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 funds. There was \$43,285 in the 17-18 biennium that was thought to be decreased from the program budget, but was not. The amount was not split between 17-18 because the contract had already been completed for 2017. We chose not to do an amendment but to use it on special projects moving forward. Going forward the full amount will be split between the two years.
- Three full-time Regional Long Term Care Ombudsmen are employed to cover the entire State of Wyoming with a caseload of 1,567 facility beds per Regional Ombudsman; this past year there has been a 33% turnover in the regional ombudsman positions. The program has continued to maintain positive stakeholder relationships and foster those in order to benefit recipients of long-term care services.
- The primary type of complaints received by the program regard 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 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
% of complaints fully resolved to the satisfaction of the complainant per year.	60%	60%	**	**	34.53%	52.21%	40.34%
% of complaints partially resolved to the satisfaction of the complainant per year	16%	16%	**	**	16.60%	17.26%	21.02%
% of complaints not resolved to the satisfaction of the complainant per year	0%	0%	**	**	4.15%	3.98%	3.41%
% of complaints related to 'Autonomy, Choice, Exercise of Rights, Privacy' that were resolved	60%	50%	**	**	52.94%	65.52%	57.14%
% of complaints related to 'Admission, Transfer, Discharge, Eviction' that were resolved	60%	50%	**	**	53.06%	58.18%	55.88%

(-) 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 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of visits to all LTC facilities/services by an Ombudsman	**	**	334	319	327	159	160	159	168
% of nursing homes, assisted living facilities, & boarding homes (79 total) visited by an Ombudsman quarterly	**	**	78.2%	98.7%	98.7%	N/A*	N/A*	N/A*	N/A*
# of cases closed	**	**	403	200	151	110	90	73	78
# of complaints received	**	**	572	231	182	125	106	92	90
# of activities completed	**	**	1,653	1,342	1,448	646	696	681	767
EFFICIENCIES									
Cost per person served (Cases opened + Activities / Total \$)	**	**	\$130	\$168	\$202	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 (LTCOP) went into effect July 1, 2016. Previously, LTCOP 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 the 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.

- The program experienced a 33% turnover in regional ombudsmen during FFY2018, a new regional ombudsman was hired in March of 2018 and continues to train.
- The program continues to maintain and improve stakeholder relationships, work toward a pilot volunteer program, distribute resident packets for residents in nursing homes, assisted living, and boarding homes, and change 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 them to remain physically, mentally, and socially active to prevent premature institutionalization. The four categories of Title III-B service are:

- 1) **Health:** Increasing participation in physical activity to remain active.
- 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

	2016	2017	2018
Total Program Cost (Federal and State)	\$1,513,739	\$1,383,473	\$1,458,358
People Served (Unduplicated Count)	17,101	16,931	17,719
Cost per Person	\$89	\$82	\$82
Non-600 Series*	23%**	21%**	21%**

* 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 what is required.

Program Staffing

- 0.70 FTE
- 0 AWEC
- 0 Other

Program Metrics

In FFY 2018, Title III-B had a total of 36 grantees covering 23 counties in Wyoming. These grantees served a total of 17,719 clients, or 14.76% of Wyoming’s adults aged 60 and older, based on 2016 Census data. A total of 768,228 unit of service 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 are projected to 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 and an active life style enable older individuals to continue living independently and with dignity. A holistic health environment may alleviate high medical expenses and prevent premature 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 programs, 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 services.



Title III-B Supportive Services

PROGRAM CORE PURPOSE

To help Wyoming's older adults to remain physically, mentally, and socially active to prevent premature institutionalization by providing comprehensive, coordinated, and cost effective services.

OUTCOMES

Performance Metric	FFY 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
% and # of Wyoming's population (age 60 and older) served	13.5%	14.5%	15.53% (17,204/ 110,760*)	15.02% (17,328/ 115,340*)	14.25% (17,101/ 119,985*)	14.11% (16,931/ 119,985**)	14.76% (17,719/ 119,985**)
# of Clients who received III-B Services	17,000	19,465	17,204	17,328	17,101	16,931	17,719
# of clients who received transportation services	2,100	2,404	1,822	1,669	1,902	2,157	2,025
# of clients who received assisted transportation services	600	687	758	826	783	777	848
# of outreach events provided	1,100	1,259	3,145	3,321	3,306	3,155	3,032

(*) Denominator data is reported from the United States Census Bureau, Wyoming population 60 years and older in the United States.

