Wyoming Department of Health

HealthStat 2023

Final Report

March 1, 2024

Message from the Director

Dear Reader:

HealthStat is a performance management initiative that began in 2011 in the Wyoming Department of Health (WDH). HealthStat is now entering its thirteenth year of implementation and has progressed to be a consistent and objective standard by which WDH programs can be evaluated. The WDH has some of the best and most talented staff who are deeply knowledgeable about the programs they oversee and the services they provide to Wyoming residents. HealthStat supplements that talent by providing a clear and concise method and process to regularly communicate with decision makers regarding the performance of our various programs.

HealthStat helps WDH leaders respond to program issues in an informed, timely, and coordinated fashion. Through HealthStat, WDH managers and staff all speak a similar language when it comes to program performance and evaluation. By reading the "program snapshots," leadership across the agency, as well as interested decision makers and stakeholders, are offered a unique way to easily understand the basics (staffing, financing, legal authority) of nearly every program operated by the department. By reading the "program performance reports," readers can view objective data on each program's "value chain" (outputs, efficiencies, outcomes) to gauge general program performance over several years.

During 2022 and 2023, the department put a great deal of emphasis on HealthStat and our culture of performance. The numerous department level performance improvement meetings and presentations held with various programs produced actionable analysis, performance improvement opportunities, and real, tangible results. A few notable examples include:

- Incorporating the newly-reconstructed and re-missioned State Hospital and Life Resource Center into the HealthStat process.
- Critical performance deficits relating to staffing deficiencies in critical areas of direct care, leading to new efforts around recruitment and retention, as well as supporting the investments the legislature made in state employee compensation.
- Identification of a performance deficit in colorectal screenings, which led to the legislature passing a law to lower the age Wyoming residents qualify for these free or low-cost cancer screenings.
- Identification of performance deficits and potential provider shortages for Wyoming Medicaid members, which led to legislative increases to reimbursements for dentists, nursing homes, PRTFs, and an extension of healthcare coverage for pregnant women from 60 days postpartum to 12 months.

These are only a few examples of the value that HealthStat brings to the department. Our mission is to promote, protect, and enhance the health of all Wyoming residents. We do that through numerous programs that provide funding for various services, through population health efforts, and through direct care operations at our facilities and field offices. Put simply, our agency is trying to improve the lives of the residents of this great state, and we must ensure that our programs and services are continually progressing toward that objective. I am confident that HealthStat continues to be a valuable tool to assist the agency in fulfilling its critical mission.

The work from the most recent year of HealthStat is represented in the pages that follow.

Sincerely,

Stefan Johansson
Director
Wyoming Department of Health

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Legal Services and Legal Developer Program

FFY 2023 Program Snapshot

Program Description

The Legal Services and Legal Developer Program is a federally mandated program, under Section 420 of the Older Americans Act of 1965, as amended in 2020, 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

	2021	2022	2023
Total Program Cost	$133,592	$185,227	$158,859**
People Served	366	726	681
Cost per Person	$365.00	$255.13	$233.27
Non-600 Series*	0%	0%	0%

* 600 series is defined as direct service. 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 for all seven programs, per the AOA Fiscal Guide for OAA for Titles III and VII.
** FY2023 Total Program Cost (Federal & State) from 10/1/22 through 9/30/23, ARPA SSC6 expenditures are included.

Program Cost Notes

- The Legal Services provider's required match is at 12.3% of federal funds, and the state match is at 5.3% of federal funds for FFY2023. A total of 31.4% match was contributed by the provider for FFY2023.
- Total expenditures included regular III-B Funds of $143,012.00 and COVID III-B SSC6 Funds of $15,847.05.
- Number of unduplicated clients served was 681. This number is based on the OAAPS Data Element for Federal Reporting.

Program Staffing

- 0.1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In FFY2023, 681 unduplicated seniors were afforded legal assistance via direct assistance from the provider. No qualifying clients were turned away. Cases were resolved or referred for outside affordable legal assistance.
- In FFY2023, total client hours performed by the provider equaled 1986.5 hours.
- In FFY2023, the average number of hours spent per client was 2.91 hours.
- For both Federal and State funds, the average cost per client was $233.27, and the average cost per hour was $43.77.
- A total of 58.5 hours of outreach and public education was provided by the Legal Services grantee in FFY 2023.
- A total of 42.5 In-kind Service hours was provided by Legal Services administrative staff and volunteers.
- The average cost savings per client, based on an average of $250 per hour for private legal assistance, was $729.25.
- This program helps Wyoming citizens 60 and over with a variety of legal services including basic estate planning, housing issues, debt collection, adult guardianships, social security benefits and other legal issues. These funds allow this program to provide these services to be offered to our citizens over the age of 60 at no charge allowing them to keep more of their money to spend on food, clothing, shelter, medicine, transportation, etc.

Legal Services and Legal Developer Program

Events that Have Shaped the Program

- There is no means test to be eligible for services.
- The Legal Services and Legal Developer Program served all eligible clients with no waiting list.
- No criminal cases are accepted through this program.
- 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.

FFY 2023 Legal Services Cases	*Number of Clients*
Bankruptcy, Collections and Garnishments	86
Wills/Estates	251
Advance Directives/Powers of Attorney	70
Divorce	41
Employment discrimination	5
Custody/Visitation	2
Adult Guardianship/Conservatorship	19
Private Landlord/Tenant	59
Other housing	24
Social Security (Not SSDI)	9
Case Rejected or lost contact before case type gathered	0
Case Type not listed above	115
TOTAL CLIENTS	**681**

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 2022 Target**	**FFY 2023 Target**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
Percent of cases resolved within 3 months	50%	50%	47%	68%	64%	69%	67%
Percent of respondents who claimed improved quality of life	100%	100%	69%	55%	68%	43%	59%
Percent of respondents who would have restricted their expenses if legal services were not received	50%	50%	56%	11%	28%	15%	28%

OUTCOMES data is based on annual customer surveys, self-reporting data (approximate 28% of clients responded).
53% of respondents stated that receiving Legal Services has helped them save money. 18% applied their savings to food expenses, 17% applied their savings to transportation services, and 19% of the respondents stated that they applied their savings to housing expenses.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
OUTPUTS									
Total number of clients	293	496	366	726	681	352	374	348	333
Total number of hours of service provided	1,082	3,995	1,810	4,169	1,987	2,355	1,813	892	1,095
Number of financial assistance/estate planning cases	282	399	304	308	403	139	169	213	190
Number of power of attorney and advance directives cases	44	68	83	69	71	43	26	33	38
Number of real estate/housing cases	80	76	104	123	96	60	63	49	47
EFFICIENCIES									
Average cost per unduplicated client	$245	$304	$365	$255	$233	$237	$166	$243	$223
Average cost saving per client at the market rate ($250/hour)	$9237	$2,013	$1,237	$1,435	$729	$1,673	$1,212	$640	$822

Legal Services and Legal Developer Program

Story Behind the Performance

History

- The case priorities of Legal Aid are: domestic law, public benefits, consumer, housing, Native American rights, senior services, adult guardianship/conservatorship, 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. 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.
- Title VII, Legal Services Developer Program is a non-funded program. The State of Wyoming inclined to incorporate both Title VII, Legal Services Developer Program with the Title III-B Legal Services Program to offer statewide legal assistance to Wyoming seniors. Title III-B. Legal Aid of Wyoming (LAW) is the only provider in the state.

Trends

- Legal aid services in non-means tested. People that participate in legal aid service tend to have higher income.
- Legal aid uses an education platform to encourage individuals to engage with legal services.

Efficiency

- Cost per hour of service is far lower than the market value of legal services.
- An increase in the funding allocated to Legal Aid in 2020 resulted in a direct increase in the number of participants served, as well as, the number of cases provided assistance. There was also an increase in the number of hours made available for more complex cases to be resolved.

Current Efforts

- Promote for Legal Aid to work with tribal entities within the state. Areas of adult protection advocacy are of higher concern.
- Engaged in the OAAPS initiative and serves as a pilot state in legal services data analysis and development of a better data collection system for program effectiveness.

Challenges

- Legal Aid is trying to recruit more people that meet the OAA criteria for eligibility (minority, low income, etc.) that are of the most social and economic needs.
- Client confidentiality is seen as a barrier when trying to engage potential clients to participate. This is more prevalent in small and rural communities.
- Legal Aid received additional requests to have clinics in communities and to provide face-to-face visits to assist with end-of-life planning which is a result of concerns due to COVID.
- The increasing cost for providing personal and safe distancing services during the pandemic made a great impact for the program operation.

Long Term Care Ombudsman Program

FFY 2023 Program Snapshot

Program Description

Title VII of the Older Americans Act, 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. Wyoming Senior Citizens, Inc. is the one statewide contractor for these services.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$255,998	$264,126**	$265,166
People Served	1,151	1,370	1,414
Non-600 Series*	9.0%	5.7%	12%

*600 series is defined as direct service

**$52,771.52 received under the CARES Act & LOC 5

Program Cost Notes

- 65% federal funds
- 35% state funds
- 0% local funds (not required; local contractor will supply additional funds as available)

Program Staffing

- 1 FTE
- 3 FTE through contract
- 0 AWEC

Program Metrics

- The Long-Term Care Ombudsman and elder abuse prevention program educates, investigates, advocates, mediates, and resolves issues on behalf of long-term care recipients to protect their health, safety, welfare, and rights.
- The program evaluates caseloads and activity level, including cases opened and closed, type of cases, and the number of program activities completed.
- All complaints or requests for assistance are reported monthly to the State Long-Term Care Ombudsman through the OmbudsManager Data System. A yearly report, OAAPS, is submitted to Administration on Community Living, ACL.
- All licensed nursing homes, assisted living facilities, and boarding homes in the state are to be visited quarterly by the Regional Ombudsman, per federal regulations. Other agencies the LTC Ombudsman may assist with are senior centers, hospice centers, adult day cares, home health companies, and individuals' homes. The Regional and State Ombudsman provide information, education and presentation about the signs and symptoms of abuse, prevention of abuse and when and how to report abuse.
- The Ombudsman program will work on Systems Advocacy, by recommending changes to our system to benefit long-term care residents. The program's current effort is to raise the personal needs allowance for Long Term Care residents.
- The program is working on developing the Volunteer Long Term Care Ombudsman program, VLTCOP, across the state.

Long Term Care Ombudsman Program

Events that Have Shaped the Program

- Three full-time Regional Long-Term Care Ombudsman are employed to cover the entire State of Wyoming with an average caseload of 1,551 facility beds per Regional Ombudsman a total of 4655 in 76 facilities; this past 11 months there was no turnover of three Regional Ombudsman positions.
- The last two quarters the Regional Ombudsman focused on increasing their attendance to Adult Protective Service meetings and community education presentations. This was done and the program looks to increase these numbers even more the second half of the year.
- There were a variety of complaints received by the program, but almost half of the cases were regarding Admissions, Transfer, Discharges and Evictions.
- Two Nursing Homes, Bonnie Blue Jacket in Basin and Saratoga Care Center in Saratoga closed in 2023. Additionally, Willow Creek of Cody, a Boarding home, closed in 2023. The Veterans Home of Wyoming opened a 36 bed nursing home. They do not have residents yet. Wyoming Life Resource Center opened up 10 beds that can be used as skilled nursing or intermediate care beds.
- The Regional Ombudsman map was changed to reflect the closures and openings of facilities.
- The program currently has three Volunteer Long-Term Care Ombudsman that visit an assigned facility once a week, all in Fremont County.
- In FFY23 two facilities developed a Family Council, and the program will continue to encourage other facilities to do the same. In coordination with Consumer Voice, an ACL funded resource center, the program produced a poster that will be handed out to facilities regarding what is a family council, how to start up a family council and the benefits to a family council.
- The Ombudsman Program along with Adult protective Services and the Aging Division have done a World Elder Abuse Awareness Day webinar over the past four years. You can watch the recordings of these on the WDH website just search WEAAD.
- The program has continued to maintain positive stakeholder relationships and foster benefit to recipients of long-term care services.

