



HealthStat 2019 Final Reports

January 15th, 2020

HealthStat 2019: A Foreward

HealthStat is a performance management initiative that began in 2011. HealthStat is now entering its ninth 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 HealthStat provides a method and a process that is clear and concise to regularly communicate with decision-makers.

Through HealthStat, department 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 HealthStat is represented in the following pages.

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WDH | Division of Healthcare Financing

Information contained in this section includes:

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 - Comprehensive Waiver
 - Supports Waiver
 - KidCare CHIP
 - Patient Centered Medical Home (PCMH)
 - Care Management Entity (CME)
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- 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 2017	SFY 2018	SFY 2019
Total Claims Cost (millions)*	\$556.3M	\$567.5M	\$554.2M
Average Monthly Enrollment	63,247	60,263	57,330
Cost per Person (PMPM)	\$689	\$728	\$757

* 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.

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	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Estimated % and # of Uninsured Wyoming Children under Age 19, Under 138% of Federal Poverty Level (FPL) (CY 2017 regional average** – 8.3%)	▼	10.4% 3,221 (CY 2013)	10.6% 3,332 (CY 2014)	12.9% 3,825 (CY 2015)	12.9% 3,596 (CY 2016)	13.3% 3,734 (CY 2017)	(-)
Estimated % and # of Uninsured Wyoming Adults Age 18 to 64, Under 138% of FPL* (CY 2017 regional average** – 24.1%)	▼	37.9% 22,437 (CY 2013)	33.1% 19,340 (CY 2014)	31.4% 17,008 (CY 2015)	30.1% 16,425 (CY 2016)	31.0% 16,515 (CY 2017)	(-)
Estimated % and # of Uninsured Wyoming Children under Age 19, All Incomes* (CY 2017 regional average** – 5.57%)	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)	8.8% 12,381 (CY 2017)	(-)
Estimated % and # of Uninsured Wyoming Adults Age 18 to 64, All Incomes* (CY 2017 regional average** – 12.25%)	N/A	19.3% 68,779 (CY 2013)	17.1% 60,856 (CY 2014)	15.5% 54,927 (CY 2015)	15.6% 54,527 (CY 2016)	16.4% 56,134 (CY 2017)	(-)

* US Census Small Area Health Insurance Estimates. <https://www.census.gov/data-tools/demo/sahie/#/>
 ** 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	SFY 2019
OUTPUTS						
Enrolled Members (unique count, total SFY)	88,642	91,062	88,775	84,785	80,475	76,964
% 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)	13.3% (577,737)
Member Months	844,694	896,103	815,075	781,641	743,735	716,570**
Average Monthly Enrollment	70,389	74,628	66,696	63,247	60,263	57,330
Recipients (unique count of members who used at least one service)	72,660	74,062	73,067	71,720	74,056	71,324
<p>* 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.</p> <p>**As of 10/11/2019</p> <p>(-) Indicates data not yet available</p> <p>N/A indicates data not yet available due to the creation of a new metric</p> <p>N/A* indicates data not available on a quarterly basis</p>						

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	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019*	
Per Member Per Month (PMPM)	▶	\$609	\$585	\$687	\$708	\$728	\$757	
Children PMPM	Children	▶	\$189	\$190	\$213	\$227	\$242	\$240
	Foster Care Children	▶	\$647	\$604	\$566	\$621	\$643	\$587
	Newborns	▼	\$636	\$657	\$674	\$682	\$922	\$766
Non-Disabled Adults PMPM	Family-Care Adults	▶	\$459	\$437	\$452	\$461	\$485	\$520
	Former Foster Care	▶	\$61	\$464	\$372	\$322	\$374	\$411
	Pregnant Women**	▶	\$928	\$762	\$1,036	\$1,114	\$1,056	\$1,072
Aged Individuals PMPM	Community Choices***	▶	\$1,645	\$1,654	\$1,719	\$1,682	\$1,636	\$1,648
	Nursing Home	▶	\$3,738	\$3,763	\$4,347	\$4,324	\$4,294	\$4,253
	PACE	▶	\$2,504	\$2,483	\$2,440	\$2,368	\$2,174	\$2,359
Disabled Individuals PMPM	Acquired Brain Injury	▶	\$4,151	\$4,165	\$3,816	\$3,756	\$3,889	\$4,504
	Adults with ID/DD	▶	\$5,488	\$5,243	\$5,421	\$5,091	\$4,982	\$5,397
	Children with ID/DD	▶	\$2,400	\$2,490	\$2,569	\$2,339	\$2,389	\$2,737
	Suppl. Security Income (SSI)	▶	\$733	\$730	\$781	\$827	\$774	\$817
Benchmark PMPM****	CHIP (Plan A)	▶	N/A	N/A	\$237	\$246	\$267	\$281
	Child Marketplace	N/A	N/A	N/A	\$261	\$283	\$452	\$413
	Adult Marketplace	N/A	N/A	N/A	\$525	\$560	\$693	\$690

*SFY 2019 as of 10/11/2019

** 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 2019 is \$280.70 (Plan A) and 2019 Marketplace child premium is \$413 (lowest price gold plan with \$750 deductible and \$7,900 max out of pocket). 2019 adult Marketplace premium is for a 40-yr old, non-smoker \$690 (lowest price gold plan with \$750 deductible and \$7,900 max out of pocket)

OUTPUTS AND EFFICIENCIES						
Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018*	SFY 2019
OUTPUTS						
Recipients (unique count of members who received services)	72,660	74,062	73,067	72,209	69,804	66,419
Enrollment	88,642	91,062	88,775	84,785	80,475	76,964
Member Months	843,001	897,281	815,075	783,206	748,391	716,570
Claims Expenditures (by service date)**	\$513.0M	\$524.5M	\$559.6M	\$554.2M	\$544.9M	\$542.7M
EFFICIENCIES						
% Enrolled that used services	82.0%	81.3%	82.3%	85.2%	86.7%	86.3%
Cost per Recipient	\$7,060	\$7,082	\$7,659	\$7,676	\$7,806	\$8,171
Cost per Enrolled Member	\$5,787	\$5,760	\$6,304	\$6,537	\$6,771	\$7,052
*6+ months of claim lag, SFY 2019 as of 10/11/2019 **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.
- From SFY2016 to SFY2018, Tribal facilities experienced an \$11 million increase in expenditures due to a change in reimbursement methodology that utilizes 100% federal funding. These changes include an increase in the number of encounters allowed, a rate increase for primary and behavioral health services, and an increase in the number of prescriptions allowed.



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		Desired Trend	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Physicians	% of Licensed and Practicing	►	99% + (est.)	99% + (est.)	99%+ (est.)	99%+ (est.)	99%+ (est.)
	# In-State	N/A	1,800	1,891	1,786	1,915	1,965
	# Out-of-State	N/A	7,664	7,472	7,133	6,785	6,417
Nursing Facilities	% of In-State	►	100%	100%	100%	100%	100%
	# In-State	N/A	38	38	38	37	37
	# Out-of-State	N/A	15	16	14	16	13
Hospitals*	% of In-State	▲	100%	100%	96.8%	96.7%	100% (est.)
	# In-State	N/A	30	31	31	31	29
	# Out-of-State	N/A	310	270	234	201	149
Pharmacies	% of In-State	►	95%** (est.)	98.5%	100%	100%	100% (est.)
	# In-State	N/A	132	131	134	126	125
	# Out-of-State	N/A	101	93	98	90	85
Dentists	% of Licensed and Practicing	▲	78%	79%	79%	72%	(-)
	# In-State	N/A	324	327	346	343	329
	# Out-of-State	N/A	131	142	143	135	102

(-) Indicates data not yet available

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

*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	SFY 2019	
Physician rates as a % of the regional average	121%	111%	111%	100%	116%	-	
Nursing facilities % cost coverage with the upper payment limit (UPL)*	87%	83%	91%	91%	89.4%	86%	
Hospital % cost coverage with the qualified rate adjustment (QRA)**	Inpatient	83%	85%	90%	99%	100%	-
	Outpatient	67%	68%	66%	99%	99%	-
Dental rates as a % of the estimated provider cost***	96%	88%	90%	91%	124%	-	
% of hospital inpatient days paid by Medicaid	15.89%	13.41%	13.77%	13.93%	-	-	
EFFICIENCIES							
ALL Claims Processing Time (days)	Service to Bill	26.9	27.4	29.2	33.6	35.7	45.4
	Turnaround Time, Receipt to Payment	4.4	4.6	4.2	4.4	3.95	3.7
	Service to Payment	31.3	32	33.3	38	39.6	49.2
% of all claims denied	9.7%	10.6%	12.9 %	13.7%	12.7%	16.5%	
(-) 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 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.

Performance Metric		Desired Trend	OUTCOMES					
			CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
(W15-CH) % of Children with 6+ Well Visits (15 Months Old)	Medicaid	▲	N/A	29.9%	30.0%	35.6%	37.4%	-
	National		N/A	60.1%	60.8%	59.3%	59.3%	-
(W34-CH) % of Children with 1+ Well Visit (Age 3-6)	Medicaid	▲	51.3%	46.2%	49.5%	53.0%	49.5%	-
	National		67.4%	66.9%	68.0%	66.9%	66.7%	-
(AWC-CH) % of Adolescents with 1+ Well Visit (Age 12-21)	Medicaid	▲	37.0%	31.5%	34.2%	37.9%	40.1%	-
	National		43.5%	45.5%	45.1%	44.7%	44.7%	-
(PQ101-AD) Rate of Diabetes Inpatient Admits per 100,000 Member Months (Age 18+)	Medicaid	▼	11.0	N/A	N/A	17.1	19.6	-
	National		N/A	N/A	18.5	17.9	18	-
(OHD-AD) Rate of High Dosage Opioids per 1,000 Opioids (Age 18-64)	Medicaid	▼	33.32	33.02	30.62	26.59	28.5	-
	National		N/A	N/A	N/A	N/A	N/A	-

(-) Indicates data not yet available
 - Data is not yet available and will be reported in early 2020.
 * 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	SFY 2019
OUTPUTS							
Emergency Room Visits per 1,000 Member Months		58.9	58.3	58.6	60.4	62.7	-
Inpatient Admissions per 1,000 Member Months		12.1	11.3	11.9	11.6	11.1	-
Seattle Children's Hospital	# of Med Reviews	N/A	N/A	N/A	13	28	16
	# of Completed MDT*	N/A	N/A	N/A	119	153	95
	# of PAL Calls**	N/A	N/A	N/A	226	304	247
# of Clients Enrolled in Diabetes Incentive Program		N/A	N/A	70	86	60	171
EFFICIENCIES							
PMPM	Age 0-21	\$310	\$307	\$351	\$368	\$395	\$389
	Age 22-64	\$1,210	\$1,087	\$1,213	\$1,206	\$1,185	\$1,280
	Age 65+	\$1,380	\$1,364	\$1,634	\$1,641	\$1,572	\$1,529
# of Unique Members	Age 0-21	59,697	60,682	57,823	54,049	48,465	47,617
	Age 22-64	22,742	24,703	25,546	24,499	22,043	22,904
	Age 65+	6,439	6,614	6,596	6,753	6,648	7,198
% of Unique Members	Age 0-21	67.2%	66.0%	64.3%	63.4%	62.8%	61.3%
	Age 22-64	25.6%	26.9%	28.4%	28.7%	28.6%	29.5%
	Age 65+	7.2%	7.2%	7.3%	7.9%	8.6%	9.3%
(-) Indicates data not yet available * 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							

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.

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	2017	2018	2019
Total Long Term Care Expenditures*	\$164,744,930	\$170,227,185	\$174,507,017
Unique People Served	4,740	4,876	5,015
Cost per Person	\$34,756	\$34,911	\$34,797

Community Choice Waiver (CCW)

SFY	2017	2018	2019
Total Program Cost (by service date)	\$38,554,005	\$40,484,581	\$44,366,172
Unique People Served	2,471	2,613	2,755
Cost per Person	\$15,603	\$15,494	\$16,104

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

SFY	2017	2018	2019
Total Program Cost (by service date)	\$3,496,938	\$3,502,181	\$3,909,316
Unique People Served	141	167	163
Cost per Person	\$24,801	\$20,971	\$23,984

Nursing Homes (NH)

SFY	2017	2018	2019
Total Program Cost (by service date)**	\$90,268,202	\$89,234,036	\$87,299,676
Unique People Served	2,416	2,395	2,390
Cost per Person	\$37,363	\$37,258	\$36,527
Total Provider Tax & Gap Payments***	\$32,425,785	\$37,006,387	\$38,931,853
Total Program, Tax, and Gap Costs	\$122,693,987	\$126,240,423	\$126,231,529
Cost per Person with Tax & Gap Costs	\$50,784	\$52,710	\$52,817

*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		Desired Trend	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Community-based Program (CCW or PACE)	% of LTC enrolled members	▲	52%	54%	55%	57%	58%
	% of LTC Member Months	▲	51%	53%	54%	56%	58%
	% of LTC Expenditures	▲	25%	25%	26%	26%	28%
Total Cost for Extraordinary Care Clients (% of total NH w/ tax & gap costs)*		▼	\$1,470,960 (1.4%)	\$1,481,129 (1.3%)	\$1,221,211 (1.0%)	\$840,239 (0.7%)	\$1,792,789 (2.0%)
Average LT-101 Score**	CCW	N/A	N/A	22.7	23.2	23	22.4
	PACE	N/A	N/A	25.5	24.3	24.5	24.2
	Nursing Home	N/A	N/A	32.5	32.9	32.4	31.6
Rate of ER visits (per 1,000 members months)***	CCW	▼	120.4	113.1	121.2	131.0	126.6
	PACE****	▼	29.6	38.1	27.3	39.2	N/A
	Nursing Home	▼	38.6	37.3	38.1	36.1	41.6
Rate of inpatient admits (per 1,000 members months)***	CCW	▼	50.8	48.1	49.9	52.6	48.0
	PACE****	▼	54.9	58.0	64.2	79.1	N/A
	Nursing Home	▼	27	24.5	27	23	29.5

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) and were not reported for SFY 2019

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		Desired Trend	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
OUTPUTS							
# of unique enrolled*	CCW	N/A	2,124	2,322	2,471	2,613	2,755
	PACE	N/A	97	121	141	167	163
	Nursing Home	N/A	2,285	2,349	2,416	2,395	2,390
Member Months	CCW	N/A	19,776	21,643	22,912	24,922	26,889
	PACE	N/A	911	1,206	1,464	1,606	1,659
	Nursing Home	N/A	19,667	20,255	20,854	20,860	20,521
Expenditures as % of Total Medicaid	CCW	N/A	6.2%	6.6%	7.2%	8.1%	8.2%
	PACE	N/A	0.4%	0.5%	0.6%	0.7%	0.7%
	Nursing Home	N/A	14.0%	15.7%	16.8%	17.8%	16.1%
EFFICIENCIES							
Per Member Per Month (PMPM) – total costs	CCW (waiver & medical)	N/A	\$1,648	\$1,715	\$1,683	\$1,624	\$1,650
	PACE	N/A	\$2,482	\$2,440	\$2,389	\$2,181	\$2,356
	NH (w/o tax & gap)	N/A	\$3,747	\$4,334	\$4,329	\$4,278	\$4,254
	NH (w/ tax & gap)	N/A	\$5,294	\$5,787	\$5,883	\$6,052	\$6,151
PMPM Index to NH (w/ tax & gap)	CCW (waiver & medical)	N/A	31%	30%	29%	27%	27%
	PACE	N/A	47%	42%	41%	36%	38%
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.



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

	2017	2018	2019
Total Medical & Waiver Cost	\$108,809,060	\$108,558,674	\$125,020,693
Total Waiver Cost	\$88,718,492	\$94,059,283	\$113,032,242
Total Medical Costs	\$20,090,568	\$14,499,391	\$11,988,451
Total People Served	1,890	1,989	1,983
Cost per Person (Medical & Waiver)	\$57,958	\$54,580	\$63,046

Program Cost Notes

- Once funded on the waiver, the participant receives Medicaid medical and waiver services.
- Program staffing for the Developmental Disabilities (DD) waivers is based upon the number of DD Section staff proportional to the number of participants active in the program.

Program Staffing

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

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of \$6,212 per person in FY19.
- The Waiver average costs per participant in FY19 was \$63,046
- 241 participants received some self-directed waiver services in FY19.
- There were 642 providers, certified and monitored by the DD Section, that were available to provide services for this Waiver during FY19.

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 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.
- **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 or 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	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
The number of participants ages 21+ living independently or semi-independently	▲	N/A	351/1,441 (24.4%)	375/1,632 (23.0%)	380/1,623 (23.4%)	432/1,695 (25.4%)	443/1631 (27.16%)
The number of participants ages 21+ working in competitive and community integrated settings earning at least minimum wage	▲	N/A	258/1,469 (17.2%)	296/1,593 (18.6%)	206/1,435 (14.4%)	298/1,683 (17.7%)	340/1598 (21.27%)
The number of individualized plans of care that pass quality review	▲	N/A	N/A	N/A	N/A	327/457 72%	757/1124 (67%)
The percentage of reported incidents found to be a result of a provider's failure to meet criteria established in statute, rule, or policy	▼	N/A	N/A	N/A	N/A	318/802 39%	329/1598 (21%)

(-) 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	SFY 2019
OUTPUTS						
# of participants on waiver	N/A	1,832	1,927	1,890	1,989	1929
# of waiver participants ages 18+ living in residential services or with family	N/A	1,090	1,257	1,224	1,249	1241
# of participants ages 18+ using waiver supported employment services	N/A	165	176	188	229	224
EFFICIENCIES						
Average cost per participant (waiver and medical)	N/A	\$39,391	\$58,678	\$57,958	\$54,580	\$63,046
Average cost per participant (waiver only)	N/A	\$36,380	\$45,863	\$47,513	\$47,941	\$57,699
(-) Indicates data not yet available N/A indicates data not yet available due to the creation of a new metric						

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.
- **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 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.

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

	2017	2018	2019
Total Medical & Waiver Cost	\$7,712,009	\$9,555,008	\$9,658,045
Total Waiver Cost	\$4,387,059	\$5,889,330	\$6,503,214
Total Medical Costs	\$3,324,950	\$3,665,678	\$3,154,831
Total People Served	556	580	569
Cost per Person (Medical & Waiver)	\$14,105	\$16,474	\$16,538

Program Cost Notes

- Once funded on the Waiver, the participant receives Medicaid medical services in addition to Waiver services.
- Program staffing for the Developmental Disabilities (DD) waivers is based upon the number of DD Section staff proportional to the number of participants active in the program.

Program Staffing

- FTE: 3.75
- 0 AWEC
- 0 Other

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of \$5,747 per person in FY19.
- The Waiver average costs per participant in FY19 was \$11,429.
- 129 participants self-directed some of their waiver services in FY19.
- 418 eligible individuals were on the waiting list for the Supports Waiver as of June 30, 2019.
- There were 331 certified providers monitored by the DD Section during FY19.

Events that have Shaped this Program

- **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 or 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	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY19
Average Utilization of Individual Budget Amount for Child and Adult Supports Waiver Participants	▲	N/A	21.8%	37.3%	46.5%	50.68%	61.72%

(-) 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	SFY 2019
OUTPUTS						
# of total participants	N/A	203	425	556	580	578
# of participants all ages using community integration services.	N/A	2	38	44	51	27
# of participants of all ages using supported living services.	N/A	3	107	133	179	143
# of participants ages 18+ using waiver supported employment services.	N/A	3	7	16	21	22
EFFICIENCIES						
Average cost per participant (waiver and medical)	N/A	\$6,097	\$11,629	\$14,105	\$16,474	16,538
Average cost per participant (waiver only)	N/A	\$4,302	\$6,542	\$8,093	\$10,424	\$11,429

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

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.



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 from birth through age eighteen living in a household with income between 134% and 200% of the Federal Poverty Level.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$10,534,583	\$11,693,766	\$12,466,059
People Served	5,782	5,143	5,844
Cost per Person	\$1,822	\$2,274	\$2,133

Program Cost Notes

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

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Medical and dental provider networks have high participation.
- Reporting for CHIP children receiving primary care, medical, and dental services are under review due to not meeting federal regulations.
- CHIP enrollment data and premiums, including comparable PMPM with children in Medicaid and K03 children (former Kid Care 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.
- Implementation of the Affordable Care Act in 2014 increased the income guidelines for Medicaid causing 1,252 Kid Care CHIP children to transition to Medicaid (K03 children tracked in Medicaid) and increase Kid Care CHIP funding by 23% effective 10/1/2014.
- 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% increase.

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	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	
% of Uninsured Children between 138% and 200% FPL*	▼	10.7%	9.9%	11.5%	11.4%	11.2%	(-)	
% of Wyoming Medical Providers in Network**	▲	4,308/ 4,900	4,363/ 4,939	4,549/ 5,146	4,834/ 5,465	4,890/ 5,511	4,719 /5,412	
		87.9%	88.3%	88.4%	88.5%	88.7%	87.2%	
% of Wyoming Dental Providers in Network**	▲	279/297	312/335	315/338	325/340	328/341	331/341	
		93.9%	93.1%	93.2%	95.6%	96.2%	97.1%	
% of CHIP Children with at least one Visit with a Primary Care Provider** ***	▲	4,280/ 8,307	2,961/ 5,891	2,901/ 5,967	3,017/ 5,782	3,124/ 5,143	2,293/ 5,844	
		51.5%	50.3%	48.6%	52.2%	60.7%	39.2%	
% of CHIP Children Receiving any kind of Dental Service**	▲	3,565/ 8,307	2,787/ 5,891	3,093/ 5,967	3,012/ 5,782	2,926/ 5,143	2,102/ 5,844	
		42.9%	49.8%	51.8%	52.1%	56.9%	36.0%	
CAHPS Positive Response Rates ****	▲	Customer Service	N/A	87.9%	92.1%	92.1%	83.0%	88.0%
		Getting Care Needed	N/A	93.3%	90.8%	94.2%	83.9%	96.1%
		Getting Care Quickly	N/A	95.4%	94.2%	96.6%	93.2%	95.9%
		Doctor Communicating Quickly	N/A	94.9%	98.5%	93.8%	96.5%	97.2%

*Small Area Health Insurance Estimates (SAHIE) data: https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=56&s_iprcat=3&s_agecat=4&s_year=2017,2016,2015,2014,2013,2012&s_measures=ui_snc&s_searchtype=s

**The data in these 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	SFY 2019	
OUTPUTS							
# of Unique Children Enrolled	8,307	5,597	5,967	5,782	5,143	5,844	
Monthly Average Enrollment	5,300	3,306	3,545	3,459	3,490	3,406	
% 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	72.8% 4,253/5,844	
EFFICIENCIES							
CHIP Premium (Plan A)	N/A	N/A	\$237	\$246	\$267	\$281	
Per Member Per Month	Medicaid	\$189	\$190	\$213	\$214	\$217	\$240
	K03	N/A	N/A	N/A	\$195	\$213	\$223
Child Marketplace*	N/A	N/A	\$261	\$283	\$452	\$413	
<small>*The 2019 Marketplace child premium is \$413 at > 400% FPL (lowest price gold plan with \$750 deductible, \$7,900 max out of pocket, and 80% actuarial value). Medicaid actuarial value is 97+%. Subsidies and tax credits are available for < 400% FPL. Online: https://www.healthcare.gov/see-plans/#/ (-) Indicates data not yet available N/A indicates data not yet available due to the creation of a new metric</small>							

STORY BEHIND THE PERFORMANCE

- Kid Care CHIP covers children from birth through age 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 2017 Small Area Health Insurance Estimates (SAHIE), 1,999 children are uninsured in the Kid Care CHIP age/income category (under 19 years of age with family income of 138% FPL to 200% FPL). There are 17,777 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 national health care accrediting bodies.