(**) 2016 data, 2017 data not yet available for 60 and older.

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

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Total # of clients served	17,204	17,328	17,101	16,931	17,719	13,066	13,113	13,635	13,999
Total # of Title III-B Services units provided	728,659	716,764	773,065	729,980	768,228	361,973	368,006	378,895	389,334
Units of transportation services provided*	100,612	90,772	119,291	128,293	127,217	61,661	66,632	62,775	64,442
Units of assisted transportation services provided	65,927	66,917	60,513	55,570	56,684	27,856	27,714	27,371	29,313
Units of outreach services provided**	40,595	34,779	36,641	27,725	22,141	16,022	11,704	11,123	11,018
EFFICIENCIES									
Cost per client (Federal & State funds)	\$91	\$86	\$89	\$82	\$82	\$49.66	\$56.03	\$53.11	\$52.45
Cost per unit (Federal and State funds)	\$2.15	\$2.08	\$1.96	\$1.90	\$1.90	\$1.79	\$1.99	\$1.91	\$1.89

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

*In previous years, assisted transportation services were included in the total; these have been removed from the total and all FFYs updated.

**In FFY 2018 the definition of outreach was narrowed and counts were recalculated for all previous FFYs for comparability. Counts will be lower than what was reported in previous years.

STORY BEHIND THE PERFORMANCE

- Based on the projected Census data for FFY 2018, Title III-B served approximately 14.76% (17,719/119,985*) of Wyoming's total population age 60 and older adults in FFY 2018.
- 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 3,143 clients who live below 100% of the federal poverty level, 6,468 clients who live alone, and 624 clients who are minorities in FFY 2018.
- 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 referrals to other services. This program gives priority to older adults with greatest economic need and older adults with greatest social need, including low-income minority individuals, low-income individuals who have a high nutritional risk score, and individuals who live alone.

Program Expenditures and People Served

	2016	2017	2018
Total Program Cost	\$1,744,391	\$1,516,933	\$1,647,562
People Served	17,125	17,635	18,466
Cost per Person	\$101.86	\$86.02	\$89.22
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

- The total program cost listed above includes the Federal and State funding amounts expended during each FFY.
- 85% federal with a required 15% local match.
- The State currently provides 5% of the required 15% local match.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In FFY18 the Title III-C1 Congregate Nutrition Program had a total of 35 grantees covering 23 counties in Wyoming. These grantees served a total of 18,466 eligible clients representing approximately 15.39% of Wyoming's population of adults age 60 and older based on 2016 Census data. These 18,466 eligible clients received a total of 636,671 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 FFY 2018 a total of 5,981 clients age 60 and older who live alone were provided services.

Events that have Shaped this Program

- In FFY17 all Title III programs switched to a reimbursement payment process.
- The contract amounts are always based on a closed federal year; thus, FFY1208 contract amounts were based on the FFY20016 meal counts.
- Updated Title III-C1 Policies and Procedures were implemented in April of 2018 and may increase the number of people served and the number of meals served in the future. For example, the unregistered eligible participants policy allows providers to count previously ineligible meals for individuals who are eligible for the program but decline to complete an assessment. The emergency meal policy also allows providers to receive reimbursement for emergency meals given to C1 participants.

Title III-C1 Congregate Nutrition Program

PROGRAM CORE PURPOSE

To reduce food insecurity and hunger while promoting socialization among Wyoming's older adults.

OUTCOMES							
Performance Metric	FFY 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
% and # of WY population age 60 and older served with income <100% of federal poverty level	27.08%*	33.00%	44.43% (3,248/ 7,310)	40.15% (3,288/ 8,189)	33.28% (3,074 ^A / 9,238 ^B)	32.66% (3,017/ 9,238 ^C)	32.29% (3,035/ 9,238 ^C)
% and # of clients age 60 and older served with high nutrition risk	15.28%*	15.05%	17.67% (2,984/ 16,888)	16.61% (2,895/ 17,426)	15.86% (2,683/ 16,914)	15.02% (2,614/ 17,404)	14.93% (2,702/ 18,089)
% and # of WY population age 60 and older served who live alone	20.00%*	13.73%	13.26% (5,920/ 44,636)	12.80% (5,979/ 46,712)	12.96% (5,801/ 44,754)	13.15% (5,887/ 44,754)	13.36% (5,981/ 44,754)
% and # of WY population age 60 and older served who are of a minority population	4.55%*	5.81%	5.00% (421/ 8,417)	4.57% (422/ 9,227)	4.61% (431/ 9,358)	5.17% (484/ 9,358)	5.72% (535/ 9,358)
Total % of WY population served age 60 and older	13.85%*	15.57%	15.25% (16,888/ 110,760)	15.11% (17,426/ 115,340)	14.10% (16,914/ 119,985)	14.51% (17,404/ 119,985)	15.08% (18,089/ 119,985)