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 to protect their health, safety, welfare, and rights.

OUTCOMES							
Performance Metric	**FFY 2022 Target**	**FFY 2023 Target**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
% of complaints partially or fully resolved to the satisfaction of the complainant per year.	60%	98%	40.51%	74%	89%	98%	89%
% of complaints not resolved to the satisfaction of the complainant per year.	0%	0%	3.08%	4.47%	4.44%	0%	6%
% of complaints withdrawn by the complainant.	N/A	3%	N/A	N/A	N/A	3%	5%
% of complaints related to 'Autonomy, Choice, Exercise of Rights, Privacy' that were resolved.	50%	100%	53.33%	84.61%	82.14%	100%	100%
% of complaints related to 'Admission, Transfer, Discharge, Eviction' that were resolved.	50%	100%	58.33%	100%	85.71%	100%	93%
Number of Volunteer Long-Term Care Ombudsman (VLTCO), Trained.	5	6	0	0	6	2	1
Number of VLTCO	5	6	1	1	5	2	3
N/A indicates metric previously not recorded							

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022Q 3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
OUTPUTS									
# of visits to all LTC facilities by an Ombudsman	294	114	107	270	325	131	139	151	174
% of nursing homes, assisted living facilities, & boarding homes (75 total) visited by an Ombudsman quarterly	98.7%	34%	69.7%	86%	100%	86%	85%	100%	100%
# of cases opened	124	54	80	103	50	61	42	20	30
# of complaints received	174	67	107	124	57	74	50	22	35
# of activities completed	1,493	1,969	1,069	1,261	1,364	555	706	662	702
*At this time this is just the 3rd quarter.									

EFFICIENCIES									
Cost per person (Cases + Activities / Total $)	$130	$104	$222	$192	$187	N/A*	N/A*	N/A*	N/A*
N/A* indicates data not available on a quarterly basis.									

Story Behind the Performance

- There were two complaints that the LTCOP were unable to resolve, one the resident went to a nursing home out of state to be closer to family and the other the son's were very upset about the Medicaid resource guidelines, two cases were withdrawn by the complainant and three cases were referred to the Office of Healthcare Licensing and Surveys.
- The potential decrease in the number of cases opened by the Ombudsman program in the first half of FFY2023 compared to the two previous years may be a combination of two factors. One a need for training in cases vs activities, this has been done, and the other reason may be the lack of program awareness. Cases increased by 50% in the second half of FFY2023.
- The program had one new Volunteer to the program this year, a former Regional Ombudsman.
- FFY2023 all facilities are open and were visited in all 4 quarters. Facilities are still experiencing outbreaks but facilities are still allowing visitors and the Ombudsman access.
- The Program started the year off with a new Regional Long-Term Care Ombudsman in the Riverton office in November. The program is currently fully staffed.
- The program continues to maintain and improve stakeholder relationships, recruit for the volunteer program, reach out to residents and their loved ones in nursing homes, assisted living facilities, and boarding homes through various ways and to provide Ombudsman training and education to improve job performance and knowledge.

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 services 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 needs

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost (Federal and State)	$2,142,659**	$2,368,767**	$2,127,449***
People Served (Unduplicated Count)	15,450	16,099	17,729
Cost per Person	$138.55	$147.14	$119.99
Non-600 Series*	21%	11%	12%

* 600 series is defined as direct service. 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 for all seven programs, per the AOA Fiscal Guide for OAA for Titles III and VII.
**FY2021& FY2022 Total Program Cost (Federal & State), CARES Act expenditures are included.
*** FY2023 Total Program Cost (Federal & State), ARPA expenditures are included.

Program Cost Notes

- 60.2% Federal Funds, 3.4% General Funds, 30.7% local match, 5.0% Program Income & 0.7% Other.
- Grantees have typically contributed more than what is required for local match contributions.
- Program expenditures include regular III-B funds of $1,601,788.38, ARPA III-B SSC6 funds of $511,991.99 & ARPA2 SSC6 funds of $13,668.64 for FFY2023.

Program Staffing

- 0.80 FTE
- 0 AWEC
- 0 Other

Program Metrics

In FFY2023, Title III-B had a total of 36 grantees covering 23 counties in Wyoming. These grantees served a total of 17,729 unduplicated clients. There is a 4% increase in the eligible population served from FFY2021 to FFY2022 due to the rebound from the pandemic. This is approximately 11.65% of Wyoming's adults aged 60 and older, based on the 2020 American Community Survey, Census Bureau data. A total of 534,023 units of Title III-B service have been provided in FFY2023.

Title III-B Supportive Services

Events that Have Shaped the Program

- 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 enable older individuals to continue living independently and with dignity. A holistic health environment may alleviate high medical expenses and prevent premature institutionalization.
- Title III-B funds a broad array of services that enable seniors to remain in their homes for as long as possible. These services include, but are not limited to;
  - ► Access: transportation, health & wellness programs, and information and assistance
  - ► Preventive Health: health screenings and referrals for follow-up services as needed
  - ► Community services: legal services, mental health services, and ombudsman services
    - During the pandemic, providers developed new ways to provide IIIB services to homebound clients. This has allowed programs to potentially reach more clients living within the community who are homebound.

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 2022 Targets**	**FFY 2023 Targets*** **	**FFY 2019**	**FFY 2020**	**FFY 2021****	**FFY 2022**	**FFY 2023**
% and # of Wyoming's population (age 60 and older) served*	14% / 19,336	14% / 20,188	13.47% (18,298/ 135,830)	14.83% (18,967/ 127,891)	11.18% (15,450/ 138,116)	11.65% (16,099/ 138,116)	12.29% (17,729/ 144,204)
# of clients who received Health Services	N/A	5,500	6,206	4,894	3,518	5,051	5,722
# of clients who received Socialization Services	N/A	10,000	10,804	8,843	6,324	8,680	9,554
# of clients who received assisted and non-assisted transportation	N/A	2,000	2,580	1,713	1,117	1,672	1,657
# of clients who received Support Services	N/A	12,000	9,172	7,288	8,000	9,659	10,144

(N/A) Indicated targets were not set due to a change in performance metrics for 2023.
(*) Denominator data is reported from the United States Census Bureau, Wyoming population 60 years and older in the United States utilizing the American Community Survey (ACS)
(**) FFY2021 Performance Metric covers regular III-B as well as COVID III-B services from 10/1/2020 through 9/30/2021
(***) FFY2023 targets are aimed to get back to pre-pandemic levels

Title III-B Supportive Services

OUTPUTS									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
Total # of clients served	18,298	18,967	15,450	16,099	17,729	12,104	12,236	13,211	13,367
Total # of Title III-B Services units provided	773,939	641,848	483,504	506,876	534,023	250,639	257,400	258,688	278,862
Units of assisted and non-assisted transportation services provided	165,904	76,109	37,143	78,147	84,190	38,283	46,563	40,773	43,407
Units of Health Services	98,283	48,928	37,474	76,329	90,799	36,557	43,138	42,222	48,430
Units of Socialization Services	338,582	164,416	122,649	212,196	234,882	101,465	121,643	111,172	123,286
Units of Support Services	158,117	85,439	95,343	139,679	123,193	72,461	75,379	64,062	61,289

Notes: 1) Outputs and Efficiency section consists of regular III-B services and COVID 19 adapted services from 10/1/20 – 9/30/22
2) A unit of service is an occurrence or encounter of services, example - a one way transportation is one unit of service.

EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
Cost per client (Federal & State funds)	$100.00	$84.00	$138.50	$147.14	$119.99	$97.51	$97.13	$92.52	89.52
Cost per unit of service (Federal and State funds)	$2.38	$2.49	$4.43	$4.67	$3.98	$4.71	$4.62	$4.72	4.29

1) FFY21 & FFY22 - Cost per client and cost per unit of service is using total Title III funds and CARES Act funds combined.
2) FFY23 - Cost per client and cost per unit of service is using total Title III funds and ARPA funds combined.

Story Behind the Performance

History

- Funded by the Administration on Aging (AoA), Section 321 of the Older Americans Act.
- By 2030, Wyoming's population over the age of 65 is expected to increase from approximately 90,000 in 2016 to 138,000, a 56% increase. Wyoming's entire population is expected to increase by less than 12% during that time. Therefore, the vast majority of growth will come from the senior population.
- $1,000,000 of CARES Act funds were allocated to providers during the pandemic in support of any supplemental expenditures related to supporting older adults, for example; personal protective equipment.
- $743,762 of ARPA funds were allocated to providers in FY23 in support of any supplemental expenditures related to supporting older adults.
- Title III-B services in non-means tested.

Trends

- Based on the projected 2020 Census data, Title III-B Program served approximately 12.29% (17,729/144,204) of Wyoming's total population age 60 for FFY2023. Performance Metric covers regular III-B as well as COVID III-B services from 10/1/20 through 9/30/23. FFY2023 data shows a steady increase in clients and units of service provided as we move farther past the pandemic.
- People that participate in Title III-B service tend to participate in more than one category of services, i.e. Nutrition Program.
- National research demonstrates that participation in social activities and an active lifestyle enable older individuals to continue living independently and with dignity. A holistic health environment may alleviate high medical expenses and prevent premature institutionalization.
- In FFY2023 the total number of people served was 1,630 more than the previous year. Overall, an increase of 1,288 units were delivered from the previous year. We believe this was due to the gradual increase of seniors' participation in activities in wake of the pandemic, while also seeing an increase in the number of innovative services and outreach activities to meet new and established needs.

Efficiency

- In FFY 2023, the annual cost for the III-B services per client was averaging $120 per year.
- In FFY 2023, no eligible participant was denied services due to waiting lists for services in their communities.

Current Efforts

- Title III-B Program provides services to older adults aged 60 and older. Special emphasis is to serve older individuals with the greatest economic and social needs, and to enable older individuals to lead an active lifestyle to prevent premature institutionalization. Title III-B Program served 3,606 clients who live below 100% of the federal poverty level, 6,865 clients who live alone, and 710 clients who are minorities, in Wyoming in FFY2023.
- The Aging Division, Community Living Section will continue to provide technical assistance and collaborate with senior centers in the outreach function to promote participation. Many of the older adult population (60+) are unaware of the services available to them to allow them to remain in their homes for a longer period of time. How do we improve on getting this information out to the public?
- The Community Living Section is working with senior centers to take on initiatives, and to collaborate with state and communities agencies for effective services. One focus area is through enhancing older adult's accessibility to technology resources.
- The Community Living Section has been collaborating with the Governor's Office task force to find potential solutions for the transportation issues in our rural state.

Challenges

- Additional outreach is needed to reduce the stigma often associated with accessing services intended for older adults.
- There are still some ongoing challenges lingering from the Pandemic, the main one being getting seniors back into the centers.

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 participants. This program gives priority to older adults with the greatest economic need and older adults with the 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

	2021	2022	2023
Total Program Cost	$1,209,599	$1,944,956	$2,606,103
People Served	9,614	13,348	14,707
Cost per Person	$125.82	$145.71	$177.20
Non-600 Series*	12.02%	8.50%	6.73%

* 600 series is defined as direct service. 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 for all seven programs, per the AOA Fiscal Guide for OAA for Titles III and VII.