Program Expenditures and People Served

	2017	2018	2019**
Total Program Cost	\$813,472	\$806,724	\$ 608,188
People Served	15,908	19,411	17,015
Cost per Person	\$6 PMPM	\$3 PMPM No Recognition \$6 PMPM Recognized*	\$3 PMPM No Recognition \$6 PMPM Recognized*

* Must be recognized by NCQA, URAC, AAAHC, or The Joint Commission

** 2019 data as of 10/07/2019

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 12 of the NCQA recognized practices currently participate as of June 30th, 2019.
- 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		Desired Trend	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019**
% of Eligible Medicaid Recipients Served by a PCMH		▲	3%	13%	20%	25%	23%
ER Visit Rate per 1,000 Member Months	PCMH	▼	116.74	81.19	82.93	77.68	74.55
	Non-PCMH (benchmark)*	N/A	68.74	66.29	63.23	65.56	62.33
Inpatient Admit Rate per 1,000 Member Months	PCMH	▼	22.39	18.34	18.67	16.20	15.31
	Non-PCMH (benchmark)*	N/A	16.76	16.87	15.77	15.93	16.10
CY Average Percent for Clinical Quality Measures (CQMs) for All Participating Clinics	Breast Cancer Screening	▲	35%	45%	40%	41%	41%
	Childhood Immunization	▲	35%	43%	44%	34%	30%
	Diabetes Hemoglobin	▼	31%	36%	41%	50%	49%
	Controlling High Blood Pressure	▲	66%	74%	67%	62%	59%
	Colorectal Cancer Screening	▲	33%	34%	48%	37%	45%

* Non-PCMH Benchmark is Medicaid members who have had at least one claim during the SFY
 Clinical Quality Measures versions are updated on a calendar yearly basis and data is presented that way to stay in alignment with the measure
 ** 2019 Data as of 10/07/2019

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019**	
OUTPUTS						
# of Practices Participating	3	7	13	19	20	
% and # of Medicaid Eligible NCQA Practices Participating	19% (3/16)	38% (6/16)	59% (10/17)	85% (11/13)	79% (12/14)	
% and # of Medicaid Providers in Participating Practices*	3% (20/648)	6% (36/665)	19% (130/686)	20% (168/829)	20% (167/841)	
Required # of Reported CQMs	9	9	9	12	12	
EFFICIENCIES						
Eligible WY Accredited Clinics Participating /Total Clinics Participating in Program	3/3	6/7	10/13	13/19	12/20	
Total # of Continuity of Care Documents (CCDs) Viewed	N/A	5,901	13,912	14,893	24,319	
Per Recipient Per Month Cost (PRPM)	PCMH	\$995	\$748	\$734	\$722	\$714
	Non-PCMH (benchmark)	\$702	\$804	\$815	\$847	\$881

* Taxonomies used - 207R00000X, 207Q00000X, 208D00000X, 208000000X, 363L000000X, 363LA2200X, 363LP0200X, 363LF0000X, 363LP2300X, 363LC1500X – these represent Family Practice Physicians, Internist, Pediatricians, and Nurse Practitioners enrolled in WY
 ** 2019 Data as of 10/07/2019

STORY BEHIND THE PERFORMANCE

- Providers must meet the following qualifications to participate in the PCMH program:
 - Must be National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission, 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.
- The program has aligned the current 12 CQMs with those for the Promoting Interoperability Program 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 have been acquired by larger practices.
- 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, AAAHC, or The Joint Commission 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.
- On January 23rd, 2019 the PCMH-Technical Assistance task plan was initiated to help currently enrolled practices adhere to the PCMH model and to provide support.
- 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 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

	2017	2018	2019
Total Program Cost	\$4,663,605	\$4,605,389	\$3,118,300*
People Served	431	494	402
Cost per Person	\$10,820	\$9,323	\$7,757

*Due to new program payment methodology, SFY19 program costs and number of people served decreased.

Program Cost Notes

- Funding is 50% federal & 50% state general funds
- Risk-based capitated payments from SFY16-18, moved to non-risk methodology in SFY19
- *SFY19 non-risk capitated payments=\$1,438,613
- *FFS payment for TCM state plan services=\$1,679,687

Program Staffing

- 1 FTE
- 0 AWEC
- 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.
- Several CME network provider agencies were unable or unwilling to correct course to the higher level of accountability required for a fee for service claiming environment and left the network. Individual providers within the agencies who left the network have formed their own groups or independent practice to continue to deliver CME services.



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		Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% and # of all youth served who were served for 6+ months		▲	N/A	N/A	54% (196/ 363)	54% (233/ 431)	47% (230/ 494)	42% (167/ 402)
% and # of youth served 6+ months who graduated		▲	N/A	N/A	20% (40/ 196)	24% (56/ 233)	47% (107/ 230)	53% (89/ 167)
# (%) of youth (with 6+ months enrollment) with an admit to:	Psychiatric Residential Treatment Facility (PRTF)	▼	N/A	N/A	13% (25/196)	10% (24/233)	6% (13/230)	13% (22/167)
	Detention Center	▼	N/A	N/A	6% (12/196)	5% (12/233)	4% (9/230)	1% (2/167)
	Acute Psychiatric Hospital	▶	N/A	N/A	12% (23/196)	5% (12/233)	8% (19/230)	8% (14/167)
	Overall*	▼	N/A	N/A	24% (47/196)	21% (48/233)	16% (36/230)	13% (21/167)
% and # of youth served 6+ months moving from a lower level of care to institutional care at 6 months post discharge		▼	N/A	N/A	0.5% (1/196)	0% (0/233)	0% (0/230)	(-)

*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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	
OUTPUTS							
% and # of youth discharged	N/A	N/A	40% (131/ 328)	45% (194/ 431)	60% (295/ 494)	61% (247/ 402)	
# of CME youth served	N/A	N/A	328	431	494	402	
# of Recipients using additional services	Family Care Coordination	N/A	N/A	328	431	494	402
	Family Support Partner	N/A	N/A	153	213	219	162
	Youth Support Partner	N/A	N/A	N/A	19	26	37
	Respite Services	N/A	N/A	21	14	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	402 \$20,072
	youth served 6+ months	N/A	N/A	196 \$39,663	233 \$21,165	230 \$24,856	167 \$24,647
	graduated youth*	N/A	N/A	40 \$42,275	56 \$11,914	107 \$14,898	89 \$11,445
# served and total Medicaid cost per PRTF youth (non-CME)	N/A	N/A	236 \$55,197	228 \$57,265	228 \$58,027	243 \$48,892	

* "Graduated youth" is defined as those youth who have successfully transitioned from the CME program meeting all of their goals.

(-) Indicates data not yet available

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

STORY BEHIND THE PERFORMANCE

- The change in payment methodology for CME network providers moved from a risk-based capitated payment to fee-for-service payment on July 1, 2018. The change brought more accountability in encounter/claims data and new challenges in reimbursement of activities that don't easily lend themselves to fifteen minute billing units. For example, the lowest acceptable billing time to round up to one fifteen minute unit is 8 minutes. Network providers are required to check in with families frequently and use the family's preferred method of contact such as texts, emails, calls, or face-to-face. Some of these methods don't meet the 8 minute minimum rule which didn't matter when payment was made on a capitated basis but does matter when reimbursing via a fifteen minute unit fee-for-service.
- A pay for performance initiative is in the initial stages of identifying performance metrics and potential budgetary impact to the program to implement a tiered-rate payment structure based on individual network provider performance and outcomes.
- The CME is working with in-state PRTFs (WBI & St. Joseph's) to begin an "opt-out" approach to enrolling youth admitting to a PRTF at admission. Initial outreach is provided by Family Peer Support Partners to families of PRTF-involved youth to assist with successful transition to the community upon discharge.



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 2017	CY 2018	CY 2019 (Jan. – June)
Total Program Cost*	\$306,001	\$348,793	\$274,954
People Served**	2,866	2,011	1,195
Cost per Person	\$107	\$173	\$230

* 100% State General Fund; Costs for 2019 include moving costs, equipment installation, & increased staffing expenses

** This is a combination of patients helped directly from our central location & from our dispensing sites. It is also a reflection of unduplicated patients (unique records). The number of patients served from our central location has remained relatively steady over the last 3 years, but it has decreased from our dispensing sites over the same time period; this could be due to underutilization of the program, underreporting, or misreporting numbers.

Program Cost Notes

- Revenue Source:
 - Grants: 2015-13%, 2016-2018-0%
- Return on Investment (Value of Rx's dispensed/program cost):
 - 2016 = \$6.92
 - 2017 = \$8.79
 - 2018 = \$6.70
 - 2019 (Jan.-June) = \$3.95

Program Staffing: 4.5 FTE

- 1.5 FTE for pharmacists (RPh)
- 2.25 FTE for pharmacy technicians (CPhT)
- Other - 0.75 FTE for AWEC CPhT
- Short 0.75 FTE for RPh in June 2019.
- Volunteer hours:
 - 2016 = 390
 - 2017 = 195
 - 2018 = 484
 - 2019 (Jan.-June) = 166

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 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 March 2018, the Legislature approved additional funding to support program expansion
- In December 2018 – January 2019, we doubled our staffing and moved into a larger facility in the Hathaway Building with the State of Wyoming.



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	Desired Trend	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019 (Jan.-June)
Total patients served by re-dispensed medication ¹	▲	1,558	2,948	2,967	2,866	2,011	1,195
Total value of re-dispensed prescriptions ^{1,2}	▲	\$1,765,148	\$2,718,536	\$2,353,926	\$2,691,470	\$2,337,156	\$1,087,957
Patient medication compliance rate on mailed prescriptions	▲	62%	86%	88%	86%	73%	87%
Return on Investment (ROI) to communities (value of Rx's dispensed ² / program cost)	▲	\$6.09	\$10.77	\$6.92	\$8.79	\$6.70	\$3.95

(-) 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	CY 2019 (Jan. – June)
OUTPUTS							
Number of prescriptions filled using re-dispensed medication ¹		17,115	22,341	24,641	25,959	16,302	6,242
Rxs mailed ¹	Number	2,959	6,215	9,583	11,949	10,607	4,768
	AWP Value	\$510,022	\$1,101,064	\$1,403,106	\$2,015,763	\$1,959,608	\$847,420
# of 30 Day Fills (mailed)		2,373	5,458	8,624	11,918	11,699	4,991
Patients served via mail	Number	255	611	713	775	724	566
	Percent	16%	21%	24%	27%	36%	47%
Donated Medication	Pounds	12,902	15,948	14,675	14,510	5,947	3,320
	AWP value	\$3,198,712	\$3,274,153	\$3,132,899	\$4,165,753	\$3,464,516	\$1,652,306
Donation Sites	Number ²	25	28	28	33	29	30
	Pounds of unacceptable medication properly disposed	3,167	4,101	3,614	4,034	2,586	1,420
EFFICIENCIES							
Average program cost per prescription dispensed ³		\$16.93	\$11.30	\$13.80	\$11.79	\$21.40	\$44.05
Average AWP value per prescription dispensed		\$103.13	\$121.68	\$95.53	\$103.68	\$143.37	\$174.30
Donation usage rate (\$ dispensed / \$ donated)		55%	83%	75%	65%	67%	66%
(-) Indicates data not yet available							
N/A indicates data not yet available due to the creation of a new metric							
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.
- Spring 2018- Program expansion approved by the Wyoming legislature.
- December 2018- New staff start, doubling the previous amount of staffing.
- January 2019 the pharmacy moved and opened for business in the basement of the Hathaway Building.



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 use disorders.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost*	\$32,062,769	\$27,296,006	\$24,775,091
People Served	16,263	16,189	13,996
Cost per Person	\$1,981	\$1,686	\$1,770

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

Program Cost Notes

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

Program Staffing

- 0.6 FTE
- 0 AWEC
- Other - Contractor

Program Metrics

- The top three BH diagnoses by expenditures for all ages served in SFY2019 were:
 - Depression (\$5,045,223, 20%)
 - Adjustment Disorder (\$3,195,350, 13%)
 - Post-Traumatic Stress Disorder (\$2,201,863, 9%)

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.
- 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 outpatient community-based behavioral health services that are medically necessary and meet clinical criteria.

OUTCOMES							
Performance Metric	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 7 Days of Discharge: Ages 6-20 (National)*	▲	N/A	N/A	N/A	48.3% (47.8%)	53.3% (-)	(-)
Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 30 Days of Discharge: Ages 6-20 (National)*	▲	N/A	N/A	N/A	72.4% (69.2%)	76.4% (-)	(-)
Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 7 Days of Discharge: Ages 21-64 (National)*	▲	N/A	N/A	N/A	37.7% (N/A)	39.8% (-)	(-)
Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 30 Days of Discharge: Ages 21-64 (National)*	▲	N/A	N/A	N/A	60.1% (N/A)	57.8% (-)	(-)
% of adult prior authorization requests approved (# approved / # reviews)**	▲	N/A	N/A	N/A	N/A	87% (3,267/3,752) CY2018	(-)

(-) Indicates data not yet available

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

*These metrics are part of the CMS Core Measure set, and are reported for the previous calendar year (i.e. values under SFY2017 above is based on CY2016 data). National Benchmarks represent the median. Online:

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

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

OUTPUTS AND EFFICIENCIES							
Performance Metric		SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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)	17 (9,215/ 151,255)
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)	12.3 (4,813/ 56,922)
Outpatient BH service expenditures **	Total	\$31,995,615	\$35,144,285	\$36,206,409	\$32,064,078	\$27,296,006	\$24,775,091
	Children	\$21,069,903	\$21,819,733	\$20,484,119	\$20,187,426	\$20,021,130	\$19,276,236
	Adult	\$10,925,712	\$13,324,178	\$15,721,601	\$11,875,343	\$7,274,876	\$5,498,855
% of enrolled clients w/ mental health diagnosis ***	Children	13.3%	13.7%	15.6%	17.5%	18.1%	13.8%
	Adult	14.7%	15.3%	18.7%	20.6%	19.9%	15.4%
% of clients with mental health diagnosis who received a BH outpatient treatment****	Children	84.1%	84.8%	83.7%	82.2%	81.9%	84.8%
	Adult	73.2%	75.3%	74.2%	73.6%	70.4%	75.3%
# of unique BH Providers*****	In State	1,705	1,911	2,015	1,990	1,931	1,644
	Out of State	433	677	675	428	412	331
EFFICIENCIES							
% of total BH expenditures paid to Community Mental Health Centers and/or Substance Abuse Treatment Centers		44%	42%	34%	35%	36%	36%
PMPM for outpatient BH services*****		\$36.14	\$37.81	\$43.20	\$37.80	\$34.07	\$31.82
(-) 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 by paid date ***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. ****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. *****Decrease in the number of unique providers is due to final reenrollment in SFY2016. *****PMPM Report							

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.
- Rehabilitative services for adults with more than 20 dates of service require prior authorization to determine if additional services are medically necessary and rehabilitative. The policy was effective January 1, 2017. Per 42 C.F.R. §440.130, rehabilitative services are defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to his best possible functional level."
 - Restorative (Rehabilitative) Services – Services that help clients keep, get back, 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 keep, learn, or reach developmental milestones or improve skills and functioning for daily living that they have not yet acquired.
- Starting January 1, 2018, the Wyoming Division of Healthcare Financing contracted with Comagine (Qualis) to provide clinical reviews of medical necessity and rehabilitative services for clients over the age of 21 years 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. Full preventative and treatment services are covered for Medicaid eligible children while Medicaid covers a limited number of services for adults.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$13,978,457	\$11,826,020	\$11,179,864
People Served	31,152	28,665	27,215
Cost per Person	\$448	\$412	\$408

People Served and Total Program Costs have decreased due to adult benefit reductions. The Medicaid Program Manager identified inconsistencies with prior year data and has updated the methodology to a standardized report.

Program Cost Notes

- Dental is a 50/50 cost share between state general funds and federal match.
- In 2016, the reduction to adult dental benefits were proposed to reduce overall dental expenditures by \$3.5M over the biennium. Currently the biennium reductions have measured \$3.5M.

Program Staffing

- 0.2 FTE Program Manager
- 0 AWEC
- 5 Other - 1 Orthodontic Consultant Contract, 4 Dental Advisory Group Member Contracts

Program Metrics

- Metrics were identified to provide a comprehensive overview of the Dental Program.
- Additional metrics are defined to develop and refine services for our children (0-20) and adult (21+) age groups.

Events that have Shaped this Program

- Adult dental benefits were reshaped in 2016 which saved \$3.5M in the 2017/2018 biennium.
- Provider workshops are conducted annually to identify positive and negative trends within the dental community and provide feedback to Wyoming Medicaid on program strengths, weaknesses, opportunities, and threats.



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 services.

OUTCOMES

Performance Metric		Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Actively Enrolled Providers (in-state and out-of-state)		▲	438	455	490	495	485	464
Recipients per Enrolled Provider		▼	66.9	67.5	65.1	62.9	59.1	58.6
Unique Recipient Count for Teeth Cleaning	Children (0-20)	▲	20,716 85.7%	21,245 85.8%	21,460 85.6%	21,261 85.6%	20,038 85.9%	19,183 86.2%
	Adult (21+)	▲	2,145 41.1%	3,219 53.4%	3,700 53.6%	3,352 52.6%	2,976 55.3%	2,711 54.1%
Tooth Extraction Count	Children (0-20)	▼	3,620	3,720	3,750	3,747	3,670	3,259
	Adults (21+)	▼	2,145	2,544	2,976	2,604	2,117	1,987
Emergency Care Event Count	Children (0-20)	▼	175	160	155	99	49	69
	Adults (21+)	▼	589	622	718	388	283	260

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
OUTPUTS						
# of unique children (0-20) served	24,163	24,738	25,045	24,821	23,305	22,237
# of unique adults (21+) served	5,215	6,026	6,899	6,363	5,380	5,003
Unique Children (0-20) Expenditures	\$10.4M	\$10.7M	\$11.1M	\$11.1M	\$10.4M	\$9.8M
Unique Adult (21+) Expenditures	\$2.9M	\$3.6M	\$4.2M	\$2.9M	\$1.4M	\$1.2M
EFFICIENCIES						
Expenditures per Recipient Children (0-20)	\$432	\$435	\$446	\$445	\$446	\$441
Expenditures per Recipient Adult (21+)	\$574	\$602	\$613	\$460	\$264	\$259
Per Member Per Month	\$15.93	\$16.02	\$18.80	\$17.74	\$15.50	\$15.48

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

STORY BEHIND THE PERFORMANCE

- The adult dental program is malleable based on a desired capped budget through controlling the Expenditures per Recipient Adult metric. This is reflected by showing the reduction in Expenditures per Recipient Adult saved \$3.5M in the 2017/2018 biennium and is above target for the 2019/2020 biennium having saved \$2.7M from the 2015/2016 biennium level.



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

	2017	2018	2019
Total Program Cost (Before Rebate, All Pharmacies)	\$52,229,638	\$58,178,767	\$61,472,386
Total Program Cost (Before Rebate, Excludes IHS)	\$52,229,638	\$49,716,062	\$47,336,051
Total Program cost Net of Rebate, Excludes IHS)	\$24,516,145	\$19,301,785	\$18,054,954
People Served	44,291	43,455	40,717
Cost per Person (Before Rebate, Excludes IHS)	\$1,179	\$1,144	\$1,163

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 IHS expenditures which are 100% FFP.
- The first row of data reflects reimbursement to all pharmacies for outpatient drug claims.
- The second row of data reflects the reimbursement to pharmacies that included State funds (excludes IHS claims paid by 100% federal funds).
- The third row of data 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 (PBMS)—Change Healthcare (CHC)
 - Drug Utilization Review (DUR)—University of Wyoming School of Pharmacy

Program Metrics

- All Medicaid enrollees are eligible for pharmacy coverage. Approximately 54% of enrollees used the pharmacy benefit in SFY 2018, while approximately 53% used the pharmacy benefit in SFY 2019.
- Pharmacy expenditures were approximately 8.8% of total expenditures in SFY 2018 and 8.5% of total expenditures in SFY 2019.

Events that have Shaped this Program

- In September of 2017, 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. A third tribal pharmacy enrolled in May 2019. These pharmacies are reimbursed per prescription at the All Inclusive Rate (AIR) published annually in the Federal Register. This rate was \$427 in calendar year 2018 and is \$455 in calendar year 2019. The State program is a pass-through for these claims as they are paid at 100% FFP.
- In April 2017, Wyoming changed pharmacy reimbursement logic to include the National Average Drug Acquisition Cost (NADAC) in the lesser of logic used to price pharmacy claims. This change brought the program into compliance with the Final Covered Outpatient Drug Rule.



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		Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Short Term Outcomes—Cost Effective Coverage								
Rebate Savings	Mandatory	▶	\$22,528,038	\$21,274,188	\$29,542,136	\$25,427,155	\$27,973,723	\$26,868,678
	Supplemental		\$2,242,400	\$1,686,750	\$1,859,403	\$2,286,338	\$2,440,555	\$2,412,419
	Total		\$24,770,438	\$22,960,938	\$31,402,539	\$27,713,493	\$30,414,278	\$29,281,097
Savings generated by Preferred Drug List and Prior Authorization ^{a,2}		▲	\$7,844,047	\$8,894,753	\$9,821,265	\$10,476,821	\$10,756,339	\$10,562,232
State Maximum Allowable Cost Savings ²		▶	\$14,359,484	\$15,085,685	\$17,045,765	\$14,454,219	\$900,210 ^b	\$1,137,119 ^b
Intermediate Outcomes—Clinically Sound Treatment								
% and # of Prior Authorizations approved / # reviewed (% approved)		▶	4,693/8,507 (55.2%)	4,520/9,471 (47.7%)	4,783/10,472 (45.7%)	4,479/10,969 (40.8%)	4,757/11,797 (40.3%)	4,830/12,056 (40.0%)
% and # of prescriptions that changed due to Drug Utilization Review (DUR) edits / # that hit DUR edits (% of prescriptions changed)		▶	9,468/48,508 (19.5%)	8,572/49,055 (17.5%)	7,230/43,277 (16.7%)	7,236/43,498 (16.6%)	9,751/45,743 (21.3%)	11,618/44,202 (26.3%)

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	SFY 2019
OUTPUTS							
# of Clients Served		47,166	47,696	44,333	44,291	43,455	40,717
# of Prescriptions Paid		571,568	578,236	542,427	523,104	515,395	489,626
Average # of prescriptions per client per month		2.84	2.89	2.88	2.87	2.95	2.98
#/\$ of claims recovered on by program integrity ^d		375 / \$239,247	409 / \$380,732	210 / \$80,263	302 / \$125,153	753 ^e / \$280,937	374 / \$79,311
EFFICIENCIES							
Avg. Cost	Per client served before rebate ²	\$979	\$1,088	\$1,148	\$1,179	\$1,144	\$1,163
	Per client served net of rebate ²	\$454	\$607	\$440	\$554	\$444	\$443
	Per prescription ²	\$74.16	\$80.81	\$93.85	\$99.85	\$100.93	\$103.44
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	\$5,726,005
Program Integrity Cost Avoidance ^e		\$56,765	\$57,597	\$327,818	\$317,320	\$1,092,461	\$1,638,099
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). Additional edits implemented in SFY18 and SFY19 that contributed to cost avoidance were edits for maximum days supply of diabetic products, refill too soon edits for IHS or tribal clients, and pack size edits (where quantity of product dispensed on the claim did not match the pack size available for the product).

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 2017	SFY 2018	SFY 2019
Total Program Cost	\$12,391,507	\$12,540,772	\$10,561,389
People Served	285	289	300
Cost per Person	\$43,479	\$43,394	\$35,205
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 19 - \$10,391,372
 - SFY 18 - \$12,530,436
 - SFY 17 - \$12,366,081
- Non-Medicaid youth SGF costs:
 - SFY 19 - \$170,017
 - SFY 18 - \$10,336
 - SFY 17 - \$25,426

Program Staffing

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

Program Metrics

- Number of unique clients served in SFY 2019: 289 Medicaid-funded, 11 state general funds
- Number of PRTFs currently enrolled: 3 in-state and 13 out-of-state
- Average length of stay in SFY 2019: 147 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. A transition period of up to thirty (30) days may be authorized to permit time for the necessary court hearings, MDT meetings, and court orders to be updated. Upon expiration of the thirty (30) days, no further reimbursement is authorized.



Medicaid Psychiatric Residential Treatment

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		Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of PRTF admits with a previous PRTF admit*	Past 12 months	▼	21% (56/267)	19% (45/237)	15% (32/217)	12% (26/211)	15% (33/224)	18% (41/227)
	Past 5 years		33% (87/267)	34% (81/237)	32% (69/217)	28% (59/211)	31% (70/224)	30% (68/227)
Average length of stay (days)**		▼	178	203	185	206	200	147
% of discharged recipients with 6+ month length of stay (LOS)		▼	44%	46%	47%	50%	57%	26%

All data is based on Medicaid Chart A client information
 * Medicaid only. ** 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	SFY 2019
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	225 1,072
# of recipients	Medicaid	332	317	285	283	288	289
	SGF	22	14	5	2	1	11
	Discharged w/6+ month LOS	78	84	74	82	98	51
# of placements**	In-State	144	166	171	190	190	186
	Out-of-State	212	174	129	106	114	39
# of Medicaid covered/paid days		48,615	44,298	38,062	39,632	38,370	30,562
# of reported incidents		283*	179*	237*	36***	149****	192
* 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							
% of PRTF placements	In-State	40%	49%	57%	64%	63%	83%
	Out-of-State	60%	51%	43%	36%	37%	17%
Average cost per client		\$44,119	\$41,988	\$40,548	\$43,479	\$43,394	\$35,205

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

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)
 - Average OSCR Score: Year 4 (SFY 2019) = 2.89 - Admin, 2.52 - Records (6 visits)
- In SFY 2019 there were 16 PRTFs enrolled with Wyoming Medicaid: 3 in-state and 13 out-of-state



Wyoming Department of Health Customer Service Center

Program Description

The Wyoming Department of Health Customer Service Center determines eligibility for Modified Adjusted Gross Income (MAGI) groups, Medicare Saving Programs, Employed Individuals with Disabilities (EID), Breast and Cervical Cancer (BCC), and Tuberculosis.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$4,870,906	\$4,503,380	\$4,528,380
People Served	54,783	57,733	56,192
Cost per Person	\$122.01	\$78.00	\$80.59

Program Cost Notes

- 75% Federal match on the cost of staffing the Customer Service Center and State staff
- Customer Service Center Operations Cost was \$377,365 per month from July 2018 –June 2019.
- If Maximus had met all SLAs and exceeded the SLA criteria in five high-priority areas, they would have received a monthly incentive payment of up to 7% of the monthly invoice amount. Maximus did not meet this criteria in SFY2019.