*Targets from FFY18 are not updated with the new data source and therefore have different census data than the report outcome percentages. FFY18 targets were previously estimated based on SFY data.

^A Data is collected via the voluntary Aging Needs Evaluation Summary (AGNES) 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 (5 year estimate).

^C Data from the Census Bureau for 2017-2018 is not available. Data from the Census Bureau for 2016 was used as a reference for all FFY 2017 and FFY 2018 metrics, with the exception of metric “% of clients age 60 and older served with high nutrition risk”.

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Total number of meals provided to clients age 60 and older	634,658	644,575	629,505	627,261	626,860	311,699	315,873	308,042	318,818
Total units of Nutrition Education provided to clients age 60 and older	1,682	965	9,608	13,408	9,583	6,858	6,563	5,392	4,191
Total number of meals provided to all eligible clients	640,730	652,070	637,702	637,062	636,793	316,362	320,695	312,939	323,854
Total units of Nutrition Education provided to all eligible clients	2,368	1,432	9,762	13,561	9,700	6,915	6,650	5,447	4,253
Average total cost per meal	\$9.02	\$9.83	\$9.50	\$9.79	(-)	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	\$0.20	\$0.19	\$0.20	\$0.19	\$0.19	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	\$2.32	\$2.44	\$2.52	\$2.40	\$2.47	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

- In 2018 all data was updated to reflect a federal fiscal year rather than a state fiscal year. The Title III-C program reports and contracts during a federal fiscal year so data can better be captured during this time frame. Numbers will vary slightly from previous reports due to this change.
- Data collected via the Aging Division data management system is “point in time” and may change until the end of the program reporting period.
- An individual “served” is defined as a client receiving any of the following services: meals, nutrition education, and/or 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 (AGNES) assessment that is used to collect data.

STORY BEHIND THE PERFORMANCE, CONTINUED

- 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.
- Title III-C1 Policies and Procedures were updated and implemented in April 2018. A key policy that may effect performance and reporting is clients refusing to fill out the evaluation tool but whom are still eligible to receive Title III-C1 services (Unregistered Eligible Participants) are counted as a specific sub-service in the aging Division data system. Providers are now able to receive reimbursement for these individuals.
- In FFY14 and FFY15 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 average cost per meal was updated from years FFY14 through FFY16. Previous years had reported an average cost from each facility. This was updated to reflect the overall average program cost per meal vs. the average cost per meal at each facility. The average cost per meal is based on the total program cost (federal, state, local match, and program income).
- As the expected annual average growth rate of people between ages 65 and 79 years of age is expected to be approximately 3.3% per year, the nutrition program must be capable of serving an increased number of clients each year. The nutrition program must also be prepared to reach and recruit an increased number of potential clients. Targets for FFY19 are based on the expected 3.3% increase per year.

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 the gateway to additional services. This program gives priority to older adults with greatest economic need and older adults with greatest 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

	2016	2017	2018
Total Program Cost	\$1,443,879	\$1,234,432	\$1,352,688
People Served	4,821	4,779	4,978
Cost per Person	\$299.50	\$258.30	\$271.73
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

- The total program cost listed above includes the Federal and State funding amounts expended during each FFY.
- 85% federal with a required 15% local match.
- The State currently provides 5% of the required 15% local match.

Program Staffing

- 0.5 FTE
- 0 AWEC

Program Metrics

- In FFY2018 the Title III-C2 Home Delivered Nutrition Program had a total of 34 grantees covering 23 counties in Wyoming. These grantees served a total of 4,978 eligible clients representing approximately 4.15% of Wyoming's population of adults age 60 and older based on 2016 Census data. These 4,978 eligible clients received a total of 550,955 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 FFY2018 a total of 2,429 clients who live alone were provided services.