Program Cost Notes

- The total program cost listed above includes the Federal and State funding amounts expended during each FFY.
- The Title III-C1 program is 85% federal with a required 15% local match. The State currently provides approximately 5% of the required 15% local match.
- During FFY2021, most grantees did not serve congregate meals consistently during the COVID-19 pandemic. The decrease in the number of people served is due to the COVID-19 pandemic.
- Grantees were reimbursed for meal services from both the HDC3 CARES and HDC5 Consolidated Appropriations Act funds during the COVID-19 pandemic. These funds are reflected on the Title III-C2 Healthstat Snapshot.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- In FFY2023 the Title III-C1 Congregate Nutrition Program has a total of 35 grantees covering 23 counties in Wyoming. These grantees have served a total of 14,707 eligible Title III-C1 participants representing approximately 10.08% of Wyoming's population of adults age 60 and older based on Census data. These 14,707 Title III-C1 eligible participants received a total of 474,962 congregate 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 FFY2023 a total of 5,331 Title III-C1 eligible participants aged 60 and older who live alone have been provided congregate services.

Title III-C1 Congregate Nutrition Program

Events that Have Shaped the 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 FFY2023 contract amounts were based on FFY2019 meal counts.
    - Due to the COVID-19 pandemic, Title III-C2 grantees were reimbursed for all take-out and delivered meals that were served to Title III-C1 congregate participants. Therefore, there will be no accurate FFY2021 data to determine the future funding formulas. Title III-C1 meal counts for future funding formulas will be based on FFY2019 meal count numbers, as approved by the Administration for Community Living.
- Flexibility granted by the Administration for Community Living allowed nutrition grantees innovative strategies to provide meals to older adults during the COVID-19 pandemic. Meal types that are normally not eligible for reimbursement (i.e. takeout meals, delivered meals for Title III-C1 participants) were allowed to be provided. Looking forward, some of these adaptations are being discussed as potential changes in normal Title III-C services.
- Due to the COVID-19 pandemic food and supply shortages, many grantees experienced an increase in the overall cost of meals. This is reflected in the total program cost and increased cost per person served.
- In FFY23 the program is beginning to see a return of Title III-C1 eligible clients to the nutrition sites. The expectation is that congregate meals will once again account for 50% of all meals served under the Older Americans Act in Wyoming, more equally sharing the burden with the home delivered meal program.

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 2022 Target***	**FFY 2023 Target***	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
% and # of WY population age 60 and older served with income <100% of federal poverty level	15.70%	19.00%	25.99% (2,980[A]/ 11,463[B])	21.53% (2,468/ 11,463)	15.19% (1,741/ 11,463[C])	22.76% (2,609/ 11,463)	31.21% (2,946/ 9,438)
% and # of participants age 60 and older served with high nutrition risk	16.55%	17.00%	14.65% (2,744/ 18,727)	15.58% (2,158/ 13,849)	15.61% (1,501/ 9,614)	15.96% (2,131/ 13,348)	16.44% (2,418/ 14,707)
% and # of WY population age 60 and older served who live alone	6.57%	8.00%	11.09% (6,020/ 54,279)	9.10% (4,940/ 54,279)	6.36% (3,453/ 54,279)	8.90% (4831/ 54,279)	15.45% (5,331/ 34,504)
% and # of WY population age 60 and older served who are of a minority population	4.65%	5.00%	6.03% (593/ 9,837)	4.52% (445/ 9,837)	4.50% (443/ 9,837)	4.46% (439/ 9,837)	4.20% (525/ 12,528)
Total % of WY population served age 60 and older	7.00%	7.00%	13.56% (18,727/ 138,116)	10.03% (13,849/ 138,116)	6.79% (9,373/ 138,116)	9.53% (13,167/ 138,116)	10.08% (14,541/ 144,204)

(A) Data is collected via the voluntary Aging Needs Evaluation Summary (AGNES) completed by eligible participants 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 (2019: 1 year estimate).
(C) Data from the Census Bureau for 2020-2021 is not available. Data from the Census Bureau for 2019 was used as a reference for all FFY 2020 and FFY 2021 metrics, with the exception of the metric "% of participants age 60 and older served with high nutrition risk".
*Targets are based on current COVID-19 efforts and the expected 3.3% growth per year of aging older adults.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
Total number of meals provided to participants age 60 and older	617,493	294,396	235,239	417,052	474,962.	189482	227570	225,330	249,632
Total units of Nutrition Education provided to participants age 60+	12,415	5,629	5,029	250*	212*	137*	113*	110*	102*
Total number of meals provided to all eligible participants	629,096	300,171	239,004	422,310	479,652	191,911	230,399	227,769	251,883
Total units of Nutrition Education provided to all eligible participants	12,633	5,722	5,061	250*	212*	137*	113*	110*	102*

*An aggregate unit number is used for FFY2023 to report nutrition education.

Title III-C1 Congregate Nutrition Program

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
EFFICIENCIES									
Average total cost per meal	$10.39	$12.46	$17.40	$14.39	$14.74	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	$0.19	$0.19	$0.19	$0.19	$0.27	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	$2.96	$2.78	$3.57	$3.72	$4.75	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

History

- The Congregate Nutrition Program was established in 1972.
- The program targets older adults aged 60 and older who are in greatest social and economic need.
- The Congregate Nutrition Program is not a means-tested program.
- Eligible participants 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.
- An individual "served" is defined as an eligible participant receiving any of the following services: meals, nutrition education, and/or nutrition counseling.

Trends

- The total number of eligible participants served has increased over recent years, aside from the COVID-19 pandemic. Total meals served has seen a slow increase back to pre-pandemic numbers over recent years.
- Reimbursement per meal has been trending up as there has been an increased amount in grant continuation funds each year.
- Reduced participation in FFY2020 & FFY2021 is attributed to the COVID-19 pandemic.

Efficiency

- Per the Older Americans Act, satisfaction surveys are required to be completed each year. This is to ensure that eligible participants are given the opportunity to share their concerns and suggestions for the meal program. FFY2020 survey results reported that 84% of eligible participants felt that the nutrition program has helped them in some way. FFY2022 survey results showed 86% of eligible participants felt that the nutrition program had helped them in some way.
- In 2018 a meal cost tool was developed for grantees to submit each fiscal year. This information is used to review the difference in expenses (personnel, food, etc.) across the state.
- Increased participation has been seen in the congregate meals served from FFY2021 to FFY2023 due to the meal sites reopening after COVID-19 restrictions were lifted.

Current Efforts

- In FFY2019 changes were made to the Emergency Meal policy for both Title III-C1 and Title III-C2 programs.

Reimbursement for emergency (shelf-stable) meals is now a separate agreement from the Title III-C1 and Title III-C2 reimbursement. Nutrition grantees are not required to participate, but are given the option.

- Title III-C1 grantees are working hard to increase the number of people they are serving during the COVID-19 pandemic. The grantees have been quick to adapt to closures and changes in serving meals to older adults.
    - Because congregate meals were not being served, take out and delivered meals were offered to congregate participants during the COVID-19 pandemic. These meals were reimbursed from the Title III-C2 program based on guidance from the Administration on Community Living (these meal counts are shown on the Healthstat Title III-C2 document).
    - Data entries in A&D for FFY2020 & FFY2021 were adapted based on meals served during COVID-19. The Community Living Section will be able to identify each type of meal that was served during the COVID-19 pandemic.
- Title III-C1 and Title III-C2 grantees received Families First funding in response to the COVID-19 pandemic. This funding was only expended during FFY2020.
    - $400,000 CMC2 funding was awarded to pay for congregate meals.
    - $800,000 HDC2 funding was awarded to pay for take-out and any delivered meals.
    - Families First funding was reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC3 CARES funding in response to the COVID-19 pandemic. This funding was expended during FFY2020 and FFY2021.
    - $2,400,000 HDC3 funding was awarded to pay for any meals (congregate, takeout, delivered) served during the COVID-19 pandemic.
    - HDC3 funding was reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC5 Consolidated Appropriations Act funding in response to the COVID-19 pandemic. The project period for this funding award is through September 30, 2022.
    - $840,000 HDC5 funding was awarded to pay for expenses related to the pandemic (increased meal service, increased supply cost, increased personnel cost, etc).
    - HDC5 funding is reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received CMC6 American Rescue Plan Act funding in response to the COVID-19 pandemic. The project period for this funding award is through September 30, 2024.
    - $1,492,500 CMC6 funding was awarded to pay for expenses related to the pandemic (increased meal service, increased supply cost, increased personnel cost, etc).
    - CMC6 funding is reimbursed by expenditures, not by meals served.

Challenges

- 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 eligible participants each year. The nutrition program must also be prepared to reach and recruit an increased number of potential eligible participants. Targets for FFY2022 are based on the expected 3.3% increase per year.
- Due to the COVID-19 pandemic, most Title III-C1 grantees were not serving congregate meals for several months. Therefore, there will be no accurate FFY2020 & FFY2021 data to determine the future funding formulas. Title III-C1 meal counts for future funding formulas will be based on FFY2019 meal count numbers, as approved by the Administration for Community Living.

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 participants. This program gives priority to older adults with the greatest economic need and older adults with the 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

	2021	2022	2023
Total Program Cost	$3,132,738	$3,423,605	3,022,441
People Served	12,797	14,361	8,383
Cost per Person	$244.80	$238.40	$360.54
Non-600 Series*	12.02%	7.56%	6.73%

* 600 series is defined as direct service. 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 for all seven programs, per the AOA Fiscal Guide for OAA for Titles III and VII.

Program Cost Notes

- Title III-C2 program is 85% federal with a required 15% local match. The State currently provides approximately 5% of the required 15% local match.
- The total program cost listed above includes the Federal and State funding amounts expended during each FFY.
- Grant funds expended $2,333,478 during FFY2021
    - The total program cost for FFY2021 includes HDC3 CARES and HDC5 Consolidated Appropriations Act funding received during the COVID-19 pandemic. There was no match requirement for these federal dollars.
        - HDC3 funding $675,182 expended ($2,400,000 NOA). *Funds fully expended.*
        - HDC5 funding $124,075 expended ($840,000 NOA).
- Grant funds expended $1,399,398 during FFY2022
    - The total program cost for FFY2022 includes HDC5 Consolidated Appropriations Act funding received during the COVID-19 pandemic. There was no match requirement for these federal dollars.
        - HDC5 funding $579,333 expended ($840,000 NOA). *Funds fully expended.*
- Grant funds expended $2,175,673 during FFY2023
    - The total program cost for FFY2023 includes HDC6 American Rescue Plan Act funding received during the COVID-19 pandemic. There was a 15% matching requirement for these federal funds.
        - HDC6 funding $1,027,042 expended ($2,238,750 NOA).
- Flexibility to transfer funds between Title III-C1 and III-C2 was granted by the Administration on Community Living, based on grantees needs and service delivery.
- The number of people served for FFY2021, and FFY2022, includes individuals who were provided takeout, C1 delivered, and C2 delivered meals that were served during the COVID-19 pandemic.

Program Staffing

- 0.5 FTE
- 0 AWEC
- 0 Other

Title III-C2 Home Delivered Nutrition Program

Program Metrics

- In FFY2022 the Title III-C2 Home Delivered Nutrition Program has a total of 35 grantees covering 23 counties in Wyoming. These grantees have served a total of 4,568 eligible Title III-C2 participants (60 and older) representing approximately 5.31% of Wyoming's population of adults age 60 and older based on 2019 Census data.
    - 7,338 Title III-C2 eligible participants (including all) were served 416,465 meals. This includes meals that were served to eligible participants during the COVID-19 pandemic.
    - 2,999 Title III-C1 eligible participants (including all) were served 51,873 *takeout* meals. These meals were reimbursed from HDC3 & HDC5 CARES funding, and Title III-C2 grant funds (based on guidance from the ACL).

- The Title III-C2 Home Delivered Nutrition Program targets older adults who live alone to prevent social isolation and loneliness. In FFY2022 a total of 3,081 participants (60 and older) who live alone were provided services.