Program Staffing

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

*An Assistant Vendor and Contract Manager began employment May 1 2019

Program Metrics

- Average total call volume: 11,884 per month from July 1, 2018, through June 30, 2019, with March 2019 being the highest month at 16,901.
- Average speed to answer in March 2019, was 22.79 minutes, but for the month of June 2019, that decreased to 14.75 minutes.
- Average application processing time has been as low as 4 days, but for the month of June 2019, the average was 8.97 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 their Technical Proposal, the State continues to pay the monthly cost set in the contract.



Medicaid Customer Service Center

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Average Speed to Answer (Minutes)*	▼	N/A	22.54	10.9	9.8	4.75	11.18
Client Satisfaction Survey Results (1 to 5, with 5 Being Most Satisfactory)	▲	N/A	4	4.52	3.8**	4.62	4.16
Average Processing Time for Application (days)***	▶	N/A	15.5	6.5	13	15.11	7.58
Quality-Eligibility Error Rate	▼	N/A	N/A	N/A	N/A	12.82%	5.46%
First Call Resolution	▶	N/A	N/A	N/A	95.02%	96.46%	92.58%

*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 again 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 taken.

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2014	SFY 2015*	SFY 2016	SFY 2017	SFY 2018	SFY 2019
OUTPUTS						
New Applications	N/A	8,883	22,591	23,281	18,858	15,245
Renewals	N/A	10,740	22,413	31,502	38,875**	40,947
Total	N/A	19,623	45,004	54,783	57,733	56,192
Total Call Volume	N/A	108,965	140,769	134,015	145,938	142,612
EFFICIENCIES						
Average Handle Time (minutes)	N/A	11.1	12.65	14.15	13.86	17.92
# of Abandoned Calls	N/A	40,317	33,785	30,689	12,740	27,467
Abandonment Rate	N/A	37%	24%	22.9%	8.74%	19.26%

* 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 due to the creation of a new metric

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 MAGI (Modified Adjusted Gross Income) 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 WDH Customer Service Center (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. We are in the process of re-procuring the CSC Contract
- 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/CSC Contract Managers closely monitor both vendors to verify that deliverables are of high quality and all 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/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.



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, Supports Waiver, Acquired Brain Injury Waiver, Children’s Mental Health Waiver, PACE, Nursing Home, Inpatient Hospital, and Hospice. Applications and renewals are taken via telephone, online, fax, email, walk-ins, and mailed hard copies.

Program Expenditures and People Served

	2017	2018	2019
Total Yearly Cost	\$1,701,398	\$1,582,833	\$1,619,774
Average # of Cases Per Month	6,578	6,644	6,817
Cost Per Case Per Month	\$21.55	\$19.85	\$19.80

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 SFY2019 the case load mix was:
 - 73% Waiver programs
 - 24% Nursing Home
 - 2% PACE
 - 0.5% Hospice
 - 0.5% Inpatient Hospital

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	Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Average processing time for new application approvals (days)**	▶	N/A	20.98*	20.35	16.70	13.07	13.55
Average processing time for new application denials (days)**	▶	N/A	22.87*	23.34	18.13	14.70	14.62
Average processing time for renewal approvals (days)	▶	N/A	8.41*	4.01	2.34	3.70	4.44
Average processing time for renewal denials. (days)	▶	N/A	18.24*	15.68	13.42	7.88	2.92

(-) Indicates data not yet available
 N/A indicates data not available due to creation of new metric
 *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	SFY 2019
OUTPUTS						
Average # of new Applications processed monthly	N/A	132*	152	168	167	161
% of new Applications denied monthly	N/A	38%*	33%	23%	11%	10%
Average # of Renewals processed monthly**	N/A	305*	325	358	353	359
% of cases closed at renewal monthly***	N/A	N/A	N/A	N/A	21%	25%
EFFICIENCIES						
Average number of active cases per month	5,519	5,966	6,376	6,578	6,644	6,817
Average number of active cases per worker	587	597	633	548	554	568

(-) Indicates data not yet available
 N/A indicates data not available due to the creation of the new metric
 *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 and 2019 data are listed.

STORY BEHIND THE PERFORMANCE

- 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 weekly. 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 number of cases in the unit as well as average caseload per worker to ensure that cases are evenly distributed across the unit.
- New staff are provided with extensive training before they are given a caseload. They are provided one on one training on policy and procedures, how to interview clients, how to document cases, customer service, technology systems (WES, EMWS, RIS, MMIS, and AVS systems) and Administrative Hearing procedures.
- Ongoing training for all staff 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 processes that need to be addressed.
- The number of average monthly cases has increased from SFY 2015 to SFY 2019. Some of the increase is due to changes in waiver programs and an appropriation to reduce the wait list and an increase in individuals on PACE. Increases are also due to the growing older 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 identify when another individual, entity, insurer, or program has the responsibility to pay part or all of a claim prior to Medicaid paying.

Program Expenditures and Total Dollars Recovered

	2017	2018	2019
Total Program Cost	\$873,821	\$898,969	\$924,458**
Total TPL Dollars Recovered*	\$4,565,124	\$5,128,958	\$6,038,557

*Includes estate recovery and TPL recovery.

** Beginning 12/10/2018, salaries from the Attorney General’s Office include part-time paralegal and 1 part-time attorney.

Program Cost Notes

- The Attorney General’s Office performs legal services for TPL and estate recovery.
- Recoveries made by TPL are reported on the CMS-64 report. Using the current federal medical assistance percentage (FMAP) rate of 50%, federal funds are returned to CMS for TPL services. However, during reviews of the CMS-64 report, the Centers for Medicare and Medicaid Services (CMS) requires that TPL recoveries be returned at the FMAP rate the claims originally paid under.

Program Staffing

- 1 FTE State Staff
- 0 AWEC
- Other
 - Contractual (Conduent) Staff 10 FTE for TPL and credit balance services.
 - 2 part-time attorneys and 1 part-time paralegal at the Attorney General’s Office

Program Metrics

- Medicaid’s Fiscal Agent (currently Conduent, Inc.) performs cost avoidance, pay and chase recoveries, pursues small personal injury recoveries involving medical payments coverage, tort recovery for criminal restitution, products liability and worker’s compensation and conducts preliminary research for estate recovery.
- 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		Desired Trend	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019***
Total TPL excluding cost avoidance*		▲	\$3,824,062	\$4,104,768	\$4,633,132	\$4,565,124	\$5,128,958	\$6,038,557
Total TPL including Cost Avoidance**		▲	\$16,573,460	\$17,574,611	\$19,673,818	\$16,684,199	\$16,541,272	\$16,024,407
% of Medicaid claims expenditures offset by total TPL****	Excluding Cost Avoidance	▲	0.74%	0.78%	0.84%	0.82%	0.90%	1.09%
	Including Cost Avoidance*****	▲	3.20%	3.33%	3.55%	3.01%	2.91%	2.89%
Estimated return on investment*	Excluding Cost Avoidance	▲	\$6 to \$1	\$5 to \$1	\$5 to \$1	\$5 to \$1	\$6 to \$1	\$7 to \$1
	Including Cost Avoidance*****	▲	\$25 to \$1	\$22 to \$1	\$23 to \$1	\$19 to \$1	\$18 to \$1	\$17 to \$1

* These figures include estate recovery and third party liability recoveries by deposit date.
 ** These figures include estate recovery, third party liability recoveries, and cost avoidance by deposit date for recoveries and by paid date for cost avoidance.
 *** SFY2019 figures are through 06/30/2019 for recoveries (deposit date) and for cost avoidance (paid date).
 **** Based on four years of paid claims history in SFY 2016 Annual Report and MMIS Report of Expenditures for SFY 2017, for 2018 and for 2019 per BPO.
 ***** 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	SFY 2019**	
OUTPUTS							
Total Estate Recovery	\$2,441,084	\$2,623,778	\$2,629,995	\$3,271,222	\$3,603,406	\$3,853,730	
Total Third Party Liability – Pay and Chase	\$1,382,978	\$1,480,990	\$2,003,137	\$1,293,902	\$1,525,552	\$2,184,827	
Total Cost Avoidance*	\$12,749,398	\$13,469,843	\$15,040,686	\$12,119,075	\$11,412,314	\$9,985,850	
# of Estate Recovery Cases	Opened***	1,123	1,396	1,054	1,574	1,391	1,428
	Closed****	965	1,198	1,353	1,486	1,189	1,359
Average # of Days From Case Open Date to Case Closed Date - Estate	383	942	407	272	216	211	
# of TPL Cases	Opened***	847	627	442	446	599	527
	Closed****	797	593	232	875	483	419
Average # of Days From Case Open Date to Case Closed Date - TPL	460	486	634	630	584	502	
EFFICIENCIES							
% of recovered estate recovery cases to open cases	12.11%	10.32%	13.66%	13.87%	12.01%	14.22%	
% of recovered TPL cases to open cases – Pay and Chase	47.21%	60.77%	74.21%	70.85%	52.25%	56.16%	
% 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%	4.61%	
<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 06/30/2019 by deposit 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, and 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>							

STORY BEHIND THE PERFORMANCE

- TPL requirements were incorporated into the BMS contract.
- 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. We are developing policy for special needs trusts, pooled trusts, and estate recovery.
- Wyoming is working on a few change system requests (CSRs). The first is a data match with United Healthcare. The second is a data match with AARP.
- Wyoming implemented a CSR for the data match with BCBS of Wyoming, as BCBS of Wyoming moved to a new system. Later, Wyoming learned that BCBS of Wyoming has outsourced the processing of dental and vision claims. A CSR is in process to add the appropriate carriers to the system.
- Wyoming will continue to explore a data match with CIGNA; however, it is on hold.
- Wyoming Medicaid is receiving and reviewing a monthly report from the SDX (State Data Exchange) 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.
- The bipartisan Budget Act of 2018 mandated that prenatal services be cost avoided. The effective date of the legislation was 02/09/2018. A CSR was implemented in January 2019 to comply with the 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 exploring options to change policies and procedures for estate recovery.

WDH | Behavioral Health Division

Information contained in this section includes:

- 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



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

	2017	2018	2019
Total Program Cost	\$3,422,539**	\$3,220,374**	\$3,088,386**
People Served	596	572	579
Cost per Person	\$5,743**	\$5,630**	\$5,334**
Non-600 Series*	10%	4%	3%

*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: \$3,722,595 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
- Surcharge account from July 1, 2016 through June 30, 2019 is \$512,773.65

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- There were 18 funded CST Programs in FY19 (11 adult, 3 juvenile, 1 DUI, and 3 adult/juvenile combined).
- 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of participants who graduate (retention rate) Adult (A) Juvenile (J)	A: 59% J: 59%	A: 59% J: 59%	A: 49%* J: 58%*	A: 61%* J: 69%*	A: 51%* J: 58%*	A: 39%* J: 57%*	A: * J: *
% of participants having re-arrest during their program participation (In-Program Recidivism Rate)	A: <5% J: <10%	A: <5% J: <10%	A: 7% J: 18%	A: 5% J: 11%	A: 6% J: 24%	A: 4% J: 16%	A: 4% J: 13%
% of participants having re-arrest within three years after their program participation (Post-Program Recidivism)	A: <3% J: <15%	A: <3% J: <15%	A: 8% J: 20%	A: 4% J: 19%	A: 4% J: 24%	A: 4% J: 24%	A: 4% J: 8%

*Metrics are broken out by year cohort. The SFY19 cohort includes all participants who entered the program between July 1, 2018 and June 30, 2019 and participants are projected to graduate within SFY21.

59% is the national graduation standard

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
# of unique participants Adults (A) Juveniles (J)	635 A: 551 J: 84	610 A: 545 J: 65	596 A: 542 J: 54	572 A: 515 J: 57	579 A: 515 J: 64	437 A: 401 J: 36	436 A: 393 J: 43	563 A: 503 J: 60	451 A: 407 J: 44
# of ancillary services per month, per participant	A: 5 J: 2	A: 4 J: 2	A: 4 J: 2	A: 4 J: 1	A: 4 J: <1	A: 5 J: 1	A: 6 J: 1	A: 4 J: <1	A: 5 J: 1
# of supervision contacts per month, per participant	A: 5 J: 6	A: 5 J: 10	A: 5 J: 8	A: 5 J: 7	A: 2 J: 4	A: 6 J: 9	A: 6 J: 10	A: 2 J: 5	A: 4 J: 5
# of substance abuse tests per month, per participant	A: 5 J: 4	A: 4 J: 5	A: 4 J: 4	A: 5 J: 3	A: 9 J: 4	A: 6 J: 4	A: 6 J: 4	A: 5 J: 2	A: 5 J: 2
Units of service per month, per participant	A: 19 J: 16	A: 17 J: 22	A: 17 J: 19	A: 18 J: 14	A: 14 J: 9	A: 23 J: 20	A: 24 J: 19	A: 15 J: 11	A: 19 J: 11

EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
Cost per unit of service (ancillary, treatment, supervision, drug test) A: Adult J: Juvenile	A:\$26.08 J: \$30.97	A: \$30.23 J: \$23.36	A:\$28.15 J: \$28.19	A:\$26.06 J:\$33.51	A:\$31.75 J:\$49.38	N/A*	N/A*	N/A*	N/A*
Annual program cost per participant (cost per day per participant)	\$6,083 (\$16.67)	\$6,114 (\$16.75)	\$5,743 (\$15.73)	\$5,630 (\$9.84)	\$5,334 (\$14.61)	N/A*	N/A*	N/A*	N/A*

*Indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

- Local programs conducted self-evaluations to determine what policies and procedures needed to be updated to align with the Wyoming CST Guidelines implemented in SFY19.
- In SFY19, a new data system was procured and customized to meet Wyoming needs. Training on the new system was conducted in June 2019. The new system went live on July 1, 2019. As a result, there was a gap in entering quarter 4 data. Quarter 4 data was not relied upon in order to allow for errors caused while learning the new system. With the new data system, it is possible that the data reported is not complete for the fiscal year which may impact the metrics.
- Retention is measured by fiscal year cohorts. This means that individuals who begin within a fiscal year are tracked together as they progress through the program. A typical CST program lasts, on average, one and a half years. As a result, no adults or juveniles have graduated from the SFY19 programs, as a result, the program is unable to report on SFY19 graduation rates at this time. That rate will change as participants complete the program.
- Local CST Coordinators were trained on National Best Practice Standards and the Wyoming CST Guidelines during SFY19.
- Research was conducted to see if the recidivism formula needed to be revised in order to accurately reflect program success. In SFY20, recidivism will reflect the number of arrests of participants during the program and after graduation.
- Several programs obtained new local CST Coordinators during the fiscal year which may have resulted in a pause in participant recruitment or a drop in services.

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 through age five years who are identified with developmental delays and/or disabilities. Part B/619 is a federally mandated program.

Program Expenditures and People Served

	2017	2018	2019
Total State Program Cost*	\$21,753,382	\$21,730,018	\$23,349,200
Children Served	2,635	2,689	2,380
State per child amount	\$8,238	\$8,674	\$8,674
Non-600 Series**	0.2%	0.3%	0.1%

*Total program cost includes CDC contracts and state funding for ½ FTE

**600 series is defined as direct service contracts

Part B/619 SFY19 Contract Amounts*

- State Part B: \$23,325,462
- Federal Part B funds: \$1,519,263
- Total Part B federal and state funding: \$24,844,725

*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.
- In SFY19, WDE implemented a new monitoring process for all school districts which includes the Child Development Centers (CDCs). The CDC chosen for monitoring is provided with technical assistance and a file review prior to onsite monitoring.
- In SFY19, all 14 CDCs used the same process for measuring child outcomes in 5 developmental areas. This entails using a standardized assessment tool for entry and exit of a child in Part B/619 services. Training was provided to all regions on the proper administration during SFY18 and SFY19 to help ensure fidelity in administering the tool.
- There is a national focus on ensuring children enrolled in Part B/619 are receiving FAPE in the least restrictive environment alongside their typically developing peers.



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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of children who substantially increased their rate of growth in Social-Emotional skills	90%	90%**	91.2%	90.9%	88.33%	87.79%*	78.91%***
% of children who substantially increased their rate of growth in skills Acquiring and Using Knowledge and Skills	75%	75%**	92.1%	92.7%	84.71%	70.34%*	57.78%***
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Needs	82%	82%**	92.77%	91.5%	86.3%	78.50%*	61.15%***
% of children receiving special education in inclusive settings	60%	75%	N/A	N/A	N/A	58.96%	73.9%
% of students with a speech language disability with occupational and/or physical therapy	34%	Discontinue	N/A	N/A	N/A	37.25%	24.93%

N/A indicates data not available due to the creation of a new metric
 Performance Metric Explanation: Of those children who entered the program below age expectations, the percent who substantially increased their rate of growth by the time they exited. (A substantial increase is identified as an increase of at least 1% point)

*Does not include COS scores from the three pilot regions

** Targets are the same for SFY 2019 and SFY 2020 as the targets were not met for 2018

***First full SFY of all 14 regions using same child outcome process

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Number of children served based on annual child count**	2,695	2,612	2,635	2,689	2,380	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)**	3,972	3,548	3,493	3,338	3,107	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted**	\$8,659	\$8,319	\$8,238	\$8,674	\$8,674	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually**	\$6,057	\$6,577	\$6,221	\$6,503	\$7,507	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.

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 rolled out a new process for determining child outcomes based on administering a standardized assessment tool to all children upon entry to the program and then again at exit. The SFY19 final percentages are indicative of the new process.
- In 2017, the Wyoming State Legislature approved an update to W.S. § 21-2-701 through -706 that requires a child ages three through five be placed on an Individualized Education Program as of December 1 in order to be included in the child count.
- SFY19 is the last year for the current Child Outcome targets. Through work with the Wyoming Department of Education, Part B/619 will develop new targets for Child Outcomes.
- Part B/619 was successful in exceeding expected targets for increasing the percentage of children receiving special education in inclusive settings alongside their typically developing peers (Least Restrictive Environment-LRE). Part B/619 will continue to collect data on LRE as this is also a national focus.
- Part B/619 shows success in decreasing the percentage of students with a speech language disability who are also receiving Occupational and/or Physical Therapy as related special education services. However, the EIEP is concerned that the lower child outcome percentage for Taking Action to Meet Needs may not accurately reflect valid data collection regarding Occupational and/or Physical Therapy. The EIEP will discontinue reporting on this metric and focus on providing training opportunities and technical assistance on comprehensive evaluation processes.
- In SFY20, the EIEP is implementing a new data system, which will result in being able to gather additional data on program performance.



Early Intervention & Education Program – Part C

Program Description

The Early Intervention and Education Program (EIEP) provides oversight of fourteen (14) Regional Child Development Centers that are contracted to provide IDEA Part C early intervention services to eligible children birth through age two. The program is State mandated in accordance with W.S. § 21-2-701 through -706. Children must meet eligibility criteria in order to receive Part C services.

Program Expenditures and Children Served

	2017	2018	2019
Total State Program Cost*	\$11,294,513	\$10,997,872	\$10,656,073
Children Served	1,289	1,254	1,215
Cost per Person	\$8,743	\$8,751	\$8,751
Non-600 Series**	0.2%	0.3%	0.2%

*Total Program Cost includes State funding for CDC contracts and state funding for ½ FTE

**600 series is defined as direct service contracts.

Part C SFY 19 Contract Amounts*

- State Part C: \$10,632,380
- Federal Part C funds: \$1,656,586
- Total Part C federal and state funding: \$12,888,966

*Contract amounts for CDC programs only

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

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

Events that have Shaped this program

- Individuals with Disabilities Education Act (IDEA), 1997 and IDEA Improvement Act, 2004
- The 2004 IDEA Improvement Act re-authorized and continues to require children, age birth through two years, to have access to early intervention services.
- Part C monitoring for CDC programs is done on a cyclical basis with all CDCs receiving Part C onsite monitoring every three years. In SFY19 there were four onsite monitoring visits.
- 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 SFY18, the EIEP rolled out a new Child Outcome reporting process whereby all fourteen CDCs utilize a standardized assessment tool for entry and exit of children receiving Part C services in five developmental areas. SFY19 was the first full year all CDCs used the new process.
- Training was provided to all CDCs on the proper administration of the assessment tool during SFY18 and SFY19.



Early Intervention & Education Program – Part C

PROGRAM CORE PURPOSE

The Part C program provides oversight of 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 have evidence of a developmental delay and who meet State criteria for early intervention IDEA Part C services.

OUTCOMES

Performance Metric	SFY 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of children who substantially increased their rate of growth in Positive Social-Emotional skills.	88%	88%	80.3%	86.4%	78.83%	80.68%*	71.23%***
% of children who substantially increased their rate of growth in Acquiring and Using Knowledge and Skills	85%	85%**	79.7%	83.8%	71.92%	72.59%*	58.97%***
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Their Needs	88%	88%	81.8%	86.8%	78.67%	85.34%*	82.37%***
Median hours of planned IFSP service hours per month	2	Discontinue	N/A	N/A	N/A	1	1

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

Performance Metric Explanation: Of those children who entered the program below age expectations, the percent who substantially increased their rate of growth by the time they exited (A substantial increase is identified as an increase of at least 1% point)

*Does not include COS scores from the three pilot regions

**Targets are the same for SFY 2019 and SFY 2020 as the targets were not met for 2018

***Includes all 14 CDCs utilization of the same process to measure child outcomes

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Number of children served based on annual count**	1,207	1,266	1,289	1,254**	1,215	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)	N/A	2,231	2,125	2,097	2,874	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted	\$8,812	\$9,068	\$8,743	\$8,751	\$8,751	N/A*	N/A*	N/A*	N/A*
Per child amount based on total number of children served annually	N/A	\$5,146	\$5,303	\$5,233	\$3,700	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.

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 suspected of having a developmental delay or disability are evaluated through a series of research-based and professionally recognized assessment instruments in order to determine eligibility for Part C services.
- As of July 1, 2018, all children are evaluated using a standardized assessment tool to measure a child's skill level when entering the Part C program and again upon exiting the program. The assessment summarizes child outcomes into a progress category for that child's participation in services. The SFY19 final percentages are indicative of the new process.
- The percentage of children who substantially increased their rate of growth in the following child outcome areas; Positive Social-Emotional Skills, Acquiring and Using Knowledge and Skills, and Taking Appropriate Action to Meet Needs, is indicative of the effectiveness of the program. These metrics are best measured annually for accurate reporting of this measurement.
- In State fiscal year 2018, the child count was changed to December 1 from November 1 due to a change in state statute 21-2-701 through -706.
- In SFY20, the EIEP is implementing a new data system which will result in being able to gather additional data on program performance.
- Part C will discontinue reporting on the metric "Increase the amount of planned IFSP services per month," and instead focus efforts on providing substantial training to CDCs on all aspects of the Part C program from initial evaluation through exiting of a child from Part C services. In addition, the new data system does not currently have a way to gather this information.