Events that have Shaped this Program

- In FFY17 all Title III programs switched to a reimbursement payment process.
- The contract amounts are always based on a closed federal year, thus, the FFY2018 contract amounts were based on FFY2016 meal counts.
- Updated Title III-C2 Policies and Procedures were implemented in April of 2018 and may increase the number of people served and the number of meals served in the future. For example, the emergency meal policy now allows providers to receive reimbursement for emergency meals given to C2 participants.



Title III-C2 Home Delivered Nutrition Program

PROGRAM CORE PURPOSE

To reduce food insecurity and hunger while promoting socialization among Wyoming's older adults.

OUTCOMES							
Performance Metric	FFY 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
% of WY population age 60 and older served <100% of federal poverty level	14.17%*	16.41%	22.28% (1,629/ 7,310)	18.89% (1,547/ 8,189)	16.87% (1,558 ^A / 9,238 ^B)	16.46% (1,521/ 9,238 ^C)	16.35% (1,510/ 9,238 ^C)
% of clients age 60 and older served with high nutrition risk	50.00%*	51.02%	44.42% (2,260/ 5,088)	47.89% (2,214/ 4,623)	47.21% (2,257/ 4,781)	48.71% (2,317/ 4,757)	50.63% (2,470/ 4,879)
% of WY population age 60 and older served who live alone	8.33%*	5.58%	5.98% (2,670/ 44,636)	5.37% (2,510/ 46,712)	5.51% (2,468/ 44,754)	5.41% (2,422/ 44,754)	5.43% (2,429/ 44,754)
% of WY population age 60 and older served who are of a minority population	1.90%*	2.02%	1.96% (165/ 8,417)	1.64% (151/ 9,227)	1.71% (160/ 9,358)	1.77% (166/ 9,358)	1.99% (186/ 9,358)
Total % of WY population served age 60 and older	3.85%*	4.20%	4.59% (5,088/ 110,760)	4.01% (4,623/ 115,340)	3.98% (4,781/ 119,985)	3.96% (4,757/ 119,985)	4.06% (4,879/ 119,985)

* Targets from FFY18 are not updated with the new data source and therefore have different census data than the reported outcome percentages. FFY18 targets were also previously estimated based on SFY data.

^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 (5 year estimate).

^C Data from the Census Bureau for 2017-2018 is not available. Data from the Census Bureau for 2016 was used as a reference for all FFY 2017 and FFY 2018 metrics, with the exception of metric “% of clients age 60 and older served with high nutrition risk”.

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
Total number of meals provided to clients age 60 and older	519,528	512,828	528,247	534,514	541,685	270,557	264,211	268,168	273,517
Total units of Nutrition Education provided to clients age 60 and older	4,295	620.25	11,814	13,859	12,661	7,027	6,833	6,439	6,222
Total number of meals provided to all eligible clients	525,790	518,698	534,674	541,227	550,955	273,747	267,480	272,516	278,439
Total units of Nutrition Education provided to all eligible clients	4,756	1,225	12,035	13,969	12,821	7,078	6,891	6,519	6,302
EFFICIENCIES									
Average total cost per meal	\$8.21	\$9.39	\$8.57	\$9.77	(-)	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	\$0.20	\$0.19	\$0.20	\$0.19	\$0.19	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	\$2.32	\$.2.44	\$2.52	\$2.40	\$2.47	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

- In 2018 all data was updated to reflect a federal fiscal year rather than a state fiscal year. The Title III-C programs report and contract during a federal fiscal year so data can better be captured during this time frame.
- Data collected via the Aging Division data management system is “point in time” and may change until the end of the program reporting period.
- The number of people “served” is defined as a client receiving the following services: meals, nutrition education, and/or 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 data for 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.
- Home Delivered Meals is not a means-tested program. 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.
- Updated Title III-C2 policies and procedures were implemented in April of 2018.
- In FFY2014 and FFY2015 the nutrition education service changed from a per client count to an aggregate count, resulting in a large decrease in units provided for nutrition education.
- The average cost per meal was updated from years FFY2014 through FFY2016. Previous years had reported an average facility cost per meal. This was updated to reflect the overall average program cost per individual meal vs. the average facility cost per meal. The average cost per meal is based on the total program cost (federal, state, local match, and program income) and the total number of meals served.
- The annual growth rate of the population between ages 65-79 is projected at 3.3% per year. The nutrition program must be capable of serving an increased number of clients each year. The nutrition program must also be prepared to reach and recruit an increased number of potential clients. Targets for FFY2019 are based on the expected 3.3% increase per year.