Events that Have Shaped the 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 FFY2022 contract amounts were based on FFY2019 meal counts.
    - Due to the COVID-19 pandemic, Title III-C2 grantees were reimbursed for all takeout and delivered meals that were served to Title III-C1 congregate participants. Therefore, there will be no accurate FFY2021 data to determine the future funding formulas. Title III-C2 meal counts for future funding formulas will be based on FFY2019 meal count numbers, as approved by the Administration for Community Living.
- Flexibility granted by the Administration for Community Living allowed nutrition grantees innovative strategies to provide meals to older adults during the COVID-19 pandemic. Meal types that are normally not eligible for reimbursement (i.e. takeout meals) were allowed to be provided. Looking forward, some of these adaptations are being discussed as potential changes in normal Title III-C services.
- Due to the COVID-19 pandemic food and supply shortages, many grantees experienced an increase in the overall cost of meals. This is reflected in the total program cost.

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 2022 Target***	**FFY 2023 Target***	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
% of WY population age 60 and older served <100% of federal poverty level	12.39%	15.69%	12.87% (1,476/ 11,463)	12.82% (1,470/ 11,463)	11.98% (1,374/ 11,463[C])	22.50% (2579[A]/ 11,463[B])	25.92% (2446/ 9,438)
% of participants age 60 and older served with high nutrition risk	50.00%	50.00%	49.98% (2,547/ 5,096)	51.14% (2,519/ 4,926)	19.63% (2,513/ 12,797)	24.19% (3,475/ 14,361)	40.22% (3,372/ 8,383)
% of WY population age 60 and older served who live alone	4.82%	8.00%	4.37% (2,372/ 54,279)	4.48% (2,432/ 54,279)	4.67% (2,534/ 54,279)	7.34% (3982/ 54,279)	10.68% (3685/ 34,504)
% of WY population age 60 and older served who are of a minority population	1.82%	5.00%	1.96% (193/ 9,837)	2.15% (202/ 9,837)	1.76% (173/ 9,837)	3.93% (387/ 9,837)	2.76% (346/ 12,528)
Total % of WY population served age 60 and older	3.80%	7.00%	3.69% (5,096/ 138,116)	3.57% (4,926/ 138,116)	3.73% (5,152/ 138,116)	6.68% (9222/ 138,116)	5.69% (8,200/ 144,204)

(A) Data is collected via the voluntary Aging Needs Evaluation Summary (AGNES) completed by eligible participants 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 (2019: 1 year estimate).
(C) Data from the Census Bureau for 2020 is not available. Data from the Census Bureau was used as a reference for all FFY 2020 and FFY 2021 metrics, with the exception of the metric "% of participants age 60 and older served with high nutrition risk".
*Targets are based on current COVID-19 efforts and the expected 3.3% growth per year of aging older adults.

OUTPUTS									
Performance Metric	**FFY 2020**	**FFY 2021**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
Total number of meals provided to participants age 60 and older	561,478	873,140	917,797	809,948	801,870	407,260	402,688	402,197	399,673
Total units of Nutrition Education provided to participants age 60 and older	13,085	20,151	21,137	297*	255*	156*	141*	134*	121*
Total number of meals provided to all eligible participants	571,248	891,327	936,103	821,054	813,088	413,135	407,919	407,297	405,791
Total units of Nutrition Education provided to all eligible participants	13,244	20,484	21,431	297*	255*	156*	141*	134*	121*

Title III-C2 Home Delivered Nutrition Program

*An aggregate unit number is used for FFY2023 to report nutrition education.

EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
Average total cost per meal	$10.20	$10.33	$20.16	$14.66	$9.78	N/A*	N/A*	N/A*	N/A*
Average state reimbursement per meal	$0.19	$0.19	$0.19	$0.19	$0.12	N/A*	N/A*	N/A*	N/A*
Average federal reimbursement per meal	$2.89	$2.78	$3.57	$3.72	$3.35	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

History

- The Home Delivered Nutrition program was established in 1978.
- The program targets older adults aged 60 and older who are in greatest social and economic need.
- The Home Delivered Meals program is not a means-tested program. Eligible participants 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.
- An individual "served" is defined as an eligible participant receiving any of the following services: meals, nutrition education, and/or nutrition counseling.

Trends

- Reimbursement per meal has been trending up as there has been an increased amount in grant continuation funds each year.
- Increased participation in FFY2020 and FFY2021 is attributed to the COVID-19 pandemic.
- Outputs for meals and nutrition education include takeout and delivered meals to Title III-C1 participants. For FFY2021 a total of 621,982 meals were served to eligible Title III-C2 participants. The difference of 314,121 meals were takeout and delivered meals to eligible Title III-C1 participants. In FFY2022 and FFY2023 take out meals were included in the total of Title III-C2 meals served.

Efficiency

- Per the Older Americans Act, satisfaction surveys are required to be completed each year. This is to ensure that eligible participants are given the opportunity to share their concerns and suggestions for the meal program. FFY2020 survey results reported that 90% of eligible participants felt that the nutrition program has helped them in some way. FFY2022 survey results showed 93% of eligible participants felt that the nutrition program had helped them in some way.
- In 2018 a Meal Cost Tool was developed for grantees to submit each fiscal year. This information is used to review the difference in expenses (personnel, food, etc.) across the state.

Current Efforts

- In FFY2019 changes were made to the Emergency Meal policy for both Title III-C1 and Title III-C2 programs. Reimbursement for emergency (shelf-stable) meals is now a separate agreement from the Title III-C1 and Title

III-C2 reimbursement. Nutrition grantees are not required to participate, but are given the option.

- Title III-C2 grantees are working hard to increase the number of people they are serving during the COVID-19 pandemic. The grantees have been quick to adapt to closures and changes in serving meals to older adults.
    - Because congregate meals were not being served, take-out and delivered meals were offered to congregate participants during the COVID-19 pandemic. These meals were reimbursed from the Title III-C2 program based on guidance from the Administration on Community Living (these meal counts are shown on the Healthstat Title III-C2 document).
    - Data entry in A&D for FFY2020 and FFY2021 was adapted based on meals served during the COVID-19 pandemic. CLS will be able to identify each type of meal that was served during COVID-19.
- Title III-C1 and Title III-C2 grantees received Families First funding in response to the COVID-19 pandemic. This funding was only expended during FFY2020.
    - $400,000 CMC2 funding was awarded to pay for congregate meals.
    - $800,000 HDC2 funding was awarded to pay for take-out and any delivered meals.
    - Families First funding was reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC3 CARES funding in response to the COVID-19 pandemic. This funding was expended during FFY2020 and FFY2021.
    - $2,400,000 HDC3 funding was awarded to pay for any meals (congregate, takeout, delivered) served during the COVID-19 pandemic.
    - HDC3 funding was reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC5 Consolidated Appropriations Act funding in response to the COVID-19 pandemic. The project period for this funding award is through September 30, 2022.
    - $840,000 HDC5 funding was awarded to pay for expenses related to the pandemic (increased meal service, increased supply cost, increased personnel cost, etc).
    - HDC5 funding is reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC6 American Rescue Plan Act funding in response to the COVID-19 pandemic. The project period for this funding award is through September 30, 2024.
    - $2.238.750 HDC6 funding was awarded to pay for expenses related to the pandemic (increased meal service, increased supply cost, increased personnel cost, etc).
    - CMC6 funding is reimbursed by expenditures, not by meals served.

Challenges

- 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 eligible participants each year. The nutrition program must also be prepared to reach and recruit an increased number of potential eligible participants. Targets for FFY2022 are based on the expected 3.3% increase per year.
- Due to the COVID-19 pandemic, Title III-C2 grantees were reimbursed for all takeout and delivered meals that were served to Title III-C1 congregate participants. Therefore, there will be no accurate FFY2020 and FFY2021 data to determine the future funding formulas. Title III-C2 meal counts for future funding formulas will be based on FFY2019 meal count numbers, as approved by the Administration for Community Living.

Title III-E National Family Caregiver Support Program

FFY 2023 Program Snapshot

Program Description

Since 2001 the National Family Caregiver Support Program has provided 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. Caregivers are also those older relative caregivers 55 and older, who care for a child 17 and younger, or of an adult child between the ages of 19-59 who has a disability. Parents of an adult child between the ages of 19-59 who has a disability are also eligible.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$1,144,064**	$944,428	$1,168,029***
People Served	389	355	333
Cost per Person	$2,941	$2,660	$3,508
Non-600 Series*	9%	16%	15%

*600 series is defined as direct service. 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 for all seven programs, per the AOA Fiscal Guide for OAA for Titles III and VII.

** Total program cost includes Title III-E funds expended, and Title III-E CARES Act funds expended.

***Total program cost includes Title III-E funds expended, and Title III-E ARPA funds expended.

Program Cost Notes

- Grant continuation, CARES funding, and ARPA funding were utilized to support new services and additional support for Caregivers and other OAA recipients in FFY21-FFY23.
- Bucketing of funds for these projects led to an increased cost per person in FFY2021-FFY2023.
- The Provider must match the Federal funds with 25%, which is not included in the total program cost.
- Provider match (local funds and in-kind) for FFY2023 is $304,593.
- Provider's Program Income, which enhances the program, for FFY23 is $57,197.

Program Staffing

- 0.38 FTE
- 0 AWEC
- 0 Other

Program Metrics

- There were 281 Caregivers who were 18 to 59 years old in FFY 2023.
- There were 45 Older Relative Caregivers who were 55 or older in FFY 2023.
- Twelve grantees provide services to Caregivers in 16 counties in Wyoming.
- Four grantees provide services to Older Relative Caregivers in three counties.
- Services provided to Caregiver and Older Relative Caregivers are: information, assistance (case management), counseling/support groups/training, respite, and supplemental services (chore, homemaking, personal emergency response systems, etc.).

Title III-E National Family Caregiver Support Program

Events that Have Shaped the Program

- The Caregiver program was implemented in 2001.
- During the reauthorization of the Older Americans Act, (OAA) in 2016, the Administration for Community Living expanded program eligibility.
- OAA reauthorization of 2020 removed the cap of 10% spending on the Older Relative Caregiver Program. We have contracted with an additional provider during FFY21.
- In FFY 2020 the cost per person went down due to an increase in the number of caregivers served. This may eventually trend upwards post COVID-19 as we have recently added a grantee.

Title III-E National Family Caregiver Support Program

Program Core Purpose

The National Family Caregiver Support Program provides support services to Wyoming Caregivers to continue their caregiving abilities to their loved ones.

OUTCOMES							
Performance Metric	**FFY 2022 Target**	**FFY 2023 Target**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
Number of unduplicated caregivers served	400	400	324	350	389	355	333
Number of outreach events, and (estimated number of consumers reached)	650	650	629 (23,253)	460 (22,858)	439 (86,995)	637 (233,013)	503 (180,879)
Provider local match contributed to expand program	$395,575	$368,625	$251,237	$268,276[1]	$327,002[1]	$361,605	$304,822[2]
Participant contributions to expand program	$75,000	$75,000	$70,543	$80,520[1]	$88,339[1]	$77,988	$57,197[2]

(1) Local match and program income amounts include CARES Act funding totals
(2) Local match and program income amounts include ARPA funding totals

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
OUTPUTS									
# of respite units	7,984	7,381	8,438	7,840	4,628	2,986	4,854	2,177	2,452
# of counseling/support group/training units	1,304	703	620	617	694	269	348	313	381
# of supplemental services units	6,748	8,892	10,048	10,630	15,532	5,042	5,588	6,889	8,176
EFFICIENCIES									
Average cost per caregiver	$1,907	$1,597	$2,941	$2,660	$3,508	$1,795	$1,911	$2,451	$2,041

Story Behind the Performance

History

- The Caregiver Program began in 2000.
- During the reauthorization of the Older Americans Act, (OAA) 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 through the Older Relative Caregiver Program. The Community Living Section implemented these changes in October 2017.
- OAA reauthorization of 2020 removed the cap of 10% spending on the Older Relative Caregiver Program. We have since added an additional provider.
- A new evaluation tool with the score maximum of 56 was developed in FFY2022. The goal of the evaluation tool is to evaluate how the Caregiver is doing during the time they are taking care of their loved one. The lower the score the better.