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

	2017	2018	2019
Total Program Cost	\$20,400,451**	\$20,048,387***	\$19,117,393
People Served	17,851	16,269	16,832
Cost per Person	\$1,143	\$1,232	\$1,136
Non-600 Series*	3.6%	2.1%	~1.0%

* 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 2019 Funding

- 97.59% State General Funds (\$18,656,378)
- 2.41% Federal Funds (\$461,015)

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 265,183.25 hours of mental health outpatient services were delivered in SFY2019 with an average of 16.29 hours of service per client.
- Populations served: 52.81% adults with Serious Mental Illness (SMI); 15.56% youth with Severe Emotional Disturbance (SED), and 31.63% 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016*	SFY 2017	SFY 2018	SFY 2019
Wait time for services (days) (8 of 14 providers met this target)	≤ 2 days	≤ 2 days	2.79	2.24	2.19	1.86	1.59
Treatment completion	75%	75%	65%	66%	68%	75%	74%
% of clients with SMI who left treatment against medical advice (AMA) or were “no shows” for appointments and were discharged	15%	15%	22%	21%	23%	16%	13%
Number of statewide Involuntary Hospitalizations	237	237	341	357	259	245	220
% 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%	60%	59%	57%	61%	62%

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY* 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Number of persons served	17,934	18,107	17,851	16,269	16,832	11,839	11,735	11,817	12,697
Number of persons with SMI served	7,619	8,003	7,679	7,648	9,036	5,770	5,870	6,470	6,981
Number of hours of outpatient services delivered	349,426	342,632	299,490	275,239	265,183	136,460	138,779	128,393	136,790
EFFICIENCIES									
Average cost per client	\$1,209	\$1,145	\$1,143	\$1,232	\$1,136	N/A*	N/A*	N/A*	N/A*
Average cost per service hour	\$62**	\$61	\$68	\$73	\$72	N/A*	N/A*	N/A*	N/A*

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 continued.
 - In SFY18, semi-annual contract and performance reviews were conducted, resulting in three providers placed on Corrective Action Plans (CAPs) for consistently not meeting performance metrics. After training and technical assistance were provided, no providers were on CAPs by the end of SFY2019.

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

	2017	2018	2019
Total Program Cost	\$7,138,277	\$7,082,079	\$7,061,337
People Served	434	550	658
Cost per Person	\$16,447	\$12,877	\$10,732
Non-600 Series*	3.7%	2.0%	~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

- 288 individuals resided in Community Housing (group homes and supervised living environments) in SFY 2019.
- 370 persons received Crisis Stabilization services in SFY 2019.
- 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 2019.

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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016*	SFY 2017	SFY 2018	SFY 2019
Utilization rate for crisis stabilization beds	55%	55%	30.47%	55.61%	50.72%	47.71%	44.43%
Utilization rate for group homes	95%	95%	83.99%	92.57%	92.42%	89.08%	82%
Utilization rate for supervised living	95%	95%	100.07%**	103.99%**	98.23%	86.44%	86.58%
Length of stay in group homes (days)	300	300	404.46	452.90	422.22	425.40	252.43
Length of stay in supported living environments (days)	400	400	621.08	546.06	531.10	575.95	621.57

*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 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Number of persons served – crisis stabilization	50	232	231	317	370	N/A*	N/A*	N/A*	N/A*
Number of persons served – group homes	80	118	104	121	152	N/A*	N/A*	N/A*	N/A*
Number of persons served – supervised living	84	132	99	139	136	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Average cost per client for crisis stabilization	\$35,422	\$8,075	\$9,722	\$7,775	\$5,795	N/A*	N/A*	N/A*	N/A*
Average cost per client for group home and supervised living***	\$27,119	\$19,367	\$24,593	\$19,817	\$17,074	N/A*	N/A*	N/A*	N/A*

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.
 - In SFY2018, semi-annual contract and performance reviews were conducted, resulting in three providers placed on Corrective Action Plans (CAP) for consistently not meeting performance metrics. After training and technical assistance were provided, no providers were on a CAP at the end of SFY2019.
- The MHSA Section completed the mental health community living study in SFY2019. Reports were compiled and sent to all mental health community living providers. The MHSA Section plans to pursue options for determining ways to equalize funding for beds and increasing bed turnover in order to provide greater access to persons needing these specialized beds.



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

	2017	2018	2019
Total Program Cost	\$10,503,615**	\$11,348,303***	\$9,613,049
People Served	6,012	6,255	6,220
Cost per Person	\$1,747	\$1,814	\$1,546
Non-600 Series*	3.6%	2.7%	3.5%

* 600 series is defined as direct service contracts.

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

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

Program Cost Notes

SFY 2019 Funding:

- 54% State Tobacco Funds (\$5,218,281)
- 19% State General Funds (\$1,826,876)
- 27% Federal Funds (\$2,567,892)

Federal funds decreased due to changes in STR and SOR grants

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 160,875 hours of outpatient services were delivered by community substance use providers, with an average of 25.86 hours of service per client in SFY 2019.
- 49.97% of persons served in SFY 2019 were admitted with a primary problem of alcohol, 18.34% for marijuana/hashish, 19.55% for methamphetamine, 9.58% for opiates (including heroin), and 2.56% 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016*	SFY 2017	SFY 2018	SFY 2019
% of clients completing treatment	75%	75%	66%	66.04%	71.13%	73.56%	71.98%
% 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%	61%	66%	62%	68%	67%
Average wait time for services (days)	≤ 2	≤ 2	2.46	1.98	2.75	1.90	1.09

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

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Number of persons served	6,672	6,680	6,012	6,255	6,220	4,008	4,188	3,999	4,157
Number of persons admitted	5,314	4,421	4,496	5,438	4,792	2,731	2,707	2,410	2,382
Number of persons discharged	5,923	4,846	5,012	4,924	4,937	2,243	2,681	2,390	2,547
Hours of outpatient services delivered	199,863	193,942	165,977	165,006	160,875	80,014	84,992	74,639	86,236
EFFICIENCIES									
Average cost per client	\$1,424	\$1,574	\$1,747	\$1,814	\$1,546	N/A*	N/A*	N/A*	N/A*
Average service cost per hour	\$48**	\$52	\$63	\$69	\$60	N/A*	N/A*	N/A*	N/A*

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.
 - In SFY 2018, 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 were provided through monthly meetings with the providers and the Corrective Action Plans were resolved. There were no Corrective Action Plans in SFY 2019.
- During SFY 2019, staff managed two (2) federal grants targeted at increasing access to treatment and medication assisted treatment for persons with opioid use disorder. The State Targeted Response (STR) grant ended April 30, 2019. The State Opioid Response (SOR) grant began September 30, 2018 and is set to expire on September 29, 2020.
- 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 2019 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.



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

	2017	2018	2019
Total Program Cost	\$13,206,817	\$13,550,539	\$13,422,383
People Served**	1,051	962	1,042
Cost per Person	\$12,566	\$14,086	\$12,881
Non-600 Series*	3.6%	2.0%	~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 2019 Funding:
 - 80% State General Funds (\$10,788,814)
 - 20% Federal Funds (\$2,633,568)
 - 0% Tobacco Settlement Funds

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 69,417 days of primary residential treatment were delivered statewide with an average of 66.6 days of service per client in SFY 2019.
- There was a 7% increase in the numbers of persons admitted in SFY 2019 as compared to SFY 2018, resulting in a decrease in the cost per person.
- 38.48% of persons served in SFY 2019 were admitted with a primary problem of methamphetamine, 39.83% for alcohol, 11.32% for opiates (including heroin), 8.06% for marijuana/hashish, and 2.31% 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016*	SFY 2017	SFY 2018	SFY 2019
Utilization rate	96%	96%	88%	90%	92%	96%	91%
Treatment completion rate	80%	80%	73%	74%	76%	74%	72%
% 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%	91%	85%	82%	82%	81%

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Number of persons served	1,174	1,794	1,051	962	1,042	576	595	620	623
Number of persons admitted	1,044	1,090	895	835	1,027	412	423	566	461
Number of persons discharged	1,033	1,108	892	886	976	407	479	515	461
Number of days of residential services provided	81,795	80,468	65,565	65,604	69,417	34,486	31,118	34,240	35,177
EFFICIENCIES									
Average cost per client	\$11,973	\$7,485	\$12,566	\$14,086	\$12,881	N/A*	N/A*	N/A*	N/A*
Average cost per day	\$172**	\$167	\$201	\$207	\$193	N/A*	N/A*	N/A*	N/A*

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.
 - In SFY 2018, 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 were provided through monthly meetings with the providers with the providers and the Corrective Action Plans were resolved. There were no Corrective Action Plans in SFY 2019.
- There was a 7% increase in the numbers of persons admitted in SFY 2019 as compared to SFY 2018 resulting in a decrease in the cost per person.
- 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 2019 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.

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
 - Healthcare Preparedness Program (HPP)
 - Healthcare Workforce Recruitment, Retention and Development (HWRRD)
 - Office of Emergency Medical Services (OEMS)
 - Office of Health Equity

- Public Health Preparedness & Response (PHPR)
- Trauma Program
- Public Health Sciences Section
 - Communicable Disease Prevention Program
 - Communicable Disease Treatment Program
 - Infectious Disease Epidemiology
 - Public Health State Laboratory



Child Health Program

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 health care needs. The Child Health Program also strives to foster the engagement of parents and other caregivers across the state.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$388,973	\$380,547	\$263,659*
People Served**	N/A	22,651	41,220
Cost per Person	N/A	\$16.80	\$6.40
Non-600 Series***	55%	47%	16.5%

*Expenditures decreased in 2019 due to contract changes, which ensured greater alignment with priorities.

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

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

Program Cost Notes

- The Child Health Program is federally funded through the Title V Maternal & Child Health Services Block Grant. Programs within the Maternal & Child Health Unit share a unit-wide budget.
- The number of people served increased in 2019 as a result of better tracking within current program activities.

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, state fiscal year 2007 through 2017)
- 37.7% of Wyoming children 6-11 years old are physically active 60 minutes per day, compared to 28.2% nationally. (National Survey of Children’s Health, 2017)
- 40.97% of Medicaid-enrolled Wyoming children ages 1-9 years received an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen in the past 12 months compared to 55.15% nationally. (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-wide 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.
- Child injury mortality rates in Wyoming remain consistently higher than the U.S. rate.
- There are Department-wide efforts aimed at increasing EPSDT screening rates.
- In SFY 2019, CHP release a mini-grant opportunity for communities to address childhood injury based on local needs. The awards will go toward supporting community-based prevention efforts.



Child Health Program

PROGRAM CORE PURPOSE

The purpose of the Child Health Program (CHP) is to ensure all Wyoming children, including children with special health care needs, have access to early developmental services, safe communities to grow, and access to quality healthcare with engaged caregivers.

OUTCOMES

Performance Metric	CY 2019 Target	CY 2020 Target	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
% of children ages 9-35 months receiving a developmental screening using a parent-completed screening tool*	31.1%	31.1%	N/A	N/A	27.0% WY 31.1% US (2016/2017)	22.5% WY 33.5% US (2017/2018)	N/A
% of Medicaid enrolled children (1-9 years) that received at least one component EPSDT screen in the past 12 months**1	68.5%	68.5%	53.6% (11,207/ 20,890)	59.6% (11,144/ 18,693)	62.3% (10,826/ 17,374)	N/A	N/A
% of children ages 6-11 who are physically active at least 60 minutes per day*	41.5%	37.5%	N/A	N/A	37.7% WY 28.2% US (2016/2017)	34.1% WY 27.6% US (2017/2018)	N/A
Child (ages 1-18) Mortality Rate (per 100,000)***2	15.3	15.3	28.0 WY 17.5 US	19.7 WY 18.0 US	19.0 WY 17.2 US	N/A	N/A
% of parents reporting their child's doctor or health care provider always helped them feel like a partner in their child's care*	75.0%	75.0%	N/A	N/A	72.1% WY 75.1% US (2016/2017)	69.0% WY 74.9% US (2017/2018)	N/A

*National Survey of Children's Health. Data for these metrics have gone from single-year data points to two years-combined data points to report the most reliable estimates.
 **Medicaid 416 Report, Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) – calendar year, 2017 data updated 3/12/19; 2018 data not yet publicly available.
 ***National Vital Statistics Mortality data; 2018 data not yet publicly available. In previous reports, this metric was 0-18 years old. We excluded infant mortality and updated the data points accordingly.
 "N/A" – not previously collected or not available

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Ages and Stages Questionnaire (ASQ-3 and ASQ-SE) developmental screenings completed by Public Health Nurses (PHN)	722	1,018	1,241	943+ (YTD through 10/1/2018)	N/A	N/A*	N/A*	N/A*	N/A*
# of community grant recipients who implement evidence-based strategies to reduce childhood injury.	N/A	N/A	N/A	N/A	9	N/A*	N/A*	N/A*	N/A*
# of unique families served by Wyoming Parent Partner (FFY)	N/A	N/A	217	189	196	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per family served by Parent Partner as part of the Wyoming Parent Partner Project (FFY)	N/A	N/A	\$220.13 (\$47,768/ 217)	\$209.86 (\$47,132/ 189)	\$11.25 (\$41,405/ 196)	N/A*	N/A*	N/A*	N/A*

N/A - not previously collected or not available

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

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

*On October 1, 2018, Wyoming Public Health Nursing transitioned to a new data system. The new system collects ASQ screening data; however, reports on this data are not yet available. The CHP is working with PHN and MCH Epidemiology to obtain data from the new system.

STORY BEHIND THE PERFORMANCE

Trends

- EPSDT rates for children 1-9 have slightly increased over the past three year period but the rate remains relatively stable.
- In 2016, non-fatal injury hospitalization was selected as a State Performance Measure but due to data reliability concerns, the CHP replaced the measure with more stable child mortality rates. Wyoming's mortality rate among children 1-18 dropped between 2015 and 2016 and remained consistent and more near to the national average over the following two year period.

Challenges

- Due to changes in the administration and sampling for the National Survey of Children's Health, results from surveys prior to 2016 are not directly comparable and cannot be used to conduct trend analyses. This impacts performance metrics related to developmental screening, childhood physical activity, and parents feeling like a partner in their child's care.

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 2017	SFY 2018	SFY 2019
Total Program Cost	\$943,393	\$1,041,198	\$248,330
People Served	578,934	577,737	577,737
Cost per Person	\$1.63	\$1.80	\$0.43
Non-600 Series*	99%	92%	99%

* 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, which means nearly all expenditures are non-600.
- The decrease in 2019 program cost was due to a new cooperative agreement that had a scope change from the previous funding. This resulted in capacity building, requests for proposals, and contract implementation. The cost of year one was primarily staff salary and benefits during the capacity-building time. Expenditures will rebound as the grant moves from planning to implementation.

Program Staffing

- 2.15 FTE
- 1 AWEC

Program Metrics

- Heart disease, diabetes, and other chronic diseases are the leading causes of death for Wyoming residents at 54% of all mortality. (WY Vital Statistics)
- 78.5% of Wyoming adults have modifiable risk factors for chronic disease, including BMI of 25 or above, current smoker, and/or no physical activity. (WY BRFSS)
- 5.9% of Wyoming adults have been told by a provider that they have had a heart attack, angina, or a congenital heart defect (WY BRFSS)
- In Wyoming, the prevalence of diabetes in adults is 9%. (WY BRFSS)
- In Wyoming, the prevalence of pre-diabetes is 7.8%. (WY BRFSS)
- In 2017, 65.4% of Wyoming residents were considered overweight or obese. (WY BRFSS)
- 2018 hospital discharge data shows 44,495 patients were treated for heart disease, diabetes, and stroke. (WY Hospital Discharge Data)

Events that have Shaped this Program

- Due to grant requirements, 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.
- Statutes governing program responsibilities are outlined in Wyo. Stat. § 35-25-301 and 35-25-203(g)(iv).
- The program has experienced staff turnover, which has contributed to capacity challenges.
- In SFY2019, the CDC cooperative agreement changed focus and the program was limited to the areas of diabetes prevention and management as well as cardiovascular disease prevention and management.



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	2019 Target	2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of people with diabetes in targeted settings who have had at least one encounter with Diabetes Self-Management Education (DSME) ¹	5.3%	5.3%	4.4%	4.3%	4.9%	(-)	(-)
% of people with self-reported hypertension ² (national average)	30.0%	30.0%	29.9% (30.9%)	N/A*	30.8% (-)	N/A*	(-)
% of people with self-reported diabetes ² (national average)	8.8%	8.8%	8.4% (10.0%)	8.3% (10.5%)	9.0% (9.4%)	(-)	(-)

¹ Data Source: CDC DSME State Data Report

² Data Source: Wyoming Behavioral Risk Factor Surveillance System; data is weighted.

N/A* indicates data not available annually

(-) indicates data not yet available

(-*) indicates development of a new metric

NOTE: Metrics related to early childhood education sites and schools from previous reports have been removed due to changes in the grant guidance.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of CDC-recognized Diabetes Prevention Programs	0	0	0	0	3	N/A*	N/A*	N/A*	N/A*
# of pharmacists who provide medication therapy management services to promote self-management and lifestyle modification for patients with high blood pressure, high blood cholesterol, and diabetes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# of healthcare systems with policies or practices to refer persons with prediabetes or at high risk of type 2 diabetes to a CDC-recognized lifestyle change program	N/A	N/A	N/A	N/A	3	N/A	N/A	3	0
# of health care systems with electronic health records (EHRs) appropriate for treating patients with diabetes and cardiovascular disease ³	N/A	N/A	N/A	8	8	N/A	N/A	8	8
# of health care systems with EHR's appropriate for treating patients with high blood pressure	N/A	N/A	N/A	N/A	8	N/A	N/A	8	0
EFFICIENCIES									
Cost per successful DPP participant	N/A	N/A	N/A	N/A	(-)	N/A*	N/A*	N/A*	N/A*

³ Data Source: Mountain Pacific Quality Health 1305 CCM Project Report
 N/A indicates data not yet available due to the creation of a new metric
 N/A* indicates data not available on a quarterly basis
 (-) indicates data not yet available as participants have not yet completed the program.
 NOTE: Output metrics have been updated to reflect current grant guidance.

STORY BEHIND THE PERFORMANCE

- The Chronic Disease Prevention Program (CDPP) is funded by a federal grant, the Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke, financed in part by Prevention and Public Health Funds through the Centers for Disease Control and Prevention (CDC). This grant helps support state investments to implement and evaluate evidence-based strategies to prevent and manage diabetes, cardiovascular disease, and stroke in high-risk populations.
- Program metrics have been updated to reflect new grant requirements. With the new funding stream, the previous metrics were no longer relevant to the current grant.
- 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, reducing 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.
- In SFY2019 the CDPP faced significant barriers to program success and outcomes. The previous grant ended, and a new grant was introduced with only a 9-month funding cycle (September 30, 2018 and ended June 29, 2019). The 9-month funding cycle shortened the first planning year. The CDPP also faced significant staff turnover in recent years, which created great difficulty in executing contracts and expending federal funds.



Immunization Unit

Program Description

The Immunization Unit promotes childhood and adult immunizations. 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, and 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

	2017	2018	2019
Total Program Cost	\$4,508,668.27	\$3,367,550.79	\$3,987,874.43
People Served	141,910	146,480	171,570
Cost per Person	\$31.77	\$22.99	\$23.24
Non-600 Series*	33%	32%	33%

* 600 series is defined as direct service

Program Cost Notes

- Operational funding consists of 71% federal funds and 29% state funds.
- Number of people served per the WyIR.
- Standard budget was reduced by \$356,000 in BFY 2019/20.
- 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, state-funded
- 1 CDC Public Health Advisor

Program Metrics

- As of June 30, 2019, 119 public and private healthcare providers receive state and/or federally-purchased vaccines from Public Vaccine Programs operated by the Immunization Unit.
- More than 141,822 doses of pediatric and 7,240 adult vaccines were distributed to enrolled providers through the Public Vaccine Programs during SFY 2019.
- As of June 19, 2019, the WyIR contained information for 8,467,222 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 from a Universal Purchase 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 in Wyoming.

OUTCOMES

Performance Metric	CY 2018 Target	CY 2019 Target	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
7-Vaccine Series Coverage Estimate (19-35 mos.) ¹	65%	65%	61%	57%	61%	62%	(-)
School Vaccination Coverage Estimate (7 years) ²	N/A	75%	64%	65%	68%	65%	(-)
Influenza Vaccination Coverage Estimate (6 mos. – 4 yrs.) ³	N/A	80%	53.9%	63.6%	59.2%	(-)	(-)
HPV 2-doses Coverage Estimate (13 -17 yrs.) ⁴	N/A	40%	25%	25%	28%	30%	(-)

(-) Indicates data not yet available

N/A indicates target not set due to the creation of a new metric

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Percent of VFC Providers Receiving AFIX Visit ⁵	67% (73/109)	51% (56/109)	27% (33/124)	94% (103/109)	64% (73/119)	N/A*	N/A*	N/A*	N/A*
Number of Pediatric Doses Shipped ⁶	150,392	147,070	144,147	132,359	141,822	72,982	59,377	81,100	60,722
Number of VFC/WyVIP Program Providers ⁷	127	126	123	123	124	122	123	125	124
EFFICIENCIES									
Percent of PVP providers with more than 5% waste ⁸	54% (CY 2014)	26% (CY 2015)	26% (CY 2016)	27% (CY 2017)	28% (CY 2018)	N/A*	N/A*	N/A*	N/A*
WyIR Cost per Facility ⁹	N/A	\$1,586 (\$333,345/195)	\$1,546 (\$309,208/200)	\$952 (\$357,147/375)	\$1,111 (\$420,913/379)	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 are reported here by Calendar Year from the Wyoming Immunization Registry (WyIR) with the exception of influenza coverage which is obtained from the National Immunization Survey (NIS). The NIS lags at least one year on reporting data.

- 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. The national coverage rate is 70.4% (NIS 2017).
- 2 The School Vaccination Coverage estimate is measured at 7 years of age and includes: 5 DTAP, 4 Polio, 2 MMR, 3 HepB, 3 HIB, 2 Varicella and 4 Pneumococcal vaccines. The current school requirements allow children to complete the required vaccines between ages 4-6, meaning they should be fully vaccinated by age 7. The proposed rules are requesting to change this requirement so that children need to be vaccinated upon entry into any grade. This metric was previously reported as Kindergarten Coverage Estimate. It has been updated to reflect the age at which children should be fully vaccinated and to use WyIR data as opposed to the previous data source – Immunization Status Reports.
- 3 According to the CDC, children younger than 5 years, but especially younger than 2 years are more likely to develop serious flu illness that can result in hospitalization or even death. Coverage rates are from NIS. The national rate for this age group is 67.8% (NIS 2017).
- 4 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 at 13-17 years for 2-doses. Note that HPV is not provided by the Wyoming Vaccinated Important People (WyVIP) Program, nor mandatory for school entry. The national rate is 55% while the HHS Region 8 rate is 56.5% (NIS 2018). Wyoming is ranked 48th for this measure (NIS 2018).
- 5 AFIX (Assessment, Feedback, Incentive and Exchange), is the CDC's quality improvement program for VFC providers. An AFIX Visit is required for no less than 50% of eligible 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. AFIX Visits have shown to significantly impact coverage rates, decrease missed opportunities and implement best practices. This metric was previously reported as a number. It has been updated to reflect a percentage of eligible provides to better account for differences among the size of the group.
- 6 The number of pediatric doses shipped consists of doses shipped to healthcare providers enrolled in the state-funded WyVIP and federally-funded VFC Program. Data is from the CDC Vaccine Order and Tracking System (VTRCKS).
- 7 The number of providers enrolled in a pediatric Public Vaccine Program (PVP).
- 8 Vaccine loss is both costly and preventable. Sound vaccine management practices related to ordering, inventory maintenance, and storage and handling are critical to minimizing vaccine loss and waste. Vaccine loss includes expired or spoiled vaccines, wasted vaccine, and lost or unaccounted vaccine. The average vaccine waste for providers enrolled in the Wyoming PVPs is less than 3%.
- 9 WyIR Cost per Facility is calculated by taking the costs associated with the WyIR (maintenance, annual technical assistance, and product subscriptions) and dividing it by the number of active vaccinating facilities in the WyIR. As sustainability of the WyIR is a growing concern it is imperative to track costs by the facilities that utilize the system.



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

	2017	2018	2019
Total Program Cost	\$118,082	\$357,057	\$1,332,632
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.
- The increase in budget from 2018 to 2019 is a result of state general funds being appropriated for suicide prevention efforts. One million dollars are awarded to county governments via the community prevention grants.

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 Vital Statistics Services (WY VSS)).
- Wyoming has one of the top five highest injury mortality rates in the U.S.
- 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) (WY VSS) and 60% of non-fatal injury hospitalizations (2009-2015) (WY Hospital Discharge Data).
- 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 2017, the Wyoming suicide rate was almost twice the national average and the second highest suicide rate behind Montana (American Association of Suicidology).
- 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 2013 PHD strategic map.
- In 2017, suicide prevention was moved to the WIPP and the program 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.
- As of SFY2019, funding for community prevention grants for substance abuse, tobacco, and suicide prevention is distributed to county governments, 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Crude injury mortality rate per 100,000 population (National Rate) ¹	90	90	96.8 (66.7)	90.5 (71.8)	91.66 (74.62)	(-)	(-)
Older adult unintentional injury mortality rate per 100,000 population age 65+ (National Rate)	128	128	141.5 (107.7)	132.1 (107.9)	130.99 (110.01)	(-)	(-)
% of participants completing a fall prevention course with an improved Timed Up & Go score ²	85%	85%	N/A	85% (28/33)	89% (85/96)	82% (40/49)	93% (14/15)
Crude suicide rate per 100,000 population (National Rate) ¹	24	24	26.4 (13.7)	24.3 (13.9)	27.1 (14.5)	(-)	(-)

(-) Indicates data not yet available

N/A indicates data not available

¹ Data Source: WISQARS. 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. Data for the most recent years is preliminary data from Vital Records and subject to change as data is validated and rates finalized.