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

	2016	2017	2018
Total Program Cost	\$568,275	\$509,773	\$537,692
People Served	393	363	335
Cost per Person	\$1,446	\$1,404	\$1,605
Non-600 Series*	17%**	18%**	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

- The total program cost listed above includes Federal funding amounts expended during the FFY and does not include the 25% local match from providers.
- Provider match (local funds and in-kind) for FFY2018 is \$179,231.

Program Staffing

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

Program Metrics

- 27% of Caregivers were 18 to 59 years old, an increase of five percentage points from FFY2017.
- 73% of Caregivers were 60 and older, a decrease of five percentage points from FFY2017.
- Eleven grantees provide services to Caregivers in 15 counties in Wyoming.
- Two grantees provide services to Older Relative Caregiver in two counties.
- Services provided to Caregiver and 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, ages 55 and older, raising grandchildren who are 17 years of age or younger. This service is only available 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; no state funds have been available since FFY 2013.
- 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	FFY 2018 Target	FFY 2019 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
Number of unduplicated caregivers served	400	400	559	471	393	363	335
Number of outreach events (estimated number of consumers reached)	1,200	1,400	1,675 (100,989)	1,439 (17,033)	826 (18,352)	1,779 (49,610)	1,005 (26,904)
Average caregiver evaluation score	11/30	11/30	12/30	12/30	11/30	11/30	10/30
Average caregiver evaluation score for newly enrolled caregivers	12/30	11/30	N/A	11/30	12/30	8/30	11/30

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

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of respite units	8,854	8,572	7,930	5,340	5,737	2,335	3,005	2,593	3,144
# of counseling/support group/training units	1,764	1,404	1,203	1,242	1,251	647	595	624	628
# of supplemental services units	7,470	6,582	5,684	5,123	5,501	2,363	2,760	2,408	3,341
EFFICIENCIES									
Average cost per caregiver	\$1,243	\$1,268	\$1,446	\$1,404	\$1,605	\$783	\$961	\$1,046	\$1,000

(-) 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

- Beginning with the 2018 reports, the program is now reporting on a federal fiscal year (FFY). Previous reporting was done on a state fiscal year. Numbers may vary slightly from previous reports as a result.
- 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. State funds have not been available for local match since SFY 2013.
- Caregiver evaluations are done on a semi-annual basis.
- Getting Caregivers to accept the services has continued to be a challenge.
- Information Services, including radio ads, flyers, health fairs, and word-of-mouth are being used to inform potential Caregivers that there are services available to assist them.
- During the reauthorization of the Older Americans Act in 2016, the Administration for Community Living expanded program eligibility to include
 - caregivers who provide care for individuals, of any age, with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and,
 - parents, 55 and older, of individuals, 19 to 59, with a disability to be eligible to receive services.

The Community Living Section implemented these changes in October of 2017.

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

	2016	2017	2018
Total Program Cost*	\$3,213,217	\$2,285,066	\$2,853,958
People Served	2,147	1,896	1,933
Cost per Person	\$1,497	\$1,205	\$1,476
Non-600 Series**	1.15%	1.58%	1.03%

* State general fund only; does not include local matching funds or program income, which were included in previous reports.

**600 series is defined as direct service contracts.

Program Cost Notes

- The SFY 2018 funding sources for WyHS Program come from: State allocation \$2,853,958 (72%); Local matching funds of \$742,938 (19%); and Program Income (participant contributions) \$353,352 (9%). Total program cost including all sources was \$3,976,758.
- The total program cost for SFY 2017 reflects a \$931,443 budget cut for the 2017-2018 biennium.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- For SFY 2018, average annual cost per participant was \$183.
- For SFY 2018, WyHS providers generated a collective total of \$601,040 over their required match.
- In SFY 2018, the WyHS waiting list ranged from a low of 64 to a high of 101. The waiting list shows the need for the services; however, worker shortage is often a barrier to providing services.