Trends

- The providers in Wyoming have provided services to over 300 caregivers for the past five years.
- The number of outreach events for caregivers have decreased by 5% since 2020 but had a 74% increase in the estimated number of consumers reached. This is an estimate so the numbers can fluctuate.
- Supplemental services are trending up because of the adapted services due to the pandemic. Respite visits for caregivers did increase because of the increase in caregiver clients.
- Providers continue to have difficulty getting caregivers to attend support groups.
- The majority of Providers return more match funds than required.

Efficiency

- Every ninety (90) days Caregivers are contacted via the phone and/or in person to listen or provide other needed services or find other resources.

Current Efforts

- Information Services, including radio ads, flyers, health fairs, and word-of-mouth are being used to inform potential caregivers of available services.

Challenges

- Getting caregivers to accept the services has continued to be a challenge.
- 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 a local match since FFY2013.
- Finding providers in 7 counties that do not currently offer caregiver services. (Albany, Niobrara, Park, Platte, Sublette, Washakie, Weston).
- Providers report challenges in filling open employment positions due to lack of health insurance.
- Some Providers have waitlists that fluctuate. Waitlists are a snapshot in time and change month to month.

Wyoming Home Services

Program Description

Wyoming Home Services program is a state funded grant program contracted to a single provider in each 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 settings. Services are primarily care coordination, homemaking, and personal care.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost*	$2,675,372	$2,559,954	$2,587,925
People Served	1,664	1,525	1,537
Cost per Person	$1,608	$1,654	$1,684
Non-600 Series**	1.00%	1.00%	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 2023 funding sources for WyHS Program come from: State allocation $2,587,925(64%); Local matching funds of $1,079,047 (27%); and Program Income (participant contributions) $296,023 (7.3%). Total program cost for all sources was $4,014,406.

Program Staffing

- 0.37 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Program Income generated. For SFY 2023, average participant contribution for the year was $193.
- Local Match generated. For SFY 2023, WyHS providers generated a collective total of $949,651 over their required match.
- In SFY 2023, the WyHS waiting list ranged from a low of 66 to a high of 154. The waiting list shows the need for the services; however, worker shortage is often a barrier to providing services.

Events that Have Shaped the Program

- The waiting list number has decreased 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. This provided the opportunity for providers to innovate with the types of service delivery offered.
- In SFY2021 the program had two long-standing providers withdraw from service due to anticipated program cuts. New providers have since taken over, however, there were delays in transitioning services under these new providers. This resulted in a decrease in the number of clients served.
- In SFY2022 the provider in Albany County withdrew from service.
- In SFY 2023 an existing provider applied for the WyHS grant in Albany County and is currently hiring staff.
- In SFY2023 the WyHS program piloted a 'means test' where participants were asked but not required to provide a contribution based on their income. Due to legislative requirements, means testing became mandatory July 1, 2023.
- Due to program volatility CLS has seen a fluctuation in providers OR reduced stability in our provider network.

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 2022 Target**	**SFY 2023 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% of WyHS Participants with an ADL of 2 or higher	80%	80%	1,488 (79%)	1,450 (79%)	1,251 (75%)	931 (61%)	924 (61%)
% of WyHS Participants with an IADL of 2 or higher	97%	97%	1,843 (98%)	1,848 (98%)	1,602 (96%)	1,392 (91%)	1,351 (88%)
Average # of people on the waiting list	100	100	90	131	121	157	95
% of WyHS Participants Assessed by Means Testing	N/A	50%	N/A	N/A	N/A	N/A	46%
% of WyHS Participants under 200% (Contribution Level 1-4) FPL	N/A	90%	N/A	N/A	N/A	N/A	643 (90.6%)
% of WyHS Participants above 200% (Contribution Level 5-9) FPL	N/A	10%	N/A	N/A	N/A	N/A	66 (9.3%)
N/A= Fiscal Year 2023 is the first year of implementation of means testing.							

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
OUTPUTS									
# of participants served	1,920	1,882	1,664	1,525	1,537	1,289	1,260	1,299	1,250
# of service units provided	85,457	81,839	69,902	60,046	57,939	30,274	29,772	28,664	29,276
# of homemaking units provided	49,136	49,954	41,563	36,934	36,563	18,709	18,224	17,942	18,622
# of personal care units provided	13,680	13,903	9,926	6,789	6,103	3,302	3,484	2,908	3,195
EFFICIENCIES									
Average State cost per person	$1,387	$1,517	$1,608	$1,654	$1,684	$1,058	$914	$1,078	$939
Average State cost per unit of services	$31	$35	$37	$41	$38	$45	$39	$22	$23
Average cost of service for participant (Program Income)	$191	$211	$260	$219	$193	$136	$126	$113	$119
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

History

- The Wyoming Home Services Program began in 1987.
- 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.
- For SFY2020 the program received $225,000 in additional funding from the legislature.

Trends

- The WyHS waiting list has fluctuated during the years based primarily upon availability of workers.

Efficiency

- Historically the program has been based on the sliding scale fee, participants pay a fee for services based on a suggested sliding fee scale and their ability to pay. No participant is denied services based upon their inability to pay.
- Beginning July 1, 2022 Providers began the process of assessing participants with means testing and requesting fees for service based on a new scale.
- The program income generated through participant contributions is put directly back into the program to enhance the program.
- The Aging Needs Evaluation Summary (AGNES) is done annually with mini-evaluations done every three months to monitor the eligible participant's well-being.

Current Efforts

- WyHS is currently provided in twenty-two counties throughout Wyoming. Each county's provider chooses the services they provide in their county based upon the county's need and feasibility for the provider. Albany County coverage resumed with a new provider in the first quarter of SFY2024. The Converse County provider withdrew from providing grant services at the end of SFY2023.
    - Homemaker services are the most offered service.
    - Personal Care services are offered in all but 4 counties, but are cost prohibitive due to the hiring and availability of certified nursing assistants (CNAs).

Challenges

- Finding alternative resources for older adults and disabled adults will be the most difficult issue faced in the next fiscal year. We believe many individuals will go without these resources in some communities.
- Providers struggle to find additional financial resources to support the growing need for services. Many providers exceed their matching responsibilities for this program in order to meet current needs in their communities.
- Workforce shortages. The need to hire CNAs and RNs in order to provide personal care services causes problems with providing affordable care.
- Due to program volatility CLS has seen a fluctuation in providers OR reduced stability in our provider network.

Behavioral Health Division

The following section contains HealthStat reports from the Behavioral Health Division, organized by program as follows:

1. Court Supervised Treatment Programs
2. Early Intervention and Education Program (EIEP) - Part B
3. Early Intervention and Education Program (EIEP) - Part C
4. Mental Health Outpatient Treatment
5. Mental Health Residential Treatment
6. Substance Abuse Outpatient Treatment
7. Substance Abuse Residential Treatment

Court Supervised Treatment Programs

Program Description

The Court Supervised Treatment (CST) Programs exist to provide alternative sentencing options to jails or prisons within the judicial system by providing supervision, probation, substance use treatment, and community services 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

	2021	2022	2023
Total Program Cost	$2,844,735	$3,142,304	$2,982,362
People Served	660	576	520
Cost per Person	$4,310	$5,455	$5,735
Non-600 Series*	5%	5%	5%

*600 series is defined as direct service

Note: The Court Supervised Treatment Program received COVID-19 relief funding in SFY 2022.

Program Cost Notes

- Biennium funding:
  - $2,928,374 State General Funds (55%)
  - $2,398,072 State Tobacco Funds (45%)
- Funds reside in Fund 558, established in accordance with W.S. § 7-13-1605
- Surcharge account amount available as of June 30, 2023 is $506,475

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- There were 18 funded CST Programs in SFY 2023 (13 adult, 3 juvenile, 1 DUI, and 1 adult/juvenile combined).
- The CST Program provides funding primarily for supervision services, but participants may receive ancillary services also.
  - Supervision services: CST program probation officers, including those from the Wyoming Departments of Corrections and Family Services, and county officers who conduct home visits verify that a participant is adhering to their agreed-upon program schedule, and assure participants are spending time with program-approved contacts only. These services monitor compliance and identify violations of program requirements.
  - Ancillary services: Education, medical/dental, life skills, 12-Step programs, and church, all of which support completion of treatment services, reduce recidivism, and increase the duration of sobriety.

Court Supervised Treatment Programs

Events that Have Shaped the Program

- Funding for CST comes from 2001 House Enrolled Act (HEA) 67; 2002 HEA 42; and 2006 HEA 21.
- The current CST Program Act, W.S. §§ 7-13-1601 through -1615, was enacted on July 1, 2009.
- The CST Funding Panel makes funding decisions for the programs. The Panel consists of the Attorney General, Directors of the Departments of Health, Family Services, and Corrections, and the State Public Defender, or their designees, per W.S. § 7-13-1605(d).
- The surcharge account was created per W.S. § 7-13-1616 and is a surcharge in addition to any fine or other penalty prescribed by law. Revenue from this account is distributed by the Funding Panel in accordance with W.S. § 7-13-1605.
- The Department updated the CST rules in 2020: *Rules, Department of Health, Mental Health and Substance Use Disorder Services*, chapter 6 (2020) (048.0077.6.04092020).
- Pursuant to 2023 Senate Enrolled Act No. 3, the CST Program, staff, equipment, and funding will transfer from the Executive Branch to the Judicial Branch on July 1, 2024.

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 use treatment services, and substance use testing for substance offenders in order to increase program graduation and durations of sobriety, as well as reduce recidivism.

OUTCOMES^							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% of active and graduated participants within a cohort* (Retention Rate)	A: 59% J: 59%	A: 59% J: 59%	A: 62% J: 73%	A: 61% J: 53%	A: 64% J: 60%	A: 78% J: 86%	A: 83% J: 63%
% of participants having re-arrest during their program participation (In-Program Recidivism Rate)	A: <5% J: <10%	A: <5% J: <10%	A: 4% J: 13%	A: 11% J: 13%	A: 9% J: 0%	A: 6% J: 0%	A: 1% J: 0%
% of participants having re-arrest within three years after their program participation (Post-Program Recidivism Rate)	A: <3% J: <15%	A: <3% J: <15%	A: 4% J: 8%	A: 9% J: 0%	A: 1% J: 5%	A: 2% J: 0%	A: 0% J: 0%

^Adult participants identified as "(A)"; Juvenile participants identified as "(J)"
*59% is the national graduation standard.
Note: Metrics are broken out by year cohort. For example, SFY 2023 cohort includes all participants who entered the program between July 1, 2022 and June 30, 2023 and participants are projected to graduate within SFY 2025.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of unique participants*	A: 515 J: 64	A: 524 J: 60	A: 594 J: 66	A: 512 J: 64	A: 466 J: 54	A: 397 J: 49	A: 390 J: 38	A: 351 J: 38	A: 347 J: 37
# of ancillary services per month, per participant^	A: 4 J: <1	A: 5 J: 2	A: 5 J: 1	A: 6 J: 1	A: 8 J: 4	A: 6 J: 1	A: 7 J: 1	A: 9 J: 3	A: 8 J: 4
# of supervision contacts per month, per participant	A: 2 J: 4	A: 2 J: 3	A: 3 J: 7	A: 3 J: 6	A: 3 J: 7	A: 3 J: 7	A: 3 J: 7	A: 3 J: 4	A: 3 J: 10
# of substance abuse tests per month, per participant	A: 9 J: 4	A: 4 J: 1	A: 7 J: 3	A: 7 J: 4	A: 7 J: 4	A: 7 J: 4	A: 7 J: 4	A: 7 J: 4	A: 8 J: 5
Units of service per month, per participant^	A: 14 J: 9	A: 8 J: 3	A: 18 J: 11	A: 17 J: 15	A: 24 J: 19	A: 16 J: 17	A: 17 J: 15	A: 26 J: 15	A: 25 J: 24
EFFICIENCIES									
Cost per unit of service (ancillary, treatment, supervision, drug test)^	A: $31.75 J: $49.38	A: $59.80 J: $159.47	A: $23.90 J: $39.91	A: $26.70 J: $30.31	A: $19.91 J: $25.15	N/A	N/A	N/A	N/A
Annual program cost per participant (cost per day per participant)^	$5,334 ($14.61)	$5,741 ($15.67)	$4,310 ($11.81)	$5,455 ($14.95)	$5,735 ($15.71)	N/A	N/A	N/A	N/A

Court Supervised Treatment Programs

Note: A unit of service may consist of ancillary services, treatment, supervision, and/or drug testing.
N/A indicates data not available on a quarterly basis.
*The SFY annual total for participants is a unique figure, however there is crossover between quarters. Quarterly participants are non-unique.
^Between SFY 2020 and SFY 2021, the formula for calculating the number of ancillary services was changed to more accurately reflect the time a participant spends receiving services.