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. Data for the most current year is preliminary and subject to change.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of WY older adults who participated in a fall prevention course ³	N/A*	53	131	235	233	165	70	186	47
# of people trained in suicide prevention supported by WDH	N/A*	N/A*	1,799	996	945	649	347	565	380
# of personal safety devices distributed	N/A*	369	990	4,160	1,563	0	4,160	1,563	0
EFFICIENCIES									
Falls prevention training cost per participant	N/A*	\$34.66 (\$1,837/53)	\$79.39 (\$10,400/131)	\$44.26 (\$10,400/235)	\$85.83 (\$20,000/233)	N/A	N/A	N/A	N/A

(-) indicates data not yet available

N/A* indicates development of new metric

N/A indicates data not available on a quarterly basis

³ Includes individuals who participated in some of the course even if they 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 years 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 2017 the crude injury death rate was 91.66 deaths per 100,000 population compared to the U.S. crude rate of 74.62 per 100,000 (CDC WISQARS). The Wyoming suicide rate has significantly increased from 17 per 100,000 in 2004 to 27.1 per 100,000 in 2017 almost twice the national rate and the second highest suicide rate behind only Montana. (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 19 counties. In three counties, these services are provided through contract by county governments. In all counties, 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

	2017	2018	2019
Total Program Cost	\$7,860,744	\$7,667,616	\$8,055,915
People Served	94,299	88,137	82,691
Cost per Person	\$83.36	\$87.00	\$97.42
Non-600 Series*	92%	88.5%	83.3%

*600 series is defined as direct service contracts.

Program Cost Notes

- Funding provided by state general funds and the county contribution of 35% for salaries and benefits for State PHN employees working in the counties.
- 56% of total program costs are personnel costs; does not include other expenses paid by counties. It also includes funding for Natrona & Sweetwater counties' contracts, and the addition of Laramie County's contract as an independent county in 2018.
- Number of participants represents direct care services, classes, and outreach provided through PHN.

Program Staffing

- 81 State PHN positions in 19 counties and PHN administration (63 FTE, 18 PT)
- 2 AWEC positions
- ~79 other County PHN positions, including PHN staff from the 5 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 SFY2019, PHN provided direct services to 9,560 people in 43,884 visits. Classes and outreach efforts were provided to 73,131 participants (some class participant numbers may be repeat participants).
 - 34% of total PHN service time was spent in Maternal, Child, and Family services. 62% of this time was spent serving TANF-eligible clients, specifically.
 - 26% of PHN service time was spent in communicable disease work, including testing, treatment, and counseling for sexually transmitted diseases, outbreak investigations, and administering immunizations.
 - PHN spent 22% of service time in counter-terrorism work, 13% in adult health, 4% conducting LT101 assessments, and >1% in environmental health, home health, and other services.
- Each \$1 spent on public health programming generally returns \$5.06 in savings (APHA, 2013). Approximately \$40,762,930 in future savings to the State of Wyoming's social and health care systems may be realized from 2019 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

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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
# of WY adult residents reached through outreach activities*	12,820	14,071	4,937	3,456	4,065	11,702	12,792
% of eligible Children with Special Health receiving case management services through PHN	100%	100%	NA	100% (643/643)	100% (655/655)	100% (704/704)	100% (672/672)
# of communicable disease screens conducted by PHN**	7,828	11,938	6,376	7,783	7,639	7,116	10,853 ^A
% of Ryan White-eligible, HIV-infected Wyoming residents receiving PHN case management	85%	85%	NA	100% (186/186)	75% (137/183)	100% (174/174)	95% (206/218)
% of referred clients assessed for long-term care Medicaid waivers through PHN***	95%	95%	NA	NA	87% (4,267/4,911)	99.2% (7,264/7,320)	88.2% (6,185/7,011)

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

*Significant increase could be due to improved visibility of PHN in community, as well as improved definitions and tracking. Does not include classes or clinic visits.

**Includes screenings for sexually transmitted diseases (N=4,660) and tuberculosis (N=6,193). Target is a 10% increase over previous year.

***PHN began conducting LT101 assessments on brain injury clients in addition to elderly referrals in February 2019.

^A Increase in communicable disease screens is due to an increase in the number of individuals seeking screening; several counties also added county positions to increase screening efforts and address increased volume.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2018 Q1+Q2	SFY 2018 Q3+Q4	SFY 2019 Q1+Q2	SFY 2019 Q3+Q4
% of clients reporting “always” satisfied with PHN services [^]	NA	NA	NA	NA	97.2%	NA	NA	97.2%	NA*
% of chronic disease clinic visits with diabetes focus [^]	N/A	N/A	N/A	26.3% (888/3,364)	21% (852/4,056)	35.8% (451/1,259)	20.7% (437/2,105)	18% (375/2,036)	23% (477/2,010)
% and # of Wyoming adult immunizations administered by a PHN office	43.6% (37,096)/84,879)	34.6% (36,902/106,829)	26.8% (32,091/119,513)	24.7% (30,086/121,742)	21% (69,317/331,912)	23.8% (23,269/97,435)	28% (6,817/24,307)	22.3% (49,056/219,853)	18% (20,261/112,059)
EFFICIENCIES									
Nursing time in dollars spent completing data entry tasks** (# of hours)	NA	\$413,764 (14,064)	\$354,453 (12,048)	\$306,674 (10,424)	\$232,742 (7,912)	\$163,722 (5,565)	\$143,893 (4,891)	\$122,270 (4,156)	\$110,472 (3,755)
% of PHN hours spent on Maternal Child Health services for TANF clients	58%	60.3%	60.1%	63.1%	61.8%	63%	63%	63.8%	60%
ROI of PHNs providing Immunization Services [^]	N/A	N/A	N/A	N/A	\$6.37 per \$1 invested	N/A	N/A	N/A	\$6.37 per \$1 invested
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 [^] New Metric as of 2019 **Based on PHN average salary of \$29.42/hr; does not include program materials.									

STORY BEHIND THE PERFORMANCE

- State PHN is a partnership between the State and County governments for the provision of public health services in 19 counties. In three counties these services are provided independently by county governments, through contracts with PHN. PHNs in the counties are the “boots on the ground,” comprised of 79 direct care state nursing positions.
- State PHN administrative staff provides infrastructure for the State PHN offices located in the counties and provides funding, support, and consultation for the independent counties. The administrative PHN staff provides nursing oversight, human resource and administrative support of local staff, works with WDH programs that use PHN to improve delivery of programs, and implements quality improvement measures to improve service delivery and assure a competent public health nursing workforce.
- Performance of independent counties is included in the overall picture of PHN outputs and efficiencies beginning in 2018 following the alignment of contractual and programmatic reporting requirements.
- Conducted 2019 client satisfaction survey with 733 respondents. 75% of respondents were seen for immunization services. The 2020 survey will attempt to reach a broader representation of clients.



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

	2017	2018	2019
Total Program Cost (SFY)*	\$864,832	\$871,532	\$986,548**
People Served (CY)***	1,535	2,206	897****
Cost per Person	\$563	\$395	\$1,100
Non-600 Series*****	9.3%	10.5%	9.5%

* Program costs have changed from previous reports. Fiscal method for calculating expenditures changed in SFY2019 to more accurately reflect actual expenditures (and to exclude encumbrances that may not have been fully expended).

** SFY2019 expenditures increased because the program was able to expend more of the awarded TANF dollars to expand the way they serve clients and improve enrollment.

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

**** Indicates year-to-date: Best Beginnings (BB) Clients through 11-13-2019 and NFP clients through 11-22-2019.

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

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 (\$2.3 million) or higher.

Program Staffing

- 0 FTE*

*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, improve child health outcomes, and decrease infant mortality.
- In FY 2018, 82.2% of those with a positive **prenatal** depression screen received a nursing intervention, which includes a referral to treatment.
- In FY 2018, 88.4% of those with a positive **postnatal** depression screen received a nursing intervention, which includes a referral to treatment.

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, Nurse Family Partnerships (NFP), an evidence-based home visiting model for first-time mothers, was implemented in Wyoming, in addition to the already existing Best Beginnings (BB) home visiting model.
- In 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, 2019, four (4) 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 2019 Target	CY 2020 Target	CY 2016	CY 2017	CY 2018	CY 2019
% and # of referrals to Healthy Baby Home Visitation contacted	75% ¹	75% ¹	62.4% 4,607/ 7,384	58.6% 4,049/ 6,904	62.3% 3,802/ 6,101	46%* 1,686/ 3,636
% of women enrolled in Nurse Family Partnership (NFP) who quit smoking during pregnancy (national %) ²	25%	25%	23.0% (16.0 %)	23.0% (16.0%)	23.0% (16.0%)	22.0%** (17.0%)
% of infants enrolled in NFP born premature (<37 weeks gestation) (national %) ²	9.5%	9.5%	9.9% (9.6%)	9.9% (9.7%)	9.3% (9.9%)	9.8%** (10.0%)
% of women enrolled in NFP who initiated breastfeeding (national %) ²	90%	90%	87.8% (83.5%)	88.0% (84.1%)	88.0% (84.0%)	88.2%** (84.8%)

(-) indicates year to date through 6-14-2019

* indicates year-to-date through 9-30-2019 (NFP reporting is quarterly)

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2016	CY 2017	CY 2018	CY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
# of NFP clients Served ³	159	152	71	58 ⁺	79	71	48	58 ⁺
# of Best Beginning (BB) clients ⁴	1,586	1,383	2,135	839 ⁺	776	1,359	469	370
# of NFP clients graduated from the program ⁵	23	14	19	4 ⁺	5	14	4 ⁺	(-)
Cost to Healthy Baby Home Visitation (HBHV) program per client ⁶	\$688 (\$1.2 mil/ 1,745)	\$563 (\$864,832/ 1,535)	\$395 (\$871,532/ 2,206)	\$1,100 (\$986,548/ 897)	N/A*	N/A*	N/A*	N/A*

(-) indicates data not yet available

⁺ Indicates year-to-date: Best Beginnings (BB) Clients through 11-13-2019 and NFP clients through 11-22-2019.

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

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 partnered to implement the Healthy Baby Home Visitation Program.

Healthy Baby Home Visitation is delivered by Public Health Nurses using one of two models. Nurse Family Partnership (NFP) 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. In 2018 quality improvement effort continued to inform the ability of NFP to be implemented to Fidelity to the Model. As of July 1, 2019 four (4) counties will continue to implement the NFP model, which is down from five (5) counties in the previous year as Campbell County closed their NFP site. 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 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.

Footnotes:

- ¹ For performance metric #1, this is legislatively defined. It is important to note that many counties offer additional resources for pregnant women and/or families with infants beyond the Health Baby Home Visitation Program. 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, which does not provide numerators and denominators for reported outcomes. The time period from program initiation through 11-22-19 (CY 2019). These outcomes are also being collected for BB; however, we do not have WebChart data reports available yet.
- ³ Quarterly and CY 2019 figures include duplicates as clients are enrolled longer than a quarter, year-to-date as of 11-22-19. Quarterly figures do not equal CY figures due to client attrition and the closure of Campbell County NFP site.
- ⁴ A BB client is defined as a client who is not enrolled in NFP and who received at least one BB home visit. As of October 1, 2018 the BB data forms were redeveloped and entered into the Web Chart Electronic Medical Record data system. All BB data is now being entered into this system. Data reports from the Web Chart system are under development. As data reports become available this document will be updated as necessary.
- 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 evidence-based strategies to prevent alcohol abuse, opioid abuse, and other drug abuse.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost*	\$5,489,832	\$3,960,196	\$4,012,390
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series**	18%	34%	51%

* Program costs for each year have been adjusted from prior documents to include the full budget (previously only 600 and 900 series expenditures were reported).

** 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 for FY2018.

Program Staffing

- 2.5 FTE
- 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 economic benefit of delaying the onset of alcohol use for the 2014 senior high school class is approximately \$122 million.

Events that have Shaped this Program

- Pursuant to Footnote 7 to Section 048 of House Enrolled Act 62 from the 2018 Budget Session, this program, the Tobacco Prevention and Control Program, and the Injury and Violence Prevention Program made \$8,000,000 available to counties for activities designed to prevent the use, misuse, or abuse of tobacco, alcohol, or controlled substances and activities designed to prevent suicide.
- 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.
- 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.

Substance Abuse Prevention Program

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	2019 Target	2020 Target	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
Adult Binge Prevalence Percentage of Wyoming adults who report consuming 5 or more drinks (4 or more for females) on an occasion at least once in the past 30 days ¹ (national prevalence)	15%	15%	16% (16.3%)	18.4% (16.9%)	18% (17.4%)	17.4% -	-
Youth Prevalence Percentage of Wyoming high school students who have consumed alcohol within the past 30 days ²	30%	29%	-	31.6%	-	33.3%	-
Alcohol Fatal Crashes Percentage of fatal crashes with a blood alcohol content (BAC) of .08 or higher ³ (national rate)	20%	19%	32% (26%)	26% (24%)	30% (21%)	-	-
Opioid Overdose Death Crude rate per 100,000 of overdose deaths from prescription and illicit opioids ⁴ (national rate)	6.5	6	6.8 (16.3)	6.3 (19.7)	6.9 (21.6)	6.9 -	-
Opioid ER Rate Crude rate per 100,000 of opioid overdose emergency room discharges from prescription, illicit, and unspecified opioids ⁵	17	16.5	N/A	20.2	18.8	17.4	-

- Indicates data not yet available

¹ Data from the Behavioral Risk Factors Surveillance System (BRFSS); data is weighted

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). Includes deaths where underlying cause of death in X40-44, X60-64, X85, Y10-Y14 and contributing cause of death in T40 (.0-.4).

⁵ Data from Wyoming Hospital Emergency Room Data, National comparison not available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Beverage server trainings ⁶	3,547	3,158	2,668	3,496	3,498	1,411	2,085	1,245	2,253
Alcohol compliance checks no infractions	86.5% (1,073/1,240)	86% (1,213/1,410)	85.4% (1,050/1,230)	88.9% (901/1,013)	-	N/A*	N/A*	N/A*	N/A*
# of naloxone (Narcan®) doses distributed	N/A	N/A	N/A	727	986	190	537	295	691
# of individuals trained in opioid overdose response	N/A	N/A	N/A	733	510	400	333	263	247
EFFICIENCIES									
Prevention Needs Assessment Survey, cost per school district	-	\$7,266.67 [\$283,400/39]	-	\$6,912.20 [\$283,400/41]	-	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 ⁶ 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 33.3% in 2018. (Prevention Needs Assessment [PNA]).
- Wyoming, on average, has one of the highest percentages of fatal crashes with a blood alcohol content (BAC) of .08 or higher. Wyoming's percentage is currently 30% higher than the national average (30% Wyoming vs 21% National). (National Highway Traffic Safety Administration [NHTSA])
- Age-adjusted rates of poisoning deaths due to all drug overdoses in Wyoming decreased from 17.7 per 100,000 in 2016 to 12.2 in 2017. National rates during this same time period increased significantly by 9.6% from 19.9 per 100,000 in 2016 to 21.8 in 2017. (Centers for Disease Control and Prevention [CDC])

Efficiency

- Monitoring the cost per school district participating in the PNA Survey. Participation in the survey began decreasing, resulting in a loss of some county data. Since the 2016 survey, to increase school district participation, the program modified the survey to better accommodate school schedules resulting in an increase of five districts (36 in 2016 to 41 in 2018) participating and a decrease in cost per school district. Five additional school districts means 48 additional schools (128 in 2016 to 174 in 2018) and 4,327 additional valid completed surveys (13,187 in 2016 to 17,514 in 2018).

Current Efforts

- The SAPP provides an array of substance abuse prevention services that fall into two categories: (1) community-level efforts and (2) state-level efforts.
 - At the community level, the SAPP provides resources and support for local coalitions to utilize the public health approach to prevention and promotes the use of evidence-based practices to achieve a population-level change. Currently, these services are contracted with 22 out of the 23 county governments and the Wind River Indian Reservation.
 - At the state level, the SAPP works to change systems through collecting and disseminating data and other information, collaborating with law enforcement on multiple strategies including alcohol retailer compliance checks, and collaborating projects with other state and federal agencies.
- The SAPP received federal funding for the purchase of naloxone and training/education on opioid abuse and associated consequences in SFY 2017.
- The State Epidemiological Outcomes Workgroup is currently gathering data related to illegal and prescription methamphetamines and stimulants. The full report will be available in calendar year 2020.

Challenges

- Wyoming has the lowest beer tax (\$.02 per gallon) and spirits tax (\$.025 per 100 milliliters) in the nation. Increasing taxes on alcohol is one of the most cost-effective methods of reducing the harms caused by alcohol consumption
- 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 stopped conducting the YRBSS so this data is no longer collected in Wyoming. Underage alcohol use percentages are taken from the PNA, which is Wyoming-specific, and 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

	2017	2018	2019
Total Program Cost	\$4,982,876	\$4,892,320	\$3,225,931
People Served	578,934	577,737	577,737
Cost per Person	\$8.61	\$8.47	\$5.58
Non-600 Series*	50%	74%	78%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Tobacco settlement funds for this program were reduced to meet the \$2M requirement for community-based suicide prevention as directed in Footnote 7 of House Enrolled Act 62 of the 2018 budget session.
- County spending of prevention grant funds from this program is not equal over both years of the biennium.
- 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 expenditures.

Program Staffing

- 2.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Smoking costs the state \$239 million in direct healthcare costs. This is greater than costs associated with alcohol use or other drugs (WYSAC, 2010).
- Since 1995, 6 communities have passed comprehensive smoke free indoor air laws. This means that 29% of the state's population is protected from exposure to secondhand smoke in workplaces, restaurants, and bars (WYSAC, 2018).

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 program is modeled after the Centers for Disease Control'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.
- As of SFY2019, funding for community prevention grants for substance abuse, tobacco and suicide prevention is distributed to county governments.



Tobacco Prevention & Control Program

PROGRAM CORE PURPOSE
Reduce tobacco use in Wyoming.

OUTCOMES

Performance Metric	SFY 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of Wyoming employed adults surveyed who report that smoking is never allowed in indoor areas of their workplace ¹	94%	94%	91%	*	93%	*	*
% of Wyoming adults surveyed who currently smoke ² (national average)	17.1%	18.0%	19.1% (17.8%)	18.9% (17.1%)	18.7% (16.4%)	18.8% (16.1%)	-
% of Wyoming high school students surveyed who smoked cigarettes on one or more of the past 30 days ^{3,4} (national average)	11%	10%	15.7% ² (11%)	12% ⁶ (-)	*	11% ⁶	-

(-) Indicates data not yet available
* Intervening years between survey dates, or periods for which there is no data

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2015	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4	
OUTPUTS										
WQTP Enrollment ⁵ (Wyoming Quit Tobacco Program)	Total	1,781	1,592	1,851	2,067	1,851	894	1,173	854	997
	Pregnant women	32	27	17	14	16	3	11	6	10
	American Indian Commercial Tobacco Program	-	8	28	14	14	6	8	6	8
# of PHN Referrals ⁵	20	46	44	35	26	24	11	16	10	
Media Impressions ⁶ (mass, digital, social)	15,707	7,383	32.3M	34.6M	42M	NA*	NA*	NA*	NA*	
# of policies implemented in communities	22	17	16	11	6	8	3	4	2	
EFFICIENCIES										
Average cost per WQTP enrollee	\$513 (\$913,273/1,781)	\$574 (\$913,273/1,592)	\$493 (\$913,273/1,851)	\$442 (\$913,273/2,067)	\$450 (\$833,273/1,851)	NA*	NA*	NA*	NA*	

(-) Data is currently unavailable
NA* indicates data not available on a quarterly basis

STORY BEHIND THE PERFORMANCE

Trends:

- The percentage of Wyoming adults who report that smoking is never allowed in indoor areas of their workplace has remained above 80% (2006-2017) (2017 ATS).
- 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 (2015 YRBSS).
- 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. (2017 ATS).

Challenges:

- Wyoming does not have a comprehensive, 100% smoke-free state statute.
- Wyoming has one of the lowest cigarette tax rates in the nation at \$0.60/pack.
- YRBSS data is not currently collected in Wyoming; youth smoking rates will be taken from the Prevention Needs Assessment (PNA), which is Wyoming-specific, and there will no longer be a national comparison.
- While the youth smoking rate is 11%, the youth e-cigarette use rate is 36% (2018 PNA).

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 47%, and for those who use NRT the quit rate is 33%.
- 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 2017-2019 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.
- Working on an MOU with Medicaid for reimbursement of coaching calls Medicaid clients receive from the WQTP.
- Secondhand smoke campaign to focus on parents who smoke in front of their children was executed Oct 1, 2018.
- The No Amount is Ok secondhand smoke campaign was executed in August 2019. This campaign emphasizes the message from the Surgeon General that there is no safe level of exposure to secondhand smoke.

Sources:

- ¹BRFSS – Behavioral Risk Factor Surveillance System (Adults)
- ²YRBSS – Youth Risk Behavior Surveillance System (Youth)
- ³ATS – Adult Tobacco Survey
- ⁴NJH – National Jewish Health WQTP enrollment reports; criteria for enrollment have been updated so numbers reported this have been updated accordingly.
- ⁵Warehouse Twenty-One – Media analytics and metrics reports
- ⁶PNA – Prevention Needs Assessment (Youth – Wyoming specific)



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 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

	2017	2018	2019
Total Program Cost	\$1,764,517**	\$1,696,105**	\$1,620,463**
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	14%	12%	15%

*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.
- The program is standing up the Wyoming Perinatal Quality Collaborative (WYPQC), contracting with a coordinator to begin improving perinatal health care and access for women and infants in Wyoming.

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 infants.

Events that have Shaped this Program

- Title V funding requires a needs assessment every five years. The MCH Unit adopted 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 on this topic.
- 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 is implementing 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. Hospitals began implementing the screening on December 1, 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	2019 Target	2020 Target	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
% and # of births that occur in Wyoming with first newborn screen completed (Newborn Screening Database/Vital Statistics Services (VSS))	99%	99%	97.2% 6,920/ 7,113	95.8% 6,430/ 6,709	97.8% 6,135/ 6,273	98.0% 5,872/ 5,990	(-)
% and # of mothers who breastfeed their infants through 6 months of age (non-exclusive) (National Immunization Survey) ¹	60%	63%	58.1% 4,456/ 7,669	59.5% 4,393/ 7,384	61.3% 4,232/ 6,904	59.4% 3,865/ 6,508	(-)
% and # of infants born to women who smoked during first trimester of pregnancy (VSS)	15%	13%	15.7% 1,207/ 7,669	13.6% 1,007/ 7,384	13.6% 939/ 6,904	12.5% 814/ 6,508	(-)
% and # of very low birth weight (≤3lbs 4oz) infants born at facilities designated neonatal levels of care 3 or 4 (VSS)	68%	83.7%	58.2% 46/79	62.0% 62/100	81% 51/63	73.6% 53/72	(-)
% and # of infants born preterm (<37 weeks) (VSS)	9%	9%	9.6% 736/ 7,669	9.5% 698/ 7,384	8.9% 616/ 6,904	9.8% 637/ 6,508	(-)

(-) Indicates data not yet available.

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2018 Q1+Q2	CY 2018 Q3+Q4	CY 2019 Q1+Q2	CY 2019 Q3+Q4
OUTPUTS									
# of pregnant women enrolled in the Wyoming Tobacco Quit Line	32	27	17	14	16	3	11	6	10
% of counties that have at least 1 Certified Lactation Counselor trained Public Health Nurse	NA*	NA*	100%	100%	100%	NA*	NA*	NA*	NA*
# of women referred to the Maternal High Risk (MHR) Program	25	24	15	22	20*	NA*	NA*	NA*	NA*
# of infants referred to the Newborn Intensive Care (NBIC) Program	93	115	66	76	64*	NA*	NA*	NA*	NA*
EFFICIENCIES									
Cost per 1st & 2nd newborn screens (# of screens completed) ² (data is by SFY)	\$39.50 (12,926)	\$43.88 (12,769)	\$43.06 (11,897)	\$51.30 (11,291)	\$45.63* (11,014)	N/A*	N/A*	N/A*	N/A*

(-) Data not yet available

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

* The cost per screen decreased in SFY2019 due to a renegotiated contract for follow-up specialist services.