Events that have Shaped this Program

- Local matching funds from providers has increased by 113% since the decrease in funding from 2016.
- While waiting list numbers have decreased from SFY 2017, from 98 to 82 individuals, the average waiting list for the past five years is 87 individuals indicating a consistent need that is not being met in our communities.
- In SFY 2017, the program received a reduction in state general funds of \$931,443 for the biennium.
- In SFY 2017 the program moved to 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 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
# of people served	2,400	2,030	2,323	2,251	2,147	1,896	1,933
% of WyHS Participants with an ADL of 2 or higher	85%	85%	1,911 (82%)	1,839 (82%)	1,717 (80%)	1,501 (79%)	1,516 (78%)
% of WyHS Participants with an IADL of 2 or higher	98%	98%	2,269 (98%)	2,189 (97%)	2,088 (97%)	1,852 (98%)	1,889 (98%)
Average # of people on the waiting list	0	0	92	83	80	99	82

(-) Indicates data not yet available
 N/A indicates data not available due to the creation of a new metric
 Please note: Waiting list numbers have changed from previous years due to duplications in the formulas of data tracking tools.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
OUTPUTS									
# of adult protective services (APS) reports	113	159	137	200	95	113	87	41	54
# of service units provided	103,694	93,307	94,537	84,268	88,992	41,327	42,941	42,963	46,029
# of homemaking units provided	55,625	50,694	51,589	48,264	49,029	23,733	24,531	23,908	25,121
# of personal care units provided	15,773	14,812	14,649	12,936	13,095	6,321	6,615	6,257	6,839
EFFICIENCIES									
Average State cost per person	\$1,290*	\$1,366*	\$1,497	\$1,205	\$1,476	\$1,128	\$1,199	\$1,196	\$1,244
Average State cost per unit of services	\$29*	\$33*	\$34	\$27	\$32	\$21	\$33	\$32	\$31
Average cost per participant	\$218	\$151	\$168	\$225	\$183	\$111	\$107	\$103	\$116

(-) Indicates data not yet available
 N/A indicates data not yet available due to the creation of a new metric
 * Administrative cost data not available and not included in cost analysis.
 Please note: Cost per person and cost per unit of service is now calculated using state funds expended only and not total program cost.

STORY BEHIND THE PERFORMANCE

- The Wyoming Home Services (WyHS) program is a 100% state funded program.
- Grantees are required to match 5% of State funds expended. However, most Grantees choose to match significantly more, understanding the value that WyHS services add to their communities.
- Participants pay a fee for services based on a sliding fee scale and their ability to pay. No participant is denied services based upon their inability to pay.
- The program income generated through participant 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.
 - Homemaker services are the most offered service.
 - Personal Care services are offered in all but 2 counties, but are cost prohibitive due to the hiring and availability of certified nursing assistances (CNAs).
- Decreases in overall patronage are likely due to instability of Grantees in some areas.

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
Care Management Entity.....	0461
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
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

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
Emergency Medical Services.....	0503
Healthcare Preparedness Program (HPP).....	0503
Healthcare Workforce Recruitment, Retention and Development (HWRRD).....	0510
Healthy Baby Home Visitation Program.....	0524
Immunization Program.....	0522
Infectious Disease Epidemiology.....	0540
Injury Prevention.....	0539
Office of Health Equity.....	0510
Public Health Emergency Preparedness (PHEP).....	0502
Public Health State Laboratory.....	0532
Public Health Nursing.....	0526
Substance Abuse Prevention Program.....	0550
Tobacco Prevention and Control Program.....	0550
Trauma Program.....	0503
Women and Infant Health.....	0523
Women, Infants and Children (WIC) Program.....	0525
Wyoming Cancer Program.....	0531
Youth & Young Adult Health Program.....	0523

Aging Division

Legal Services & Legal Developer Program.....	5002
Long-Term Care Ombudsman.....	5002, 5004
Title III-B Supportive Services.....	5002
Title III-C1 Congregate Nutrition Program.....	5003
Title III-C2 Home Delivered Meal Program.....	5003
Title III-D Disease Prevention and Health Promotion Program.....	5002

Title III-E National Family Caregiver Support Program	5002
Wyoming Home Services	5002