Story Behind the Performance

- Retention is defined as the number of participants from a particular cohort who graduated from a local CST program and 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 local CST program lasts, on average, one and a half years. It is important that the retention formula gathers the most complete data within a timeframe that allows programs to make positive changes to operations when necessary.
    - The previous formula tracked the number of participants within a cohort who graduated from a local CST program. This formula, while accurately portraying retention, took a minimum of a year and a half for data to be usable. Because of this delay, it was increasingly challenging to hold local CST programs accountable for retention strategies.
    - The formula introduced in SFY 2022 tracks the number of participants within a cohort who have graduated or who are still active. Combining these figures allows the local CST programs to receive credit for participants who they are actively retaining while also accounting for those who graduated. It also takes much less time to identify local CST programs who meet set goals because participants are terminated faster than participants graduate.
- The state CST program has developed a monthly reconciliation report that is provided to local CST programs. The local CST programs must confirm the data included in the report is accurate and complete. If the data does not match, the local CST programs are required to provide a plan to correct the discrepancy. This process provides the state CST program with reliable data related to local CST program performance when making decisions regarding program operations and improvement.
- Pursuant to 2023 Senate Enrolled Act No. 3, the CST Program, staff, equipment, and funding will transfer from the Executive Branch to the Judicial Branch on July 1, 2024.

Early Intervention and Education Program (EIEP) - Part B

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

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost*	$22,697,058	$20,996,577	$22,160,706
Children Served**	2,438	2,438	2,387
Per Child Amount	$8,674	$8,674	$8,674
Non-600 Series***	0.1%	0.001%	0.001%

*Total program cost includes CDC contracts and state funding for .25 FTE.

**The Children Served annual child count calculation is based on a singular point-in-time snapshot.

***600 series is defined as direct service. In SFY 2021, a small federal allocation was included in the calculation, from SFY 2022 on, only state funding will be included. SFY 2022 non-600 series expenditures are relative to payroll.

Part B/619 SFY 2023 Contract Amounts*

- State Part B: $22,148,130
- Federal Part B funds: $1,347,586
- Total Part B federal and state funding: $23,495,716

**Contract amounts for CDCs only*

Program Staffing

- 2 FTE (0.25 SGF, 1.75 FF)
- 0 AWEC
- 0 Other

Program Metrics

- There are 14 Regional Child Development Centers with 41 locations statewide.
- There is an Annual Focused Monitoring of Part B/619 programs based on results of federal compliance indicators from the State Performance Plan and Results Driven Accountability.
- Collecting child outcomes data indicates growth of a child in certain areas outlined in the EIEP Part B/619 Performance Report measures, and based on the preschool, special education, and related services received.

Events that Have Shaped the Program

- Part B is authorized through the Individuals with Disabilities Education Act (IDEA), 1997 and IDEA Improvement Act, 2004.
- Part B is subject to Wyoming Department of Education (WDE): *Rules, Board of Commission Rules,* chapter 7 (2010) (206.0002.7.03222010).
- The 2004 IDEA Improvement Act reauthorized and continues to require children, ages three through 21 years, to have access to Free Appropriate Public Education (FAPE).
- WDE is the State Education Agency receiving 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 SFY 2019, WDE implemented a new IDEA monitoring process for all school districts which includes the EIEP's 14 contracted CDCs.
- In SFY 2020, all 14 CDCs used the same process for measuring child outcomes in five developmental areas, which entails a standardized assessment tool for entry and exit of a child from the Part B/619 program.
- There is a national focus on ensuring children enrolled in Part B/619 are receiving FAPE in the Least Restrictive Environment (LRE) alongside their typically developing peers. Wyoming Part B/619 continues to outperform the rest of the nation for the percentage of students receiving preschool special education in their LRE.

Early Intervention and Education Program (EIEP) - Part B

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, and who are identified with a disability that impacts their education. The program is state-mandated under W.S. § 21-2-701 through -706. Part B/619 is also a federally mandated program.

OUTCOMES

Performance Metric	SFY 2023 Target*	SFY 2024 Target*	SFY 2019	SFY 2020**	SFY 2021	SFY 2022	SFY 2023
% of children who substantially increased their rate of growth in Social-Emotional skills	80%	78.54%	78.91%	63.91%	78.33%	86.35%	79.88%
% of children who substantially increased their rate of growth in Acquiring and Using Knowledge and Skills	82%	80.15%	57.78%	47.19%	79.88%	84.41%	85.58%
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Needs	85.5%	83.70%	61.15%	42.19%	83.44%	78.43%	69.54%
% of children receiving special education in inclusive settings	73%	73%	73.90%	72.21%	80.61%	76.52%	80.91%

Performance Metric Explanation: Of those children who entered the program below age expectations, this reflects the percentage 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). During SFY 2023, the child outcomes tool was revised by the publisher and other states have also seen a drop in the "Taking Appropriate Action to Meet Needs" metric.

*Targets are adopted from the current WDE Report Card for the Early Intervention and Education Program, Part B/619.

**SFY 2020 percentages were impacted due to the COVID health crisis as children exiting the program could not be evaluated utilizing the standardized tool and less services were provided overall; due to these barriers, these figures should be viewed with discretion.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2019	SFY 2020	SFY 2021^	SFY 2022^	SFY 2023	2021 Q1-2	2021 Q3-4	2022 Q1-2	2022 Q3-4
OUTPUTS									
Number of children served based on annual child count	2,380	2,380	2,438	2,438	2,387	N/A	N/A	N/A	N/A
Number of children served annually (unduplicated)	3,107	2,946	3,161	3,118	3,268	N/A	N/A	N/A	N/A
EFFICIENCIES									
Per child amount budgeted	$8,674	$8,674	$8,674	$8,674	$8,764	N/A	N/A	N/A	N/A
Per child amount based on total number of children served annually	$7,507	$7,008	$6,690	$6,980	$6,781	N/A	N/A	N/A	N/A

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

^SFY 2021 and 2022 child count numbers were based on the count from December 1, 2019. This methodology was approved through the Legislature due to COVID effects on CDCs. The actual count for December 1, 2020 was 2,248.

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 years receive a Free Appropriate Public Education (FAPE). Section 619 of the IDEA provides funding specific to children ages three through five years.
- Through the IDEA-mandated Child Find process, all children ages three through five years suspected of having a disability are evaluated through a series of research-based and professionally-recognized assessment instruments.
- The Wyoming Department of Health (WDH), through a Memorandum of Understanding with the Wyoming Department of Education (WDE), administers the Part B/619 program. The WDE is the State Education Agency, while WDH acts as a Local Education Agency, much like a school district, receiving federal funds to manage the program.
- All children eligible for Part B/619 services are evaluated for child outcomes at entry and exit from the program. Data is used to measure a child's progress through participation in the program. Beginning in SFY 2019, a standardized assessment tool was used to capture this information.
- Progress targets for Part B/619 are determined by the WDE through stakeholder input and other states' targets for child outcome measurements. Wyoming targets for Part B/619 exceed national targets.
- The Early Intervention and Education Program (EIEP) has recently implemented a new data system which is used by the majority of Wyoming school districts. The new data system will eventually allow for automatic Part B reporting to WDE and will prospectively provide more efficient data reporting. In addition, the new data system offers technical assistance to end users.
- The EIEP continues to host data sessions with each of the 14 CDCs to review data specific to Part B/619 federal indicators for performance and compliance.
- To assist the 14 CDCs in all areas of compliance, the EIEP created and implemented a Special Education Manual and Part B policies to improve data accuracy and quality through guidance documents, resources, policy revision, and a monitoring manual. The use of these tools helps to improve the quality of services to Wyoming's children.
- To ensure that individualized evaluations are comprehensive, EIEP updated parameters around assessment resources for determining eligibility. Part B/619 providers are allowed to choose the most appropriate assessments based on the needs of individual children rather than a prescriptive list of approved assessments.
- EIEP has implemented a self-assessment process for Part B/619 providers to encourage review and verification of their work for program improvement.

Early Intervention and Education Program (EIEP) - Part C

Program Description

The Early Intervention and Education Program (EIEP) provides oversight of fourteen (14) Regional Child Development Centers (CDCs) that are contracted to provide Individuals with Disabilities Education Act (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.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost*	$10,459,594	$8,292,969	$8,820,801
Children Served**	1,207	1,207	1,171
Per Child Amount	$6,908	$6,908	$6,908
Non-600 Series***	0.4%	0.001%	0.001%

*Total program cost includes state funding for CDC contracts and state funding for .25 FTE and has been updated to reflect state funding only. Federal funds are included below.

**The Children Served annual child count calculation is based on a singular point-in-time snapshot.

***600 series is defined as direct service. In SFY 2020 and 2021, a small federal allocation was included in the calculation; from SFY 2022 on, only state funding will be included. SFY 2022 non-600 series expenditures are relative to payroll.

Part C SFY 2023 Contract Amounts*

- State Part C funds: $8,808,225
- Federal Part C funds: $1,945,470
- Federal Part C ARPA funds: $762,277
- Total Part C federal and state funding: $11,515,971

**Contract amounts for CDCs only*

Program Staffing

- 2 FTE (0.25 SGF, 1.75 FF)
- 0 AWEC
- 0 Other

Program Metrics

- There are 14 Regional Child Development Centers with 41 locations statewide.
- There is an Annual Focused Monitoring of Part C programs based on results of federal compliance indicators from the State Performance Plan.
- Collecting child outcomes data indicates growth of a child in certain areas outlined in the EIEP Part C Performance Report measures and based on the early intervention services they receive.

Events that Have Shaped the Program

- Individuals with Disabilities Education Act (IDEA), 1997 and IDEA Improvement Act, 2004.
- The 2004 IDEA Improvement Act reauthorized and continues to require children, age birth through two years, to have access to early intervention services.
- Part C monitoring for CDC programs is cyclical, with all CDCs receiving Part C onsite monitoring every three years.
- CDCs are provided with annual Report Cards showing their region's data on eight federal indicators.
- The State Performance Plan and Annual Performance Report for Part C indicates the Part C program received the highest level of performance for SFY 2022.
- The Wyoming Department of Health is the Lead Agency for the Part C federal grant.
- Since SFY 2019, all CDCs began utilizing a standardized assessment tool to determine a child's growth in skills and development as a result of early intervention.
- In SFY 2021, State General Funds were reduced by 16% resulting in a lower per child amount.
- Part C administers a Parent Survey each year in response to federal reporting requirements. The surveys in SFY 2023 showed a response rate of 58.05%, an increase of 10.57% over SFY 2022, and all targets for each area of measurement were exceeded.