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 women and infants with special health care needs; and promotes all Maternal and Child Health (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 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. There has been a decrease in the birth rate in the state, which is depicted in the number of first and second screens performed. While the state does allow for families to opt out of this program, that only accounts for a small percentage of newborns.

Women, Infants, and Children (WIC) Program

Program Description

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

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$9,590,893	\$9,697,901	\$8,620,848
People Served**	15,803	14,260	12,863
Cost per Person	\$606.90	\$680.08	\$670.21
Non-600 Series*	17.4%	17.2%	17.5%

** People served is an unduplicated count of individuals served in the federal fiscal year.

* 600 series is defined as direct service contracts

Total Program Cost and People Served for the most recent year are preliminary numbers and subject to change.

Program Cost Notes

- Additional direct service expenditures not included in the 600 series equal \$4,690,591 for 2017-2019 combined.
- Total FY19-20 Budget of \$24,268,397 includes 6% GF, 73% FF, and 21% infant formula rebates.

Program Staffing

- 43.3 Total FTE (7.9 state office, 35.4 local agencies)
 - 38 state positions: 14 FT; 12 PT; 12 AWEC
 - 12 county positions: 1 FT; 11 PT
 - 8 hospital positions: 5 FT; 3 PT

Program Metrics

- From 2017-2019, an average of 8,824 pregnant, postpartum, and breastfeeding women, infants, and young children were served each month by WIC.
- In federal fiscal year 2019, 12,863 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-six retail grocers are contracted in Wyoming to redeem participant food benefits.

Events that have Shaped this Program

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



Women, Infants, and Children (WIC) Program

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% and # of survey respondents who met with a breastfeeding peer counselor and found it helpful	92%	92%	91.6% (1,024/ 1,118)	91.3% (1,220/ 1,336)	92.8% (1,106/ 1,192)	90.9% (1,129/ 1,241)	89.4% (980/ 1,241)
% and # of survey respondents who indicate that WIC helped them eat more vegetables and fruits	80%	80%	82% (1,790/ 2,184)	80% (2,121/ 2,652)	84% (1,949/ 2,320)	73.4% (1,830/ 2,493)	69.9% (1,590/ 2,275)
% of cash value benefits spent on fresh fruits and vegetables by WIC participants	73%	73%	67.6% (\$553,962/ \$819,919)	69.4% (\$570,710/ \$822,021)	70.9% (\$567,154/ \$799,885)	73.6% (\$546,154/ \$741,778)	71.3% (\$485,031/ \$679,842)
% of WIC infants who were ever breastfed (initiation) ¹	81.9%	81.9%	N/A	79%	80%	81%	80%
% of WIC infants who are exclusively breastfeeding at 3 months ²	46.2%	46.2%	N/A	33%	34%	33%	32%

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Average # of women served/month ³	2,620	2,590	2,363	2,120	1,836	2,203	2,037	1,874	1,798
Average # of children (ages 1-5) served/month ³	5,449	5,162	5,036	4,671	4,118	4,803	4,540	4,213	4,023
Average # of infants (ages 0-1) served/month ³	2,462	2,498	2,396	2,097	1,837	2,158	2,036	1,906	1,769
Average # of nutrition education contacts/month ⁴	3,050	3,071	3,171	2,874	2,389	2,998	2,751	2,479	2,299
Average # of referrals documented/month ⁵	973	1,303	2,835	2,891	2,818	3,028	2,754	2,825	2,812
EFFICIENCIES									
Average monthly food cost/participant/month	\$47.93 (\$504,844/ 10,531)	\$48.24 (\$494,488/ 10,249)	\$47.16 (\$461,985/ 9,795)	\$47.91 (\$425,798/ 8,888)	\$47.14 (\$367,282/ 7,791)	\$48.12 (\$440,876/ 9,163)	\$47.69 (\$410,721/ 8,613)	\$47.72 (\$381,406/ 7,992)	\$46.54 (\$353,157/ 7,589)
Average nutrition education cost/participant/month ⁶	\$5.49 (\$57,178/ 10,420)	\$5.51 (\$56,216/ 10,197)	\$5.39 (\$51,697/ 9,599)	\$6.50 (\$54,564/ 8,513)	\$6.02 (\$45,819/ 7,607)	\$4.36 (\$38,783/ 8,885)	\$8.64 (\$70,345/ 8,140)	\$5.35 (\$41,784/ 7,804)	\$6.73 (\$49,854/ 7,411)

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 decrease due to declining participation.

⁵ Average # of referrals documented is expected to decrease due to declining participation.

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 screening assistance, advocacy, and education to Wyoming residents to promote cancer prevention and early detection. The Program operates the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP), the Wyoming Colorectal Cancer Screening Program (WCCSP), the Wyoming Comprehensive Cancer Control Program (WCCCP), and the Wyoming Radon Program (WRP).

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$2,994,968	\$2,533,901	\$2,521,182
People Served	1,872	2,016	2,185
Cost per Person	\$1,600	\$1,257	\$1,154
Non-600 Series*	51%	59%	44%

* 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, tobacco settlement, and private funds.
- WRP activities are funded with federal funds.

Program Staffing

- 10 FTE
- 0 AWEC
- 1 CDC Public Health Associate

Program Metrics

- The WBCCEDP began in 1997. Since then, over 10,045 women have received clinical services and 404 breast cancers, 50 cervical cancers, and 671 high-grade cervical pre-cancers have been detected.
- WCCSP began in 2007. Since then, 5,144 Wyoming residents have received colonoscopies; 47.8% had polyps removed, 26.8% had pre-cancerous polyps, and 91 had colon cancer.
- 2011/12 was the first year of the colorectal 10-year/re-screen policy. Since 2011, 617 clients have been re-screened; 60.0% had polyps removed; 32.5% had pre-cancerous polyps; and 16 had colon cancer.
- The WCCCP began in 2004. Since then, the program has developed three cancer control plans to determine strategies to reduce the burden of cancer in Wyoming. The Wyoming Cancer Resource Services Program, established through the Cancer Control Act in 2007, now covers the entire state. The WCCCP also facilitates the Wyoming Cancer Coalition, which has grown to over 300 members.

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 and Prevention (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.
- 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

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), implement evidence-based interventions across the cancer continuum through the Wyoming Comprehensive Cancer Control Program (WCCCP), and provide radon kits to Wyoming residents at no cost through the Wyoming Radon Program (WRP).

OUTCOMES

Performance Metric	SFY 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% of women aged 40 years and older who received a mammogram in the last two years statewide ¹ (national median)	x	70%	x	61% (72.5%)	x	61.6% (-)	x
% of women who have received a Pap test in the last 3 years aged 21 and older statewide ¹ (national median)	x	76%	x	70.2% (75.2%)	x	72.5% (-)	x
% of people ever having an endoscopy aged 50 and above statewide ¹ (national median)	x	69.3%	x	65.2% (70.4%)	x	64.8% (-)	x
Incidence rate of melanoma (per 100,000) ²	20.0	17.5*	22.32	24.2	23.13	-	-
HPV 2-doses Coverage Estimate (13 -17 yrs.) ³	N/A	40%	25% (CY 2015)	25% (CY 2016)	28% (CY 2017)	30% (CY 2018)	(-)
% of fecal immunochemical tests (FIT) kits completed ⁴	70%	75%	47% (46/98)	60% (89/149)	51% (223/438)	60% (364/604)	64% (341/535)

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

(-) Indicates data not yet available

* Indicates the Wyoming Cancer Plan 2020 Target

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

¹ Data from the Behavioral Risk Factor Surveillance Survey (BRFSS) is on a calendar year and available every other year.

² Data from the Wyoming Cancer Surveillance Program

³ Data from the Wyoming Immunization Registry

⁴ This measure was revised from the “% of positive FIT kits” to the “% of FIT kits completed.” The new metric can be more readily influenced by program efforts.

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of women served through the program	390	391	534	638	355	272	366	209	146
# of clients who received a colonoscopy through the program	305	345	348	362	214	201	161	120	94
# of radon kits distributed	24	133	902	656	1,993	326	330	330	1,663
EFFICIENCIES									
% of clients whose time from breast cancer screening to diagnosis > 60 days	7.9% (6/76)	5.1% (4/79)	10.1% (7/69)	11.9% (10/84)	-	N/A*	N/A*	N/A*	N/A*
% of clients whose time from cervical cancer screening to diagnosis > 90 days	18.2% (2/11)	12.5% (1/8)	9.1% (1/11)	7.7% (1/13)	-	N/A*	N/A*	N/A*	N/A*
Dollars saved through business reply postage for FIT Kit Program vs. stamps	N/A	N/A	N/A	N/A	\$437	N/A	N/A	\$159*	\$278
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 *Q2 data only available									

STORY BEHIND THE PERFORMANCE

- The Program operates the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP), the Wyoming Colorectal Cancer Screening Program (WCCSP), which provide funding for cancer screenings and diagnostic services (i.e. mammograms, Pap tests, colonoscopies, and biopsies) for low-income, uninsured, and underinsured (WCCSP only); the Wyoming Comprehensive Cancer Control Program (WCCCP), which implements evidence-based interventions across the cancer continuum and promotes the screening programs; and the Wyoming Radon Program (WRP) provides radon kits to Wyoming residents at no cost.
- All numbers for testing are state fiscal year-to-date as of June 30, 2019. 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.
- 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.
- WBCCEDP has the highest CDC data rating possible with a 0% error rate and full compliance with 11 core performance indicators.
- Wyoming's melanoma incidence rate is above the U.S. national average. The WCCCP has partnered with all Wyoming state parks to provide sunscreen dispensers in all 12 state parks and 7 historic sites. The program has distributed a total of 48 dispensers to outdoor events, pools, and schools across the state.
- Wyoming has one of the lowest HPV vaccination rates in the U.S. The WCCCP has convened a stakeholder workgroup as part of the Wyoming Cancer Coalition to prioritize increasing HPV vaccination rates through evidence-based interventions.
- The Fecal Immunochemical Test (FIT) Kit Program is funded through an annual \$5,000 grant from the American Cancer Society (ACS). A FIT kit is an at home stool-based test to screen for colorectal cancer. The program continues to partner with the State Public Health Lab for processing the FIT kits.
- The WRP is funded through the State Indoor Radon Grant by the EPA.

Youth and Young Adult Health

Program Description

The Youth and Young Adult Health Program (YAYAHP) ensures that 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 youth and young adults with special healthcare needs.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$232,883.60	\$252,483.99	\$290,444.05
People Served*	2,781	9,776	9,388
Cost per Person	\$83.74	\$25.83	\$30.93
Non-600 Series**	52.3%	31%	44%

* People served are those who received direct services from the program

**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 in SFY 2018 and 2019.

Program Staffing

- 1.1 FTE
- 0.1 AWEC
- 0 Other

Program Metrics

- 1 in 3 Wyoming 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 decreased from 24.6 births per 1,000 in 2017 to 20.6 births per 1,000 in 2018. However, the Wyoming teen birth rate still remains higher than the U.S. rate.
- Medicaid Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) data indicates that only 24.1% of Medicaid eligible adolescents (10-20 years old) received a recommended EPSDT screening in 2018.
- Since 2018, 2,388 youth and young adults (ages 12-24) participated in evidence-based, sexual violence prevention programming through the RPE Program, which was an increase from previous years.

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 Medicaid, Wyoming Department of Health Communicable Disease Unit, local youth serving organizations, school districts, Goodwill Industries, the University of Wyoming, Wyoming Institute for Disabilities, and other local organizations.
- Currently Wyoming does not conduct the Youth Risk Behavior Surveillance System (YRBSS), which leaves a gap in our data for youth and young adults. The YRBSS monitors six types of health-risk behaviors that contribute to the leading causes of death, disability, unintended injury, pregnancies, and infections, and violence within this population.



Youth and Young Adult Health Program

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	SFY 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% high school students reporting no alcohol use in last 30 days ^{(PNA)1}	70%	70%	N/A*	N/A*	68.4%	N/A	66.3%
% 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)	78%	80%	70% (262/ 376)	72% (340/ 473)	72% (340/ 473)	67% (384/ 571)	73.2% (540/ 738)
Rate of births (per 1,000) among 15 - 19 year old girls ³ (WY & National Vital Statistics Service) (national rate)	25	18.8	28.7 (22.3)	26.2 (20.3)	24.6 (18.8)	20.6 (-)	(-) (-)
% of Medicaid eligible adolescents (10-20 years) who received at least one EPSDT screen ⁴ (Medicaid) (national %)	32%	36%	19.0 % (4,830/ 25,436) (35.2%)	21.1% (5,024/ 23,802) (35.3%)	22.6% (5,008/ 22,131) (36.1%)	(-) (-)	(-) (-)
% of adolescents with special health care needs whose parents reported receiving the services necessary to transition to adult centered health care ⁵ (NSCH) (national %)	18.9%	18.9%	N/A N/A	17.9% (16.5%)	(-)	(-)	(-)

(-) 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 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of youth and young adults participating in evidence-based programming through the Rape Prevention Education (RPE) grant ⁶	N/A	N/A	N/A	2,388	(-)	N/A**	N/A**	N/A**	N/A**
# of WyPREP ² implementing sites	N/A	6	8	10	9	N/A**	N/A**	N/A**	N/A**
# of clinics serving adolescents participating in quality improvement projects	N/A*	N/A*	N/A*	4	4	4	4	4	4
EFFICIENCIES									
Dollars spent per individual youth receiving comprehensive reproductive health education ²	N/A	N/A	N/A	\$74.79 \$73,296/ 980	\$123.24 \$134,322/ 1,090	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 N/A** data not available on a quarterly basis									

STORY BEHIND THE PERFORMANCE

The priorities of the YAYAHP are to promote healthy and safe relationships among adolescents, increase access to quality and preventive health care, and promote healthy development within the youth and young adult population, including youth and young adults with special health care needs. These priorities were determined by the Maternal and Child Health (MCH) Unit Title V Needs Assessment.

- ¹ The 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.
- ² The 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.
- ³ The 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.
- ⁴ Early, 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, Children's Health Insurance Program (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.
- ⁵ From 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.
- ⁶ The 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 for critical access hospitals (CAHs), small rural hospitals, rural health clinics, and community health centers.

Program Expenditures and People Served

	SFY 2017	SFY 2018	SFY 2019
Total Program Cost	\$876,034	\$624,940	\$761,556
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	14%	24%	16%

*600 series is defined as direct service contracts.

Program Cost Notes

- 15% SGF, 85% federal funds
- Medicare Rural Hospital Flexibility (Flex) Program, 100% FF (\$550,030)
- Small Rural Hospital Improvement Program (SHIP), 100% FF (\$201,722)
- Primary Care Support Act (PCSA), 100% SGF (\$1.2 million) total received for program to date
- Reduction in expenditures from SFY 2017 to SFY 2018 is due to primary care support payouts, Flex Program carry-over, and the timing of payments made by each funding source. The increase from SFY 2018 to SFY 2019 is due to a supplemental funding award from HRSA to be applied towards emergency medical services (EMS) sustainability efforts.

Program Staffing

- 1.25 FTE
- 1 AWEC
- 0 Other

Program Metrics

- The Flex Program provides Critical Access Hospitals (CAH) support for quality, operational, and financial improvement, population health, and EMS. The Flex Program can support hospital conversion to CAH status and the development of innovative healthcare models.
- The SHIP Grant provides small rural hospitals support in development of value-based purchasing, bundled payments, prospective payment systems, and accountable care organizations.
- The PCSA grant funded four awards totaling \$1 million in SFY14; an additional \$200,000 award was funded in SFY 2016. Two new awards were issued in SFY 2019 for the remaining \$247,343 in PCSA funds. Since the inception, the Primary Care Support Act has provided \$1 million 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.

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 several federal programs.
- Federal funding requires activities to address rural health improvement.
- W.S. § 9-2-127 created the Primary Care Support Act (2011).



Community Medical Access and Capacity Program

PROGRAM CORE PURPOSE

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

OUTCOMES

Performance Metric	FFY 2019 Target	FFY 2020 Target	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
% of CAHs meeting minimum requirements in the Medicare Beneficiary Quality Improvement Program (MBQIP) ¹	100% (16/16)	100% (16/16)	94% (15/16)	94% (15/16)	94% (15/16)	100% (16/16)	100% (16/16)
% of CAHs improving in Emergency Department Transfer Communication measures (EDTC) ^{1,2}	100% (16/16)	100% (16/16)	63% (10/16)	38% (6/16)	81% (13/16)	100% (16/16)	57% (9/16)
% of CAHs improving in HCAHPS ^{1,2}	100% (16/16)	100% (16/16)	81% (13/16)	75% (12/16)	87% (14/16)	87% (14/16)	69% (11/16)
% of CAHs improving Patient Safety ^{1,2}	100% (16/16)	100% (16/16)	N/A	75% (12/16)	75% (12/16)	87% (14/16)	69% (11/16)
% of CAHs providing financial and operational data to QHi.	100% (16/16)	100% (16/16)	N/A	19% (3/16)	19% (3/16)	38% (6/16)	81% (13/16)

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

NOTE: Outcomes 1-4 for have been updated to reflect the % of CAHs improving in each domain, compared to the previous reports indicating the % who were reporting in each domain. This is more reflective of outcomes being achieved.

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 Quality Improvement Roundtables (# of people present) ³	16	5	6 (71)	7 (64)	14 (225)	6 (58)	1 (6)	6 (61)	8 (164)
# of CAHs participating in annual stakeholder meeting (# of people present) ³	6	4	5	4 (7)	4 (9)	0	4 (7)	0	4 (9)
WYQIM website # of visitors ³	N/A	N/A	185	139	1,144	75	64	480	664
# of CAHs participating in Patient Safety Culture Survey ³	N/A	5	9	9	11	9	9	4	7
# of financial improvement projects funded ³	N/A	6	6	14	21	7	7	9	12

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

Performance Metric	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	2018 Q1+Q2	2018 Q1+Q2	2019 Q1+Q2	2019 Q1+Q2
EFFICIENCIES									
Average cost per CAH participating in F/OI initiatives ³	\$21,575	\$22,167*	\$17,641*	\$16,256	\$10,154	-	-	-	-
Average cost per CAH participating in QI initiatives ³	\$4,889	\$7,206*	\$4,725*	\$5,830	\$15,789	-	-	-	-
Cost per CAH to participate in QHi ⁴	\$2,200	\$1,500*	\$1,500*	\$2,100	\$993	-	-	-	-
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.									
- indicates data not available on a quarterly basis.									

STORY BEHIND THE PERFORMANCE

1. In 2015, the Health Resources and Services Administration (HRSA) initiated a three year grant project cycle for the Medicare Rural Hospital Flexibility (Flex) Program. Federal fiscal year (FFY) 2018 was added by HRSA to the three year grant project cycle. The FFY 18 began September 1, 2018 and ended August 31, 2019. 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 healthcare models. 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 Program funds, FORHP requires CAHs to have a signed Memorandum of Understanding (MOU) to share data and report at least one core MBQIP measure for at least one quarter, in at least two of the four quality domains. Financial data is reported to Centers for Medicare and Medicaid Services (CMS) and provided through the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) and through Quality Health indicators (QHi).
2. The four domains of MBQIP are patient safety, patient engagement, care transition, and outpatient services. Patient safety is measured in flu vaccinations and antibiotic stewardship program. Patient engagement is measured through the Hospital Consumer Assessment of Providers and Systems (HCAHPS). Care transition is measured through the Emergency Department Transfer Communication (EDTC). Improvement in outpatient is through clinical measures. There is a consistent increase and frequency of CAHs reporting in all four quarters in all four domains. CAHs reporting in MBQIP provides information 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) for MBQIP. The percentage is based on the number of CAHs meeting the minimum reporting requirements.
3. 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. The CMAC program produces a monthly newsletter, maintains a Wyoming Quality Improvement Matters (WYQIM) website, conducts an annual assessment of the program, provides individual technical assistance for reporting and developing QI and F/OI projects, and hosts an annual Flex Program stakeholder meeting.
4. Through a lot of communication with CAHs, CFOs we were able to increase the number of CAHs entering the financial productivity indicators into Quality Health Indicators.

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

	2017	2018	2019
Total Program Cost	\$843,452	\$837,538	\$829,248
People Served	578,934	577,737	577,737
Cost per Person	\$1.46	\$1.45	\$1.44
Non-600 Series**	45.2%	44.5%	41.3%

** 600 series is defined as direct service contracts. In September 2018, after the Federal site visit, coalition expenses were moved from 900 series to 600 series. This line reflects that change.

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 FY19
- 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 SFY2019.
- HPP oversees the Hospital Available Beds for Emergencies and Disasters (HAVBED) and the Wyoming Activation of Volunteer in Emergencies (WAVE) programs.
- The Assistant Secretary for Preparedness and Response (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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% and # of essential member agencies participating in a healthcare coalition (HCC) ¹	75%	75%	58% (84/144)	62% (84/136)	74% (95/129)	74% (99/133)	75% (104/138)
% and # of other potential member agencies participating in a HCC ²	30%	30%	9% (15/171)	17% (31/180)	17% (31/181)	22% (55/255)	22% (56/252)
% and # of hospital member agencies which achieve full NIMS compliance ^{3,4}	95%	95%	11% (3/27)	26% (6/23)	58% (15/26)	88% (23/26)	88% (23/26)
% and # of hospital and EMS member agencies that exercised their medical surge plan	75%	75%	N/A	N/A	68% (36/53)	72% (41/57)	66% (43/65)

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY18 Q1 & Q2	SFY18 Q3 & Q4	SFY19 Q1 & Q2	SFY19 Q3 & Q4
OUTPUTS									
Awardee-Level Direct Cost ^{5,6}	N/A	\$91,263	\$109,558	\$99,644	\$89,880	\$63,212	\$36,432	\$46,626	\$43,254
EFFICIENCIES									
Awardee-Level Direct Cost Ratio ^{5,6}	N/A	10.9%	13.0%	11.9%	11.6%	18.9%	8.1%	19.9%	7.7%
Percent of Grant Funds Expended ⁷	N/A	99.97%	99.75%	100.00%	95.92%*	40.1%	59.9%	29.5%	70.5%

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

*Of the 95.92% of grant funds expended in 2019, 29.5% were expended in the first and second quarters and 70.5% were expended in the third and fourth quarters.

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 SFY16. The EMS Supervisor position (0.25 FTE) was removed from the HPP budget during SFY18.
7. Percent of grant expended includes any amount expended that was carried over to the following SFY. Wyoming received a no cost extension of \$15,000 in SFY2019 to carry into SFY2020.



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

	2017	2018	2019
Total Program Cost	\$1,009,806	\$980,487	\$572,461
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	14.24%	13.95%	18%

* 600 series is defined as direct service contracts.

Program Cost Notes

- SFY2019: 62% SGF and 38% FF
- Significant reduction in expenditures between SFY18 and SFY19 due to loss of \$1,156,000 per biennium in funding for the Wyoming Healthcare Professional Loan Repayment Program (WHPLRP) and Wyoming Provider Recruitment Grant Program (PRGP), and a reduction of \$24,000 per year for the Wyoming State Loan Repayment Program (WY-SLRP). Final payments under SFY15 WHPLRP awards were paid in SFY18 and final payments under SFY16 WHPLRP awards were paid in SFY19.

Program Staffing

- 0.90 FTE
- 0.35 AWEC
- 0 Other

Program Metrics

- WHPLRP awards physicians, dentists, and other health professionals. A total of 286 awards were issued between 2006 and 2016. WHPLRP was last funded in SFY15-16.
- The Research and Explore Awesome Careers in Healthcare (REACH) Program and the University of Wyoming's Healthcare Careers Summer Camp provide educational programs to expose students in grades 5-12 to healthcare careers. In SFY19, one REACH camp was hosted with 22 participants and two summer camps were hosted with 66 participants.
- 2015 was the WY-SLRP's first year. Twenty-two awards have been issued since 2015 (eight physicians, eight physician assistants, and six 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 PRGP in 2008. House Bill 88, passed during the 2015 General Legislative Session, increasing the maximum allied healthcare professional award under WHPLRP and expanding eligibility under PRGP 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. WY-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 20 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
# of physicians needed to eliminate primary care health professional shortage areas (HPSAs) ¹	≤ 24	≤ 24	N/A	N/A	N/A	20	24
# psychiatrists needed to eliminate mental health HPSAs ¹	≤ 25	≤ 25	N/A	N/A	N/A	25	25
# dentists needed to eliminate dental HPSAs ¹	≤ 5	≤ 5	N/A	N/A	N/A	6	5
# of obligated healthcare professionals in HPSAs (all disciplines) ²	17	17	17	17	21	17	21

N/A indicates data not available

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Loan Repayment Program (LRP) Amount awarded (# awards) ³	\$670,000 (11)	\$678,000 (12)	\$140,000 (5)	\$160,000 (4)	\$136,000 (5)	0	\$160,000 (4)	0	\$136,000 (5)
Provider Recruitment Grant Program (PRGP) Amount awarded (# awards) ³	\$200,000 (4)	\$238,520 (5)	\$235,000 (5)	\$132,447 (4)	\$244,000 (6)	0	\$132,447 (4)	0	\$244,000 (6)
# of candidates placed ⁶	4	9	6	15	13	8	7	5	8
# of new J-1 Visa Waivers ⁷	4	10	5	7	6	N/A	7	2	4
EFFICIENCIES									
LRP obligation completion rate by cohort ⁴	87.5% (7/8)	90% (9/10)	84.6% (11/13)	81.8% (9/11)	100% (12/12)	N/A	N/A	N/A	N/A
PRGP recruitment rate by cohort ⁵	0% (0/4)	60% (3/5)	60% (3/5)	25% (1/4)	17% (1/6)	N/A	N/A	N/A	N/A
Average cost per placement ⁷	\$8,000 (\$32,000 /4)	\$7,111 (\$64,000 /9)	\$5,333 (\$32,000 /6)	\$5,600 (\$84,000 /15)	\$6,407 (\$83,287/13)	\$6,500 (\$52,000 /8)	\$4,571 (\$32,000 /7)	\$4,800 (\$24,000/5)	\$7,411 (\$59,287/8)

N/A indicates data not available on a quarterly basis or for specific quarters indicated

STORY BEHIND THE PERFORMANCE

1. The Health Resources and Services administration (HRSA) publishes a quarterly summary of designated health professional shortage areas (HPSAs) by state showing the breakdown of designations by type and discipline, the total population covered by designations and the number of full-time providers needed to eliminate all designations. The increase in needed primary care physicians is the result of additional designations accomplished in SFY2018 and 2019. Data for years prior to 2018 is not included due to changes to HRSA's methodology.
2. Obligated health professionals (OHPs) are those with an active service obligation during the corresponding fiscal year. For SFY2019 there are 21 OHPs practicing in HPSAs statewide. This includes 18 loan repayment recipients and 3 J-1 Visa Waiver physicians.
3. 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 and psychiatrists, primary care and behavioral health physician assistants and nurse practitioners, certified nurse midwives, and mental health clinicians practicing full-time at approved National Health Service Corps (NHSC) sites located in a HPSA. Priority is given based on HPSA 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.

4. Since 2006, 308 loan repayment awards have been issued through both WHPLRP and WY-SLRP. As of the 4th quarter of SFY2019, 276 have either successfully completed or are currently completing their service obligation and requirements. To date, 32 awardees have withdrawn from program participation prior to the first payment or have defaulted on their service obligation or other requirements. Numbers reported under efficiencies 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. Completion rate data was moved from outcomes to efficiencies for SFY2019, and retention rate data was removed from outcomes while methodology is updated and new data is gathered.
5. Since 2008, 41 Provider Recruitment (PRGP) 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. Eighteen have been successful at recruiting and the SFY2019 awardees have through SFY2020 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 efficiencies are for each award round cohort for the corresponding fiscal year versus overall as stated above. Recruitment rate data was moved from outcomes to efficiencies for SFY2019.
6. The Wyoming Office of Rural Health (ORH) contracts with Wyoming Health Resources Network, Inc. (WHRN) to provide lower-cost Wyoming-based recruitment services to underserved communities and safety-net facilities statewide. 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.
7. 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 U.S. 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. 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

	2017	2018	2019
Total Program Cost	\$1,019,384	\$1,067,827	\$1,047,005
People Served	578,934	577,737	577,737
Cost per Person	\$1.76	\$1.85	\$1.81
Non-600 Series*	100%	98%	98%

* 600 series is defined as direct service contracts

Program Cost Notes

- 90% General Funds
- 10% Federal Funds

Program Staffing

- 6 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Ensures available manpower for local EMS agencies by providing community-based emergency medical training at five different certification levels. 75 EMT courses were provided in SFY2019
- 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 2018 recorded approximately 81,000 requests for service statewide (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 created the “comprehensive emergency medical services and trauma system.”
- Frontier and rural communities have few resources to allocate to these functions.
- Remote areas and heavy reliance on Critical Access Hospitals create a demand for EMS to transport patients to specialty hospitals.



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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Services reporting in WATRS ¹	90%	90%	91% (77/85)	89% (91/102)	89% (92/103)	93% (95/102)	94% (94/100)
% services submitting complete data ²	90%	90%	84% (65/77)	76% (69/91)	87% (78/92)	81% (77/95)	89% (84/94)
% Chute times <10 minutes ³	>95%	>95%	84% (42,542/ 50,919)	91% (41,992/ 46,145)	92% (40,949/ 44,510)	94% (43,518/ 46,444)	94% (45,029/ 47,873)
% of responses ≤ 8:59 ⁴	60%	60%	43% (22,068/ 50,919)	52% (23,995/ 46,145)	51% (22,700/ 44,510)	63% (29,027/ 46,444)	55% (26,377/ 47,912)

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Supported EMT classes	19	31	34	45	75	13	32	18	57
WATRS records (911 only)	50,952	50,437	47,611	49,580	50,745	25,224	24,356	25,672	25,073
Completed records (911 only)	47,436	46,145	44,510	45,444	47,873	23,568	22,876	24,127	23,747
WATRS trainings	16	20	16	4	4	2	2	2	2
WATRS customer support (minutes)	11,758	24,744	16,620	13,878	13,950	7,206	6,672	6,042	7,908
EFFICIENCIES									
Cost per successful student	\$122 (\$32,988/ 270)	\$218 (\$55,755/ 255)	\$77 (\$21,100/ 273)	\$85 (\$27,081/ 318)	\$72 (\$27,000/ 428)	NA	NA	NA	NA
Class completion rate	87% (270/322)	87% (255/294)	82% (273/334)	87% (318/367)	52% (428/824)	NA	NA	NA	NA

NA indicates data not relevant on a quarterly basis.

STORY BEHIND THE PERFORMANCE

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

- ¹ The Wyoming Ambulance Trip Reporting System (WATRS) is a web-based patient reporting system for EMS agencies. The OEMS began implementation of the system in 2010. This system is provided at no cost to all ambulance services and fire agencies operating in Wyoming. It is compliant with the National EMS Information System (NEMESIS) requirements, is accessible by receiving facilities, and interfaces with the Trauma Patient Registry.
- ² Following 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.

In FY19, the OEMS changed its processes for education management due to realignment of personnel. This change caused a significant disruption in the way that courses are conducted in the state, which affected our data collection efforts, but did not significantly change the actual output of new EMS workforce personnel. This should stabilize over the next one to two years and result in increased efficiencies afterward.

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

	2017	2018	2019
Total Program Cost	\$90,072	\$90,072	\$90,072
People Served	1,306*	629*	768*
Cost per Person	\$69	\$143	\$117
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 2019

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Priorities for 2019: (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, 27 in 2017-2018, and 49 in 2018-2019.
- Program utilization of interpreting services increased from 79 calls in SFY 2016 to 143 calls in SFY 2017, 569 calls in SFY 2018, and 437 in SFY 2019.

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 for public health department accreditation standards.
- 2016: Language Access Service contract began ensuring high quality and appropriate language access services.
- 2017: Health equity introduction at the Wyoming Department of Health new employee orientation began.
- 2017: Health equity course required for all PHD staff.
- 2017: Health equity goals were introduced by PHD leadership for staff selection and inclusion in employee performance and professional development goals
- 2018: Optional health equity special provision clause introduced for use in PHD contracts.
- 2019: New Language Access Service Contract Started with Cesco Linguistic Services on July 1st



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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% and # of PHD staff trained on health equity ¹	100%	100%	88% (204/ 231)	99% (230/ 231)	99% (241/ 242)	100% (242/ 242)	94% (228/ 242)
% and # of HEWTalks participants intending to use content in work ²	90%	90%	N/A	N/A	N/A	87% (86/99)	82% (55/67)
% and # of PHD programs consulted regarding HEAT ³	50%	100%	7% (2/26)	19% (5/26)	25% (6/24)	46% (11/26)	44% (13/29)
% and # of PHD programs utilizing interpreter services ⁴	27%	50%	N/A	N/A	17% (4/24)	25% (6/24)	50% (12/24)

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

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
# of Health Equity trainings offered	44	41	30	38	35	17	21	13	22
# of HEWTalks Offered	N/A	N/A	12	11	4	6	5	2	2
# of people trained ⁵	1,120	1,666	1,306	629	768	300	329	227	541
# of interpretation calls ⁶	N/A	79	143	569	489	282	287	300	189
Cost per training attendee ⁷	\$24.07 \$26,960 /1,120	\$3.07 \$5,121/ 1,666	\$2.45 \$3,204/ 1,306	\$6.46 \$4,064 /629	\$3.44 \$2,649/ 768	\$6.28 \$1,884/ 300	\$6.63 \$2,180/ 329	\$5.27 \$1,196/ 227	\$2.69 \$1,453/ 541

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. In 2018 SFY, the HEWTalks were changed from monthly to quarterly trainings.
- ³ In 2015, the Health Equity Workgroup (HEW) developed a 22-item questionnaire based on a valid and reliable tool (The Arizona Organizational Cultural Assessment). In PHD, this tool is referred to as the 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 (9) programs contributed financially to the contract and twelve (12) programs utilized the services in the contract; the OHE also supports non-contributing programs in the contract.
- ⁵ People trained reflects external partners as well as internal staff. This includes not just classes offered, but webinars, some of which are open nationwide.
- ⁶ This reflects the number of calls interpreted on behalf of PHD programs.
- ⁷ This reflects 900 and 200 series expenditures to support interpreter training and all health equity training, which include the HEWTalks.



Public Health Preparedness and Response

Program Description

The Public Health Preparedness and Response Unit (PHPR) 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 2017	SFY 2018	SFY 2019
Total Program Cost	\$3,993,826	\$3,644,004	\$4,513,649
People Served	578,934	577,737	577,737
Cost per Person	\$6.90	\$6.31	\$7.81
Non-600 Series*	59%	49%	62%

*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, 2018 - June 30, 2019 for SFY 2019
- 10% match requirement met by Public Health Nursing, county, tribal, and state match contributions

Program Staffing

- 11 FTE (plus 2 funded positions in the Wyoming Public Health Lab)
- 1 AWEC
- 1 Other - CDC Career Epidemiology Field Officer (CEFO)

Program Metrics

- PHPR maintains contracts that support 19 county public health nursing offices, four county health departments, and two tribal health departments with preparedness contract deliverables.
- 23/25 counties and tribal nations met all contract deliverables, average 93% met.
- PHPR 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 SFY2019 there were 83 calls, compared to SFY2018 with 142 calls. The CDC's ability to reach WDH through a 24/7/365 phone line is a CDC metric. In SFY2019, two test calls were 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, and most recently the opioid epidemic response).
- CDC developed 15 public health planning capabilities that PHPR used in spring 2011 to develop a Blueprint for Action which defined PHPR's five-year strategy; the blueprint was updated in October 2017.
- For SFY 2019, federal funding returned to the base amount of \$5,000,000. We have not had this level of funding since 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. PHPR is designated by WDH to be the ESF #8 lead for the state.

Public Health Preparedness and Response (PHPR)

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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Time, in minutes, for Immediate After Hours Assembly of WDH Incident Management Team in person or virtually ¹	<60*	<60*	15	23	41	6	8
Wyoming (state) status for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency ²	Established	Established	100% (US avg. 99%)	Established	Established	Established	Established
Average county status for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency ²	Established	Established	93.3% (21 counties)	96.9% (21 counties)	Established (23 counties)	Established (23 counties)	Intermediate (23 counties)
State, county, and tribal public health responders completing respirator fit testing ³	95%	95%	83.9% (256/305)	86.1% (223/259)	87.9% (227/258)	97% (249/256)	95% (250/263)
WDH Jurisdictional Risk Assessment (JRA) Score (updated every 5 years) ⁴	85%	85%	N/A	76%	N/A	N/A	N/A
*CDC and Healthy People 2020 target N/A indicates data not available							

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
% of WDH Improvement Plan recommendations associated with full scale exercise or real event addressed within 1 year of After Action Report ⁵	N/A	N/A	N/A	91% (48/53)	100% 6/6	N/A	91% (48/53)	N/A	100% 6/6
% of WDH Incident Management Team trained to role requirements for WDH response management	77% (21/27)	87.5% (14/16)	71.4% (20/28)	82% (23/28)	82% (23/28)	82% (23/28)	82% (23/28)	64% (21/33)	64% (21/33)
# of CDC 24/7 no notice bidirectional contact drill for epidemiology and lab staff	4/4	2/2	2/2	2/2	2/2	0/0	2/2	0/0	2/2
# of courses of antibiotics compared to estimated number of key personnel identified ⁶	3,313/5,060	3,313/5,060	5,644/5,060	5,644/5,060	5,644/5,060	5,644/5,060	5,644/5,060	5,644/5,060	5,800/5,060
EFFICIENCIES									
Cost per Wyoming Alert and Response Network message recipient	N/A	N/A	N/A	\$1.74 (\$12,995 /7,479)	\$1.28 (\$12,995 /10,116)	N/A	\$1.74 (\$12,995 /7,479)	N/A	\$1.28 (\$12,995 /10,116)
N/A indicates data not yet available due to the creation of a new metric									

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: Early, Intermediate, Established, Advanced. The CDC goal is for states and CRIs to be at 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. PPHR 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. PPHR 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, such as anthrax. 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 regulation.

Program Expenditures and People Served

	2017	2018	2019
Total Program Cost	\$177,833	\$190,243	\$232,161
People Served	578,934	577,737	577,737
Cost per Person	\$0.31	\$0.33	\$0.40
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts, which this program does not have.

Program Cost Notes

- 79% General Funds
- 21% Federal Funds (Wyoming Trauma Registry \$22,800 & Abbreviated Injury Scale (AIS) coding course for local trauma staff)

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- All 27 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.
- Provided 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, 46 in CY2018, and 72 in CY2019 (as of 10/1/2019). Provided 35 documented data report requests or assistance with writing reports for stakeholders in CY2016, 55 in CY2017, 42 in CY2018, 52 as of 10/2019.

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%, 25% in 2017, has decreased to 21% in 2018, and further decreased in 2019 to 14.8%.
- The trauma registry was completely redesigned and upgraded in 2017 to accommodate those sites that are American College of Surgeons (ACS) verified. 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
% and # of facilities actively contributing to the Trauma Patient Registry ¹	96%	96%	93% 26/28	100% 28/28	100% 28/28	100% 28/28	100% 28/28
% of facilities with full designation status (2-3 year status) running total ²	68%	68%	54% 13/28	61% 17/28	61% 17/28	75% 22/28	78%* 21/27
% of rural facilities with full designation status (2-3 year status) running total ³	70%	70%	58% 15/26	61% 16/26	64% 17/26	77% 20/26	80%* 20/25
% ED trauma patient overall dwell times ≤2 hours; calendar year ⁴	22%	22%	20.2%	19.2%	19.4%	18.2%	(-)
% of ED trauma patient dwell times ≤2 hours for injured patients requiring transfer to definitive care; calendar year ⁴	28%	28%	N/A	28.2%	25.2%	23.5%	(-)

(-) Indicates data not yet available
* The actual observed data in SFY2019 exceeded the 2020 target, so targets will be revisited.

OUTPUTS AND EFFICIENCIES									
Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of facility site reviews conducted	11	14	14	15	9	1	14	1	8
# of Regional Trauma Councils meeting quarterly (5 total) ⁵	5	3	4	5	4	5	3	4	3
# of formal educational opportunities sponsored to improve facility compliance	2	2	2	1	2	1	0	1	1
% and # of facilities sending representation to at least one sponsored educational opportunity per year	96% 27/28	96% 27/28	93% 26/28	75% 21/28	89% 24/27	N/A	N/A	N/A	N/A
# of trauma records in Trauma Registry by WY acute care facilities	3,906	4,295	4,209	4,030	4,827**	2,285	1,745	2,443**	2,384* *
EFFICIENCIES									
Cost per trauma registry record (\$22,800/# records)**	\$5.84 (\$22,800/ 3,906)	\$5.31 (\$22,800/ 4,295)	\$5.42 (\$22,800/ 4,209)	\$5.66 (\$22,800/ 4,030)	\$4.72 (\$22,800/ 4,827)**	\$4.99 (\$11,400/ 2,285)	\$6.53 (\$11,400/ 1,745)	\$4.67 (\$11,400/ 2,443)**	\$4.78 (\$11,400/ 2,384)**

NA indicates data not relevant on a quarterly basis.

**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 2017 the crude injury death rate was 91.66 deaths per 100,000 population compared to the U.S. crude rate of 74.62 per 100,000 (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. *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.
2. *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.
3. *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.
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. *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.

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

	2017	2018	2019
Total Program Cost*	\$1,295,079	\$1,244,567	\$1,485,224
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series**	73%	68%	67%

* Program costs for each year have been adjusted from prior documents per fiscal calculations.

** 600 series is defined as direct service contracts.

Program Cost Notes

- CY19 HIV Prevention Grant – CDC
- CY19 STD Prevention Grant – CDC
- CY19 Hepatitis Prevention Grant – CDC
- CY19 TB Prevention & Control Grant – CDC
- CY19 Personal Responsibility Education Program – HHS

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 (CAPPA), 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 2019 Target	CY 2020 Target	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
% 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	97%	91%	86%	(-)
% 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	69%** (214/308)	78%** (365/467)	85%** (116/137)	(-)
Rates of gonorrhea infections per 100,000 persons ³ (National rate)	50.0	50.0	29.7 (124)	47.8 (145.8)	71.2 (171.9)	53.7 (-)	(-)
Active TB case rate of <1 per 100,000 statewide (National rate)	<1	<1	0.7 (3.0)	0.2 (2.9)	0.3 (2.8)	0.2 (2.8)	(-)
Rates of hepatitis C infection per 100,000 persons ⁴	80.0	80.0	82.1	84.7	65.5 ⁵	65.1 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 2015	CY 2016	CY 2017	CY 2018	CY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# condoms provided to high risk populations ⁶	275,448	242,733	339,659	458,441	237,051*	206,902	257,539	169,809*	(-)
# of condom dispenser sites ⁷	102	107	209	404	(-)	113	82	435	(-)
# of WyPREP participants**	90	587	895	731	1,090	(-)	(-)	(-)	(-)
Cost per voucher – knowyo.org ⁸	\$33.04 \$115,000 /3,481	\$25.12 \$115,000 /4,674	\$21.79 \$115,000 /5,277	\$24.24 \$115,000 /4,745	(-)	\$24.00 \$57,500 /2,396	\$24.48 \$57,500 /2,349	\$21.95 \$57,500/ 2,620	(-)

(-) Indicates data not available

*Calendar 2019 data is Year-to-Date (January – August)

**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.

- ¹ This 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. A decrease in this number is reflective of individuals not responding to staff attempts to locate. Staff use phone calls, letters and social media to locate individuals.
- ² The 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.
- ³ Gonorrhea infection has been rising in Wyoming and the United States. Gonorrhea infection increases the risk of acquiring HIV. The Unit prioritizes those with gonorrhea infection for partner services, prevention messaging, and to ensure they are given proper treatment.
- ⁴ Approximately 3.5 million persons in the United States have chronic hepatitis C infection. (<http://www.cdc.gov/Hepatitis/hcv/cfaq.htm#cFAQ22>). Of the 2.2 million people in U.S. jails and prisons, about 1 in 3 have hepatitis C.
- ⁵ Hepatitis 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.
- ⁶ According 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.
- ⁷ For the quarterly data, the numbers represent the sum total of condom dispensers at that time.
- ⁸ The 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

	2017	2018	2019
Total Program Cost	\$1,797,199	\$1,569,534	\$1,562,918
People Served¹	2,086	1,262	1,075
Cost per Person	\$862	\$1,244	\$1,454
Non-600 Series	14%	14%	16%

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) 19 - Ryan White Part B/AIDS Drug Assistance Program Grant—Health Resources and Services Administration (HRSA)
- SFY 19 - Ryan White Part C Grant—HRSA
- SFY 19 - Housing Opportunities for Persons with AIDS Grant, HUD
- CY 19 - TB Prevention & Control Grant—CDC
- FFY 19 - Substance Abuse Block Grant Dollars—SAMSHA
- FFY 19 - Preventative Health and Human Services—CDC
- SFY 19 - 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 of health (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 2019 Target	CY 2020 Target	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
% of gonorrhea cases receiving the recommended dual therapy medication ¹	90%	90%	88% (151/171)	88% (243/277)	90% (374/415)	95% (298/313)	(-)
% and # of Latent TB (LTBI) clients starting treatment in TB Program completing LTBI treatment ²	80%	80%	77% 54/70	79% 45/57	90% 66/73	79% 59/75	(-)
% of newly identified HIV positive clients linked into primary care within 3 months of diagnosis ³	95%	95%	73% 11/15	80% 16/20	91% 10/11	92% 11/12	(-)
% of clients enrolled in HIV Services Program with suppressed HIV Viral load ⁴	90%	90%	61% 94/153	84% 184/219	90% 197/219	92% 222/242	(-)
% of new HIV infections considered a late diagnosis ⁵	37%	37%	31% 5/16	35% 7/20	36% 4/11	8% 1/12	(-)

(-) Indicates data not yet available

OUTPUTS AND EFFICIENCIES

Performance Metric	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of HIV clients enrolled in care with a documented CD4/Viral Load ⁶	135	200	210	222	(-)	183	142	173	(-)
# of HIV clients enrolled in HIV Services Program ⁶	179	208	218	242	(-)	181	170	199	(-)
# of individuals in the TB Program enrolled for LTBI/active TB disease treatment	93	98	83	92	(-)	40	52	24	(-)
EFFICIENCIES									
Average cost of HIV client enrolled in HIV Service Program ⁷	\$3,247	\$3,799	\$2,489	\$2,803	(-)	\$2,643	\$1,674	\$2,746 \$568,364 /207	(-)

(-) Indicates data not yet available

STORY BEHIND THE PERFORMANCE

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

¹ CDC recommends using dual therapy (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.

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

³ According to CDC, July 2019, 78% of persons receiving a diagnosis of HIV were linked to care within 1 month. Historically, linkage to care was measured within 3 months of diagnosis. Due to the frontier nature of Wyoming and the limited number of providers, the program will continue measuring linkage to care within 3 months of diagnosis. Linked to care indicates a person had a CD4 or viral load laboratory test following diagnosis.

⁴ An individual with a suppressed viral load has small amounts of virus in their blood reducing the risk of transmission (<200 copies/mL). The measurement is calculated by dividing the number of patients with a suppressed viral load at their most recent test during the time period by number of patients enrolled in the Communicable Disease Treatment Program.

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

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

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

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

	2017	2018	2019
Total Program Cost	\$761,108	\$761,108	\$785,989
People Served	584,910	579,315	577,737
Cost per Person	\$1.30	\$1.31	\$1.36
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- FY19 federal funding through the CDC Epidemiology and Laboratory Capacity Grant is \$664,387
- FY19 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 lower than the national incidence (0.00/100,000 vs. 0.08/100,000) during the 2018-2019 influenza season.
- Wyoming incidence of Pertussis, Measles, and Mumps was **above** the national incidence (10.73/100,000 vs. 4.87/100,000) in 2018.
- Wyoming incidence of Salmonellosis, Shigellosis, and *E. coli* was below the national incidence (19.38/100,000 vs. 20.17/100,000) in 2018.

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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Average # of days to complete case investigations*	3	3	2.3 (CY 2015)	2.6 (CY 2016)	2.7 (CY 2017)	4.0 ^A (CY 2018)	1.8 ^{**} (CY 2019)
# 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 17 other	8 enteric 11 other	5 enteric 16 other	16 enteric 13 other	5 enteric 12 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	0.17 (0.05)	0.0 (0.02)	0.0 (0.03)	0.17 (0.06)	0.0 (0.08)
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	5.8 (6.03)	3.6 (6.53)	3.1 (6.6)	10.73 ^B (4.87)	-
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	29.40 (23.9)	15.37 (22.64)	22.61 (19.05)	19.38 (20.17)	-

* Data for this metric is for a calendar year

**Data thru 9/30/19

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

^A The increase in the average number of days to complete case investigations in SFY2018 was due to several cases that were unable to be interviewed for an extended period of time (for example, due to travel or hospitalization). These outliers brought the average up for SFY2018.