Early Intervention and Education Program (EIEP) - Part C

Program Core Purpose

The Part C program provides oversight of 14 Regional Child Developmental Centers (CDCs) that are contracted to provide Individualized Family Service Plan (IFSP) services to children from birth through age two years in accordance with the Individuals with Disabilities Act (IDEA), and who have evidence of a developmental delay and meet State criteria for early intervention services.

OUTCOMES

Performance Metric	SFY 2023 Target	SFY 2024 Target	SFY 2019	SFY 2020*	SFY 2021**	SFY 2022**	SFY 2023
% of children who substantially increased their rate of growth in Positive Social-Emotional skills	56.40%	56.77%	71.23%	29.82%	56.03%	56.55%	60%
% of children who substantially increased their rate of growth in Acquiring and Using Knowledge and Skills	71.43%	71.80%	58.97%	37.36%	71.06%	75.16%	73.67%
% of children who substantially increased their rate of growth in Taking Appropriate Action to Meet Their Needs	90.51%	90.54%	82.37%	47.93%	90.49%	91.52%	79.79%

Performance Metric Explanation: Of those children who entered the program below age expectations, this reflects the percentage 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). During SFY 2023, the child outcomes tool was revised by the publisher and other states have also seen a drop in the "Taking Appropriate Action to Meet Needs" metric.

*SFY 2020 data represents only 250 children with child outcome exits due primarily to the COVID-19 pandemic as children could not take part in the face-to-face assessments. As a result, these figures should be viewed with discretion as this number is nearly half of typical exits.

**Data reflects the use of Change Sensitive Scores, which is a way of measuring growth built into the BDI-2 assessment.

Note: Beginning July 1, 2023, providers began using the BDI-3 for child outcome entry scores. In the SFY 2023 reporting year, only 8 children in the data set had entry and exit scores using the BDI-3.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2019	SFY 2020	SFY 2021^	SFY 2022^	SFY 2023	2022 Q1-2	2022 Q3-4	2023 Q1-2	2023 Q3-4
OUTPUTS									
Number of children served based on annual count	1,215	1,265	1,207	1,207	1,171	N/A*	N/A*	N/A*	N/A*
Number of children served annually (unduplicated)	2,874	2,081	1,873	1,998	1,992	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Per child amount budgeted	$8,751	$8,751	$6,908	$6,908	$7,627	N/A	N/A	N/A	N/A
Per child amount based on total number of children served annually	$3,700	$5,910	$4,451	$4,144	$4,428	N/A	N/A	N/A	N/A

NA indicates data not available on a quarterly basis.

^SFY 2021 and 2022 child count numbers were based on the count from December 1, 2019. This methodology was approved through the Legislature due to COVID effects on CDCs. The actual count for December 1, 2020 was 1,141.

Story Behind the Performance

- Part C allows states to apply for and receive federal funds to ensure services are provided to families and their children from birth through age two years, and 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.
- Since July 1, 2019, all children were evaluated for Part C 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 Battelle Developmental Inventory (BDI) assessment summarizes how much progress a child made in their developmental knowledge and skills during the time they were enrolled in Part C.
- In SFY 2019, the child count was changed to December 1 from November 1 due to a Legislative update to W.S. § 21-2-701 through -706.
- EIEP has recently implemented a new data system. This data system is in use by the majority of Wyoming school districts. The new data system will eventually allow for more efficient data reporting for Part C and children who transition to Part B. While the data system has Part B-specific fields, capabilities, and rules, the Part C portion of the data system was created specifically with Wyoming Part C program needs in mind.
- EIEP is currently in the process of updating Part C policies.
- In SFY 2022 and SFY 2023, the program has refocused efforts on the social emotional development of children in the Part C program by providing professional development and resources for providers.

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

	2021	2022	2023
Total Program Cost	$16,367,442	$15,357,644	$16,129,524
People Served	14,251	14,172	13,116
Cost per Person	$1,148	$1,084	$1,230
Non-600 Series*	1.13%	1.16%	1.15%

*600 series is defined as direct service. Non-600 series (administrative) costs are shared across the Mental Health Residential, Substance Abuse Outpatient, and Substance Abuse Residential Programs and have the potential to fluctuate each year.

Program Cost Notes

- SFY 2023 Funding
  - 94.91% State General Funds ($15,308,206.21)
  - 5.09% Federal Funds ($821,317.42)

Program Staffing

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

Program Metrics

- A total of 206,508 hours of mental health outpatient services were delivered in SFY 2023 with an average of 15.74 hours of service per client.
- Populations served: 56% adults with Serious Mental Illness (SMI); 15% youth with Severe Emotional Disturbance (SED), and 29% not diagnosed as SMI or SED.

Events that Have Shaped the Program

- The 2002 Chris S. Lawsuit Settlement Agreement stipulated the development of community-based treatment and support for adults with SMI and children with SED.
- House Enrolled Act (HEA) 21 (2006) 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 to expand mental health services like early intervention, group homes, psychiatric and nursing supports, and promoted the concept of regionalization of services.
- Staffing issues continued to impact the contracted Community Mental Health Centers (CMHCs) during SFY 2023, requiring CMHCs to be flexible with service delivery options to balance the need of the community with the available staff.
- At the beginning of SFY 2019, there were eighteen (18) Community Mental Health and Substance Abuse Centers (CMHC/SAC) across the state. Since that time, there has been one (1) closure, six (6) mergers, and one (1) center which, through a competing application, was not awarded a contract for SFY 2024 resulting in ten (10) contracted CMHC/SACs, covering all twenty-three (23) counties.
- 2021 HEA 56 requires a redesign of the public behavioral health system to serve specific priority populations through state funding. The framework for the system redesign was completed and agreed upon in SFY 2022. Workgroups convened in SFY 2023 to work through the details and implementation of pilot projects.

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 and Serious Mental Illness (SMI).

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Access to care: average days from time of first contact to first treatment service	≤ 7 days	≤ 7 days	N/A*	7.23	2.98	2.5	1.68
Treatment completion	75%	70%***	74%	61%	72%	74%	74%
% of clients with SMI who left treatment against medical advice (AMA) or were "no shows" for appointments and were discharged	≤ 15%	≤ 15%	13%	15%	15%	13%	10%
% of clients with a 1+ point of improved functioning as measured by the Daily Living Activities-20 functional assessment**	8%	10%	N/A**	N/A**	N/A**	N/A**	6.76%

*Metric was changed in SFY 2020; previous SFY data not retroactively available.
**The Global Assessment of Functioning (GAF) has been used in conjunction with the DLA-20 in previous fiscal years. However, the GAF is an outdated tool and has been discontinued for SFY 2023. The Agency's work on key performance indicator development is currently on hold as details around Behavioral Health Redesign outcomes are determined.
***Target updated based on SFY 2024 provider contract target.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Number of persons served	16,832	16,110	14,251	14,172	13,116	10,194	10,319	9,626	9,615
Number of persons with SMI served	9,036	8,991	8,244	7,751	7,284	5,735	5,697	5,342	5,417
Number of hours of outpatient services delivered	265,183	219,186	176,531	204,801	206,508	95,881	108,920	103,294	103,214
EFFICIENCIES									
Average cost per client	$1,162*	$1,214	$1,148	$1,084	$1,230	N/A	N/A	N/A	N/A
Average cost per service hour	$74	$89	$92	$75	$78	N/A	N/A	N/A	N/A

Note: Hours of service only reflect state pay sources (excludes Medicaid, third-party payers, etc.)
N/A indicates data not available on a quarterly basis.
*SFY 2019 was missing First Episode Psychosis dollars and has been adjusted.
Note: Outputs may include duplicated and unduplicated (unique) persons, as individuals may be counted in multiple quarters or fiscal years.

Story Behind the Performance

- Step Three budget reductions were implemented in SFY 2022. The Mental Health Outpatient Service line was reduced by approximately $4.8 million. While the number of clients served stayed relatively static, the number of service hours increased from SFY 2021. This increase resulted in a lower average cost per client and lower average cost per service hour. During the 2022 Budget Session, the legislature reinstated the budget reductions that were implemented in SFY 2022. The reinstated funding is appropriated for one biennium. The Agency has included reinstatement of the funds as a budget exception request for the 2025-2026 Biennium.

- In SFY 2021, the Emergency Diversion Bundled Service was implemented, which was intended to incentivize Community Mental Health Centers (CMHCs) to serve individuals in crisis and/or at risk of being committed to the Wyoming State Hospital. It was found that the service definition was not discrete enough for individual provider organizations, so the service was bifurcated into two different services types: Emergency Care Coordination and Gatekeeping Services (ECCGS) and Crisis Clinical Response Services (CCRS). The definitions were developed in collaboration with CMHC executive leadership and clinical directors as a way to better capture how services are delivered in communities. The initial data show that the two service types were widely adopted and proved beneficial in promoting and increasing crisis services within the CMHC network as a whole.

- The CMHCs have continued the use of telehealth services post COVID-19 pandemic. CMHCs found that some clients preferred this method of service delivery. The use of telehealth allowed the community providers to offer services in more rural areas without the need for travel by the clinician or clients. Additionally, CMHCs have found that the use of telehealth helps alleviate gaps due to workforce shortages.

- Multiple mergers have occurred since SFY 2020. At the beginning of SFY 2019, there were eighteen (18) Community Mental Health and Substance Abuse Centers (CMHC/SACs) across the state. Since that time, there has been one (1) closure, six (6) mergers, and one (1) center which, due to a competing application, was not awarded funding for SFY 2024. There are currently ten (10) contracted CMHC/SACs, covering the twenty-three (23) counties of the state.

    - The mergers may impact the amount of persons served. As an example, clients may choose private providers outside of the community system based on previous experience with that CMHC or a clinician that had been employed at a CMHC is now employed at a private provider and the client chose to continue receiving services from the individual clinician.

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 support. This program area includes community housing and sub-acute crisis residential.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$7,469,106	$7,462,981	$6,290,719
People Served	429	556**	583
Cost per Person	$17,410	$13,423	$10,790
Non-600 Series*	1.13%	1.16%	1.15%

*600 series is defined as direct service. Non-600 series (administrative) costs are shared across the Mental Health Outpatient, Substance Abuse Outpatient, and Substance Abuse Residential Programs and have the potential to fluctuate each year.

**Corrected from previous report.

Program Cost Notes

- SFY 2023 Funding:
  - 100% State General Funds ($6,290,719.08)

Program Staffing

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

Program Metrics

- 247 unique clients were served in community housing (transitional, supervised living, and long-term group homes) in SFY 2023.
- 336 unique clients received crisis stabilization services in SFY 2023.

Events that Have Shaped the Program

- The 2002 Chris S. Lawsuit Settlement Agreement stipulated the development of community-based treatment and support for adults with Serious Mental Illness (SMI).
- House Enrolled Act (HEA) 21 (2006) 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, and psychiatric and nursing supports, and it promoted the concept of regionalization of intensive services.
- At the beginning of SFY 2019, there were eighteen (18) Community Mental Health and Substance Abuse Centers (CMHC/SAC) across the state. Since that time, there has been one (1) closure, six (6) mergers, and one (1) center which, through a competing application, was not awarded a contract for SFY 2024 resulting in ten (10) contracted CMHC/SACs, covering all twenty-three (23) counties.
- 2021 HEA 56 requires a redesign of the public behavioral health system to serve specific priority populations through state funding. The framework for the system redesign was completed and agreed upon in SFY 2022. Workgroups convened in SFY 2023 to work through details and implementation of pilot projects.