^B The higher incidence rate in calendar year 2018 is due to a significant pertussis outbreak in November of 2018.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of initial case reports detected by Program through surveillance	5,396	2,924	5,585	9,099	11,500	1,092	8,007	2,500	9,000
# of influenza surveillance weekly reports created by Program	40	40	40	19	40	13	6	20	20
EFFICIENCIES									
Cost per case investigated	\$135	\$265	\$136	\$83	\$68	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 pertussis in Crook County in November 2018. The outbreak contributed to the large increase in the Wyoming rate of vaccine preventable diseases.
- The state incidence of enteric diseases is below the national incidence. Contact with farm and ranch animals continues to be common risk factor for enteric diseases in Wyoming.
- The large increase in initial case reports from SFY 2017 to SFY 2018 and SFY 2019 was due to a particularly bad influenza seasons. Both 2017-2018 and 2018-2019 influenza seasons were severe with large case counts and fatality reports.
- 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 program tests for reportable diseases involved in disease outbreaks and supports public health infectious and communicable disease programs, medical facilities, drinking water sites, and public health offices. The chemical testing program supports public safety by managing the state breath alcohol (intoximeter) program and testing biological samples for the presence of drugs of abuse. 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

	2017	2018	2019
Total Program Cost	\$3,566,647	\$3,383,658	\$3,880,970
People Served	578,934	577,737	577,737
Cost per Person	\$6.16	\$5.86	\$6.72
Non-600 Series*	100%	100%	100%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Program cost for SFY19 increased due to an increase in testing volume by the microbiology program and an increase in federal funds by 12.8%. Chemical testing program volumes continued to decrease in 2019.
- In FY19 total expenditures were broken down as follows:
 - General funds - 55% of total expenditures
 - Revenues from lab fees - 17% of total expenditures
 - Federal grants - 28% of total expenditures
 - Approximately 58% of expenditures were payroll

Program Staffing

- 28 FTE (21 state funded, 6 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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Accuracy of competency/proficiency tests performed ¹	98%	98%	99.1% 315/318	99.2% 395/398	99.8% 468/469	98.5% 445/452	98.1% 529/539
Average time (in days) from specimen receipt to result reporting in Microbiology and Preparedness (Tb culture and whole genome sequencing excluded) ²	1.3	1.3	1.29	1.22	1.26	1.04	1.18
% and # of Microbiology clients receiving real-time laboratory results ³	80%	80%	36.3%	58.6% 337/575	70.2% 501/714	67.9% 582/857	75.2% 828/1,095
# of non-WPHL employees trained ⁴	100	100	246	207	487	76	113
# of newly validated tests ⁵	≥ 5	≥ 4	5	7	5	6	6

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
# of Chemistry samples tested (# confirmed)	33,527 (12,095)	34,726 (12,418)	17,398 (8,507)	14,017 (4,368)	9,284 (3,996)	7,595 (2,301)	6,422 (2,067)	4,983 (2,297)	4,301 (1,699)
# of Microbiology tests performed	37,018	39,224	40,180	43,627	54,827	22,100	21,527	26,356	28,471
# of trainings provided	13	11	22	6	18	2	4	5	13
# of Litigation Support Packages provided	132	154	125	120	90	70	50	46	44
# of times court testimony provided	77	42	36	50	24	23	27	13	11
Cost per test ⁶	\$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> 62,012	\$56.98 <u>3,880,970</u> 68,107	\$49.96 <u>1,598,553</u> 31,996	\$59.47 <u>1,785,105</u> 30,016	\$64.85 <u>2,181,205</u> 33,636	\$49.31 <u>1,699,765</u> 34,471
% of expenses from revenues ⁷	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	16.6% <u>643,875</u> 3,880,970	21.4% <u>342,755</u> 1,598,553	26.3% <u>468,667</u> 1,785,105	19.8% <u>431,058</u> 2,181,205	12.5% <u>212,817</u> 1,699,765
% of expenses from Federal Grant (no match)	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	27.7% <u>1,075,731</u> 3,880,970	22.9% <u>366,656</u> 1,598,553	26.6% <u>475,057</u> 1,785,105	24.6% <u>536,990</u> 2,181,205	31.7% <u>538,743</u> 1,699,765

STORY BEHIND THE PERFORMANCE

- ¹ This metric accounts for the accuracy of competency and proficiency tests performed by all laboratory sections combined into one metric. The overall target for the combined metric is 98% or better, but each lab section mandates different 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 microbiology and chemistry is 80%, the WPHL has set its target for these sections at 98%.
- ² Time from specimen receipt to result reporting is the main controllable factor related to total turnaround time (TAT). Each test has a specific target TAT. In microbiology, rapid immunoassays and molecular tests should be resulted on the same day of receipt, Quantiferon and serologic assays require 2 days, and culture-based assays should be resulted in ≤ 5 days. Tb testing can take up to 8 weeks and whole genome sequencing (WGS) can take up to 2 weeks and were 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 days). Regardless, TATs are closely monitored in the Chemistry section and are reported in the lab's Program Management document.
- ³ This metric was calculated differently in SFY16 than in SFY15 and the numbers for SFY15 were changed in this document. Microbiology clients include clinical microbiology clients and water customers. 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 the 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. We are currently working with the Wyoming Department of Health, Division of Healthcare Financing for the Health Information System Exchange (Wyoming Frontier Information: WyFD).
- ⁴ The preparedness laboratory program conducts trainings for sentinel laboratorians involved in rule out/refer for select agents, biosafety and risk assessment. The chemical testing program conducts trainings for county coroners, law enforcement agencies, DFS and DOC officers involved in drug and alcohol testing. In SFY18 the microbiology laboratory program was named as a Regional Workforce Development Training (WFD) lead laboratory for bioinformatics and whole genome sequencing. As WFD lead, the microbiology program is responsible for laboratory and analytical training for up to 11 jurisdictions.
- ⁵ Before the laboratory can add a test to its test menu, the test must be validated. New testing for SFY2019 includes Rickettsia, Zika IgM, modified carbapenem inactivation method for CREs, and Verona Integron-Mediated Metallo β -lactamase for CREs.
- ⁶ 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, SFY18, and SFY19 cost per test significantly increased due to reduced sampling volume within the chemical testing program. Therefore, new tests are in the process of being implemented. Additionally, as more novel assays are brought on, they tend to be molecular in nature and these tests are more expensive but provide faster turnaround time and higher sensitivity and specificity.
- ⁷ In SFY15 and SFY16 this measure was calculated by dividing the amount of generated revenue by the 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 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

	2017	2018	2019
Total Program Cost	\$71,506	\$71,506	\$71,744
People Served	218	246	293
Cost per Person	\$328.01	\$290.67	\$244.86
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service contracts.

Program Cost Notes

- The Legal Services provider's required match is at 12% of federal funds, and the state match is at 5% of federal funds for FFY 2019.

Program Staffing

- 0.1 FTE
- 0 AWEC

Program Metrics

- In FFY 2019, 293 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 2019, total client hours performed by the provider equaled 1,081.75.
- In FFY 2019, the average number of hours spent per client was 3.69 hours.
- The average cost per client in FFY 2019 (Federal and State funds) was \$244.86. The average cost (Federal & State fund) per hour was \$66.32.
- The average cost savings per client in FFY 2019, based on an average cost of \$250.00 per hour for private legal assistance, was \$922.99.
- 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 40.75 hours of outreach and public education was provided by the Legal Services grantee in FFY 2019.

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 2019 Target	FFY 2020 Target	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
Percent of cases resolved within 3 months	75%	50%	74%	70%	65%	56%	47%
Percent of respondents who claimed improved quality of life	100%	100%	56%	33%	52%	69%	58%
Percent of respondents who would have restricted their expenses if legal services were not received	50%	50%	47%	27%	29%	56%	53%

OUTCOMES data is based on annual customer survey, self-reporting data (approximate 20% of surveyors responded).

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Total number of cases*	313	195	218	246	293	119	127	124	169
Total number of hours of service provided	1,030.25	881.25	1,110.25	1,040	1,081.75	432.5	607.5	473.5	205.84
Number of financial assistance/estate planning cases	161	111	203	287	282	153	134	127	155
Number of power of attorney and advance directives cases	17	14	14	20	44	7	13	23	21
Number of real estate/housing cases	44	9	66	69	80	26	43	36	44
EFFICIENCIES									
Average cost per unduplicated client	\$214.69	\$366.70	\$350.67	\$290.67	\$244.86	\$281.85	\$294.94	\$298.04	\$205.84
Average cost at the market rate (\$250/hour)	\$768	\$1,130	\$1,361	\$1,057	\$923	\$909	\$1,196	\$955	\$900

STORY BEHIND THE PERFORMANCE

- The case priorities of Legal Aid are: domestic law, public benefits, consumer, housing, Native American rights, senior services, adult guardianship/conservatorship, 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

	FFY2017	FFY2018	FFY2019
Total Program Cost	\$258,842	\$323,327	\$195,761
People Served	1,542	1,599	1,494
Cost per Person	\$168	\$202	\$130
Non-600 Series**	1.80%	3.56%	1.43%

** 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 and activity level, 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

- 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 2019 Target	FFY 2020 Target	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
% of complaints fully resolved to the satisfaction of the complainant per year.	60%	60%	**	34.53%	52.21%	40.34%	40.51%
% of complaints partially resolved to the satisfaction of the complainant per year	16%	16%	**	16.60%	17.26%	21.02%	16.92%
% of complaints not resolved to the satisfaction of the complainant per year	0%	0%	**	4.15%	3.98%	3.41%	3.08%
% of complaints related to 'Autonomy, Choice, Exercise of Rights, Privacy' that were resolved	50%	50%	**	52.94%	65.52%	57.14%	53.33%
% of complaints related to 'Admission, Transfer, Discharge, Eviction' that were resolved	50%	50%	**	53.06%	58.18%	55.88%	58.33%

(-) 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 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of visits to all LTC facilities/services by an Ombudsman	**	334	319	327	294	159	168	146	114
% of nursing homes, assisted living facilities, & boarding homes (79 total) visited by an Ombudsman quarterly	**	78.2%	98.7%	98.7%	98.7%	N/A*	N/A*	N/A*	N/A*
# of cases closed	**	403	200	151	384	73	78	208	176
# of complaints received	**	572	231	182	390	92	90	234	156
# of activities completed	**	1,653	1,342	1,448	1,493	681	767	809	684
EFFICIENCIES									
Cost per person served (Cases opened + Activities / Total \$)	**	\$130	\$168	\$202	\$130	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

	2017	2018	2019
Total Program Cost (Federal and State)	\$1,383,473	\$1,458,358	\$1,837,736
People Served (Unduplicated Count)	16,931	17,719	18,298
Cost per Person	\$82	\$82	\$100
Non-600 Series*	21%**	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 18,298 clients, or 13.47% of Wyoming’s adults aged 60 and older, based on 2018 Census data. A total of 773,939 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 caregivers, and coordination of community resources to maximize services.
- National research demonstrates that participation in social activities and an active lifestyle enables 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 2019 Target	FFY 2020 Target	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
% and # of Wyoming's population (age 60 and older) served	14.5%	14.0%	15.02% (17,328/ 115,340*)	14.25% (17,101/ 119,985*)	14.11% (16,931/ 119,985**)	14.76% (17,719/ 119,985**)	13.47% (18,298/ 135,830**)
# of Clients who received III-B Services	19,465	19,000	17,328	17,101	16,931	17,719	18,298
# of clients who received transportation services	2,404	2,100	1,669	1,902	2,157	2,025	2,062
# of clients who received assisted transportation services	687	750	826	783	777	848	814
# of outreach events provided	1,259	3,000	3,321	3,306	3,155	3,032	3,247

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

(**) 2018 data, 2019 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 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Total # of clients served	17,328	17,101	16,931	17,719	18,298	13,635	13,999	14,72	14,228
Total # of Title III-B Services units provided	716,764	773,065	729,980	768,228	773,939	378,895	389,334	373,880	400,059
Units of transportation services provided*	90,772	119,291	128,293	127,217	116,261	62,775	64,442	54,785	61,476
Units of assisted transportation services provided	66,917	60,513	55,570	56,684	49,562	27,371	29,313	25,195	24,367
Units of outreach services provided**	34,779	36,641	27,725	22,141	37,133	11,123	11,018	16,350	20,783
EFFICIENCIES									
Cost per client (Federal & State funds)	\$86	\$89	\$82	\$82	\$100	\$53.11	\$52.45	\$67.45	\$62.52
Cost per unit (Federal and State funds)	\$2.08	\$1.96	\$1.90	\$1.90	\$2.38	\$1.91	\$1.89	\$2.54	\$2.02

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.

STORY BEHIND THE PERFORMANCE

- Based on the projected Census data for FFY 2018, Title III-B served approximately 13.47% (18,298/135,830) of Wyoming's total population age 60 and older adults in FFY 2019.
- 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 3,224 clients who live below 100% of the federal poverty level, 6,735 clients who live alone, 682 clients who are minorities, and 13,302 clients who live in rural Wyoming in FFY 2019.

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

	2017	2018	2019
Total Program Cost	\$1,516,933	\$1,647,562	1,886,998
People Served	17,635	18,466	18,727
Cost per Person	\$86.02	\$89.22	\$100.76
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

- Total program cost includes Federal and State funding amounts.
- Total program cost increased in FFY2019 due to an increase in federal reimbursement from \$2.47/meal to \$2.96/meal.
- 85% federal with a required 15% local match.
- The State provides ~5% of the required 15% local match.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In FFY19 the Title III-C1 Congregate Nutrition Program had a total of 35 grantees covering 23 counties in Wyoming. These grantees served a total of 18,727 eligible clients representing approximately 15.15% of Wyoming's population of adults age 60 and older based on 2017 Census data. These 18,727 eligible clients received a total of 629,096 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 2019 a total of 6,020 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, FFY2019 contract amounts were based on the FFY2017 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 participant 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 2019 Target	FFY 2020 Target	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
% and # of WY population age 60 and older served with income <100% of federal poverty level	33.00%*	29.65%	40.15% (3,288/ 8,189)	33.28% (3,074/ 9,238)	29.06% (3,017 ^A / 10,381 ^B)	29.24% (3,035/ 10,381 ^C)	28.71% (2,980/ 10,381 ^C)
% and # of clients age 60 and older served with high nutrition risk	15.05%	21.98%	16.61% (2,895/ 17,426)	15.86% (2,683/ 16,914)	15.02% (2,614/ 17,404)	14.93% (2,702/ 18,089)	16.52% (2,744/ 16,607)
% and # of WY population age 60 and older served who live alone	13.73%	12.42%	12.80% (5,979/ 46,712)	12.96% (5,801/ 44,754)	11.76% (5,887/ 50,051)	11.95% (5,981/ 50,051)	12.03% (6,020/ 50,051)
% and # of WY population age 60 and older served who are of a minority population	5.81%	6.88%	4.57% (422/ 9,227)	4.61% (431/ 9,358)	5.44% (484/ 8,898)	6.01% (535/ 8,898)	6.66% (593/ 8,898)
Total % of WY population served age 60 and older	15.57%	16.65%	15.11% (17,426/ 115,340)	14.10% (16,914/ 119,985)	14.08% (17,404/ 123,584)	15.15% (18,089/ 123,584)	15.15% (18,727/ 123,584)

*Targets from FFY19 are not updated with the new data source and therefore have different census data than the report outcome percentages.
^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 2018-2019 is not available. Data from the Census Bureau for 2017 was used as a reference for all FFY 2018 and FFY 2019 metrics, with the exception of metric “% of clients age 60 and older served with high nutrition risk”.

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Total number of meals provided to clients age 60 and older	644,575	629,505	627,261	626,860	617,493	308,042	318,818	299,122	318,371
Total units of Nutrition Education provided to clients age 60 and older	965	9,608	13,408	9,583	12,415	5,392	4,191	6,387	6,028
Total number of meals provided to all eligible clients	652,070	637,702	637,062	636,793	629,096	312,939	323,854	304,040	325,056
Total units of Nutrition Education provided to all eligible clients	1,432	9,762	13,561	9,700	12,633	5,447	4,253	6,476	6,157
Average total cost per meal	\$9.83	\$9.50	\$9.79	\$10.01	(-)	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	\$0.19	\$0.20	\$0.19	\$0.19	\$0.19	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	\$2.44	\$2.52	\$2.40	\$2.47	\$2.96	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 affect 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 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 for FFY15 and 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 FFY20 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

	2017	2018	2019
Total Program Cost	\$1,234,432	\$1,352,688	1,568,668
People Served	4,779	4,978	5,096
Cost per Person	\$258.30	\$271.73	\$307.82
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

- Total program cost includes Federal and State funding amounts.
- Total program cost increased in FFY2019 due to an increase in federal reimbursement from \$2.47/meal to \$2.96/meal.
- 85% federal with a required 15% local match.
- The State provides ~5% of the required 15% local match.

Program Staffing

- 0.5 FTE
- 0 AWEC

Program Metrics

- In FFY2019 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 5,096 eligible clients representing approximately 4.12% of Wyoming's population of adults age 60 and older based on 2017 Census data. These 5,096 eligible clients received a total of 571,248 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 FFY2019 a total of 2,372 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 FFY2019 contract amounts were based on FFY2017 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 2019 Target	FFY 2020 Target	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
% of WY population age 60 and older served <100% of federal poverty level	16.41%*	14.69%	18.89% (1,547/ 8,189)	16.87% (1,558/ 9,238)	14.65% (1,521 ^A / 10,381 ^B)	14.54% (1,510/ 10,381 ^C)	14.22% (1,476/ 10,381 ^C)
% of clients age 60 and older served with high nutrition risk	51.02%	53.93%	47.89% (2,214/ 4,623)	47.21% (2,257/ 4,781)	48.71% (2,317/ 4,757)	50.63% (2,470/ 4,879)	56.44% (2,547/ 4,879)
% of WY population age 60 and older served who live alone	5.58%	4.89%	5.37% (2,510/ 46,712)	5.51% (2,468/ 44,754)	4.88% (2,422/ 50,051)	4.85% (2,429/ 50,051)	4.74% (2,372/ 50,051)
% of WY population age 60 and older served who are of a minority population	2.02%	2.24%	1.64% (151/ 9,227)	1.71% (160/ 9,358)	1.87% (166/ 8,898)	2.10% (186/ 8,898)	2.17% (193/ 8,898)
Total % of WY population served age 60 and older	4.20%	4.26%	4.01% (4,623/ 115,340)	3.98% (4,781/ 119,985)	3.85% (4,757/ 123,584)	3.95% (4,879/ 123,584)	4.12% (5,096/ 123,584)

* Targets from FFY19 are not updated with the new data source and therefore have different census data than the reported outcome percentages.

^A Data is collected via the voluntary Aging Needs Evaluation Summary completed by clients participating in the Home Delivered Nutrition Program.

^B Denominator data is reported from the United States Census Bureau, Wyoming Population 60 Years and Over in the United States (5 year estimate).

^C Data from the Census Bureau for 2018-2019 is not available. Data from the Census Bureau for 2017 was used as a reference for all FFY 2018 and FFY 2019 metrics, with the exception of metric “% of clients age 60 and older served with high nutrition risk”.

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
Total number of meals provided to clients age 60 and older	512,828	528,247	534,514	541,685	561,478	268,168	273,517	277,912	283,566
Total units of Nutrition Education provided to clients age 60 and older	620.25	11,814	13,859	12,661	13,085	6,439	6,222	6,565	6,520
Total number of meals provided to all eligible clients	518,698	534,674	541,227	550,955	571,248	272,516	278,439	282,417	288,831
Total units of Nutrition Education provided to all eligible clients	1,225	12,035	13,969	12,821	13,244	6,519	6,302	6,632	6,612
EFFICIENCIES									
Average total cost per meal	\$9.39	\$8.57	\$9.77	\$9.71	(-)	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	\$0.19	\$0.20	\$0.19	\$0.19	\$0.19	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	\$2.44	\$2.52	\$2.40	\$2.47	\$2.89	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 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 for years FFY2015 and 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 FFY2020 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

	2017	2018	2019
Total Program Cost	\$509,773	\$537,692	\$617,805
People Served	363	335	324
Cost per Person	\$1,404	\$1,605	\$1,907
Non-600 Series*	18%**	15%**	18%**

* 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. The Provider must provide a 25% match to the federal funds, which is not included in the total program cost.
- Provider match (local funds and in-kind) for FFY2019 was \$246,468.
- Provider Program Income for FFY2019 was \$69,654. These funds do not count as match and are used to enhance services.

Program Staffing

- 0.38 FTE
- 0 AWEC
- 0 Other

Program Metrics

- 27% of Caregivers were 18 to 59 years old, no change from FFY2018 to FFY2019.
- 73% of Caregivers were 60 and older, no change from FFY2018 to FFY2019.
- 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 children 17 years of age or younger, or adult children 18 to 59 with a disability, 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.



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 2019 Target	FFY 2020 Target	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY2019
Number of unduplicated caregivers served	400	400	471	393	363	335	324
Number of outreach events (estimated number of consumers reached)	1,400	1,400	1,439 (17,033)	826 (18,352)	1,779 (49,610)	1,005 (26,904)	629 (23,253)
Average caregiver evaluation score	11/30	11/30	12/30	11/30	11/30	10/30	12/30*
Average caregiver evaluation score for newly enrolled caregivers	11/30	11/30	11/30	12/30	8/30	11/30	12/30*

*Data reported for these performance metrics is 64% as of 10/25/2019.
 (-) 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 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of respite units	8,572	7,930	5,340	5,737	7,984	2,593	3,144	3598	4386
# of counseling/support group/training units	1,404	1,203	1,242	1,251	1,304	624	628	727	577
# of supplemental services units	6,582	5,684	5,123	5,501	6,748	2,408	3,341	3071	3677
EFFICIENCIES									
Average cost per caregiver	\$1,268	\$1,446	\$1,404	\$1,605	\$1,907	\$1,046	\$1,000	\$1,150	\$1,264

(-) 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 FFY 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

	2017	2018	2019
Total Program Cost*	\$2,285,066	\$2,853,958	\$2,663,638
People Served	1,896	1,933	1,920
Cost per Person	\$1,205	\$1,476	\$1,387
Non-600 Series**	1.58%	1.03%	1.00%

* 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 2019 funding sources for WyHS Program come from: State allocation \$2,663,638 (69%); Local matching funds of \$846,807 (22%); and Program Income (participant contributions) \$366,640 (9%). Total program cost including all sources was \$3,905,826.
- For SFY2020 the program received \$225,000 in additional funding from the legislature.
- The total program cost for SFY 2017 reflects a \$931,443 budget cut for the 2017-2018 biennium.

Program Staffing

- 0.37 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Program Income generated. For SFY 2019, average participant contribution for the year was \$191.
- Local Match generated. For SFY 2019, WyHS providers generated a collective total of \$714,867 over their required match.
- In SFY 2019, the WyHS waiting list ranged from a low of 64 to a high of 163. 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.
- The waiting list number has increased from the previous year; current and long term numbers indicate 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.
- One-time funding in SFY2020 for current providers.



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 2019 Target	SFY 2020 Target	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY2019
% of WyHS Participants with an ADL of 2 or higher	85%	85%	1,839 (82%)	1,717 (80%)	1,501 (79%)	1,516 (78%)	1,488 (79%)
% of WyHS Participants with an IADL of 2 or higher	98%	98%	2,189 (97%)	2,088 (97%)	1,852 (98%)	1,889 (98%)	1,843 (98%)
Average # of people on the waiting list	0	70	83	80	99	82	89

(-) 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 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	2018 Q1+Q2	2018 Q3+Q4	2019 Q1+Q2	2019 Q3+Q4
OUTPUTS									
# of participants served	2,251	2,147	1,896	1,933	1,920	1,611	1,615	1,603	1,598
# of service units provided	93,307	94,537	84,268	88,992	85,457	42,963	46,029	41,986	43,470
# of homemaking units provided	50,694	51,589	48,264	49,029	49,136	23,908	25,121	23,999	25,137
# of personal care units provided	14,812	14,649	12,936	13,095	13,680	6,257	6,839	6,662	7,018
EFFICIENCIES									
Average State cost per person	\$1,366*	\$1,497	\$1,205	\$1,476	\$1,387	\$1,196	\$1,244	\$820	\$844
Average State cost per unit of services	\$33*	\$34	\$27	\$32	\$31	\$32	\$31	\$32	\$28
Average participant contribution per year	\$151	\$168	\$225	\$183	\$191	\$103	\$116	\$136	\$121

(-) 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
Comprehensive Waiver	0485
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
Supports Waiver	0486

Behavioral Health Division

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
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
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-E National Family Caregiver Support Program.....	5002
Wyoming Home Services.....	5002