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 support. This program area includes community housing and sub-acute crisis residential.

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Utilization rate for sub-acute crisis beds (formerly known as "crisis stabilization")	50%	50%	44%	44%	34%	42%	56%
Utilization rate for long-term group homes	85%	85%	89%	89%	85%	88%	87%
Utilization rate for transitional group homes	85%	85%	76%	82%	76%	77%	77%
Utilization rate for supervised living	85%	85%	87%	91%	89%	87%	87%
Median length-of-stay in long-term group homes (days)	200	200	297	391	196	192	254
Median length-of-stay in transitional group homes (days)	100	100	62	77	92	101	94
Median length-of-stay in supervised living environments (days)	300	300	283	415	527	293	336

Note: Data for long-term group homes, transitional group homes, and supervised living environments reflect separate subsets of all group homes. Crisis Stabilization is renamed Sub-Acute Crisis Residential for SFY 2023 to more accurately reflect the service being delivered, based on the nationally accepted definition of crisis stabilization.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Number of persons served – sub-acute crisis residential	370	349	248	333	336	160	202	185	193
Number of persons served – long-term group homes	45	45	61	59	58	43	49	46	46
Number of persons served – transitional group homes	95	84	71	70	75	46	45	50	49
Number of persons served – supervised living	136	120	105	119	114	100	98	95	95
EFFICIENCIES									
Average cost per client for sub-acute crisis residential	$4,318	$4,578	$9,652	$6,533	$8,910	N/A	N/A	N/A	N/A
Average cost per client for long-term group home	$27,529	$29,796	$31,263	$29,134	$35,401	N/A	N/A	N/A	N/A
Average cost per client for transitional group homes	$19,199	$24,456	$26,890	$27,775	$16,120	N/A	N/A	N/A	N/A
Average cost per client for supervised living	$8,090	$9,168	$11,989	$13,977	$17,949	N/A	N/A	N/A	N/A

N/A indicates data not available.
Note: Outputs may include duplicated and unduplicated (unique) persons, as individuals may be counted in multiple quarters or fiscal years.

Story Behind the Performance

- The Mental Health and Substance Abuse Services (MHSAS) section allowed the contracted Community Mental Health and Substance Abuse Centers (CMHC/SACs) to determine how the Step Three budget reductions would be implemented for contracts instead of taking an across-the-board cut. This method allows the CMHC/SAC providers to ensure the needs of their communities are met. However, unlike the budget units for outpatient services, mental health residential services funding was increased by $166,039 as a result of shifts in funding from other budget units.
- MHSAS identified an increase in mental health residential services over SFY 2023. This increase coincides with the reports of the increased need for mental health services following the pandemic. MHSAS has seen an increase in requests for treatment services for adolescents, as there are only two (2) Psychiatric Residential Treatment Facilities (PRTFs) in the state. These requests are being handled on a case-by-case basis, as Behavioral Health Redesign (BHR) continues its work to develop a new continuum of care for the most acute clients within the state.

- MHSAS worked with a national consultant to complete a review of the crisis stabilization services within the state. The review assessed the state services against the national toolkit developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). One result of this work is the change of the service name to Sub-Acute Crisis Residential to better capture the service being delivered. The consultant assisted MHSAS in developing a framework for crisis continuum services that could be implemented in the future with BHR.
- SFY 2023 data shows that the utilization rates for mental health residential treatment services exceeded the target percentage in sub-acute crisis, long-term group homes, and supervised living. Transitional group homes did not meet the target of 85% utilization rate and had a median length of stay of 94 days. One factor impacting all of the housing utilization rates is the lack of affordable housing across the state. In general, the clients stay in residential services while they wait for housing to become available. Additionally, there are a number of clients that are unable to live independently based on the severity of their mental illness.

Substance Abuse Outpatient Treatment

SFY 2023 Program Snapshot

Program Description

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.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$9,044,653	$8,459,429	$10,403,622
People Served	4,757	4,380	4,272
Cost per Person	$1,901	$1,931	$2,435
Non-600 Series*	1.13%	1.16%	1.15%

*600 series is defined as direct service. Non-600 series (administrative) costs are shared across the Mental Health Residential, Mental Health Outpatient, and Substance Abuse Residential Programs and have the potential to fluctuate each year.

Program Cost Notes

- SFY 2023 Funding:
  - 47.75% State General Funds ($4,967,750.78)
  - 46.14% State Tobacco Funds ($4,800,057.40)
  - 6.11% Federal Funds ($635,813.74)

Program Staffing

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

Program Metrics

- A total of 118,040 hours of outpatient services were delivered in SFY 2023, with an average of 27.63 hours of service per client.
- Populations served: 50.85% of persons with a primary problem of alcohol, 25.67% for methamphetamine, 13.65% for marijuana/hashish, and 7.10% for opiates (including heroin). The remaining 2.73% includes a primary problem of other substances.

Substance Abuse Outpatient Treatment

Events that Have Shaped the Program

- The Substance Abuse Control Plan, authorized in 2002 by W.S. § 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.
- 2006 House Enrolled Act (HEA) 21, 2007 Senate Enrolled Act (SEA) 77, and 2008 SEA 24, resulted in substantial increases in funding for substance abuse treatment and promoted the concept of regionalization of intensive services.
- Step Three budget reductions were implemented in SFY 2022. Contracted providers were allowed to choose how the budget reductions were allocated across budget units. This budget was reduced by approximately $3.1 million.
- At the beginning of SFY 2019, there were eighteen (18) Community Mental Health and Substance Abuse Centers (CMHC/SAC) across the state. Since that time, there has been one (1) closure, six (6) mergers, and one (1) center which, through a competing application, was not awarded a contract for SFY 2024 resulting in ten (10) contracted CMHC/SACs, covering all twenty-three (23) counties.
- 2021 HEA 56 requires a redesign of the public behavioral health system to serve specific priority populations through state funding. The framework for the system redesign was completed and agreed upon in SFY 2022. Workgroups convened in SFY 2023 to work through details and implementation of pilot projects.

Substance Abuse Outpatient Treatment

Program Core Purpose

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

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% of clients completing treatment	50%	50%	72%	69%	70%	76%	69%
% of clients with a 1+ point of improved functioning as measured by the Daily Living Activities-20 functional assessment*	8%	10%	N/A	N/A	N/A	N/A	13.93%
Access to care: average days from time of first contact to first treatment service	≤ 7	≤ 7	N/A**	4.16	2.72	3.44	2.95

*The Global Assessment of Functioning (GAF) has been used in conjunction with the DLA-20 in previous fiscal years. However, the GAF is an outdated tool and has been discontinued for SFY 2023. The Agency's work on key performance indicator development is currently on hold as details around Behavioral Health Redesign outcomes are determined.
**Metric was introduced in SFY 2020, previous SFY data not applicable.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Number of persons served*	6,220	5,445	4,757	4,380	4,272	2,949	2,820	2,786	2,874
Number of persons admitted*	5,210	3,894	3,235	2,996	2,994	1,518	1,628	1,552	1,585
Number of persons discharged	5,024	4,065	3,460	3,306	3,124	1,824	1,628	1,611	1,693
Hours of outpatient services delivered	160,875	147,533	128,915	114,382	118,040	56,566	57,816	55,562	62,478
EFFICIENCIES									
Average cost per client	$1,352	$1,545	$1,901	$1,931	$2,322	N/A	N/A	N/A	N/A
Average service cost per hour	$52	$57	$70	$74	$84	N/A	N/A	N/A	N/A

N/A indicates data not available on a quarterly basis
**Persons served* indicates all persons who received any treatment, *persons admitted* indicates all new persons who began receiving treatment.
Note: Outputs may include duplicated and unduplicated (unique) persons, as individuals may be counted in multiple quarters or fiscal years.

Story Behind the Performance

- The Mental Health and Substance Abuse Services (MHSAS) section continues to refine processes for contract management and monitoring of provider performance.
    - A monthly report for monitoring compliance deliverables was deployed in SFY 2022. It was designed to give contracted Community Mental Health and Substance Abuse Centers (CMHC/SACs) a monthly single point of reference for contract compliance and would allow for easy identification of areas that may need attention. The report has been refined and automated to become part of the standard monthly report packets shared with CMHCs/SACs beginning in SFY 2023.
- The CMHC/SACs continue to struggle with recruitment and retention of staff. Budget reductions made it more difficult to compete for potential staff and retain current staff. Additionally, the inability to hire impacted current staff by requiring them to work more hours and serve as the on-call staff more frequently, generally without additional compensation.
- Multiple mergers have occurred since SFY 2020. At the beginning of SFY 2019, there were eighteen (18) Community Mental Health and Substance Abuse Centers (CMHC/SACs) across the state. Since that time, there has been one (1) closure, six (6) mergers, and one (1) center which, due to a competing application, was not awarded funding for SFY 2024. There are currently ten (10) contracted CMHC/SACs, covering the twenty-three (23) counties of the state.
    - The mergers may impact the amount of persons served. As an example, clients may choose private providers outside of the community system based on previous experience with that CMHC/SAC, or a clinician that had been employed at a CMHC is now employed at a private provider and the client chose to continue receiving services from the individual clinician.
- Crisis Clinical Response Services (CCRS) were added to the service array for Substance Use Disorder Outpatient Treatment in SFY 2022. Historically, this level of service and care coordination was only available through the Mental Health service line in an effort to divert people at risk of being involuntarily hospitalized at the Wyoming State Hospital. Through the collaboration with CMHC/SAC executive directors in developing the definitions, it was noted that crisis situations are not limited to individuals with mental illness. The SFY 2023 data shows that for approximately 161 individuals statewide, services were used for Substance Use Disorder (SUD) treatment. This is not an anomaly and is being encouraged through the U.S. Substance Abuse and Mental Health Services Administration for SUD crisis services.

Substance Abuse Residential Treatment

Program Description

The Substance Abuse Residential Treatment program provides access to community-based substance use treatment services for Wyoming residents in need of 24-hour intensive services to achieve and maintain recovery from alcohol and drug dependency.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$12,233,415	$12,314,873	$15,344,961
People Served*	868	929	943
Cost per Person*	$14,093	$13,256	$16,272
Non-600 Series**	1.13%	1.16%	1.15%%

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

**600 series is defined as direct service. Non-600 series (administrative) costs are shared across the Mental Health Residential, Substance Abuse Outpatient, and Mental Health Outpatient Programs and have the potential to fluctuate each year.

Program Cost Notes

- SFY 2023 Funding
  - 78.46% State General Funds ($12,039,702.01)
  - 5.25% State Tobacco Funds ($805,259)
  - 16.29% Federal Funds ($2,499,999.99)

Program Staffing

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

Program Metrics

- A total of 59,465 days of primary residential treatment were delivered statewide with an average of 63 days of service per client in SFY 2023.
- In SFY 2023, admission data shows the top four primary presenting drug problems as methamphetamine (42.52%), alcohol (37.75%), other opiates and synthetics (6.89%), and heroin (4.88%). The remaining 7.96% includes a primary problem of other substances.

Events that Have Shaped the Program

- The Substance Abuse Control Plan, authorized in 2002 by W.S. § 9-2-2701 *et. seq*. requires a comprehensive plan to address substance use, including prevention, intervention, and treatment methodologies.
- 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.
- 2006 House Enrolled Act (HEA) 21, 2007 Senate Enrolled Act (SEA) 77, and 2008 SEA 24, resulted in substantial increases in funding for substance abuse treatment, and it promoted the concept of regionalization of intensive services.
- Step Three budget reductions were implemented in SFY 2022. The contracted providers were given the opportunity to adjust the reductions across budget units in order to meet the needs of their communities. The residential budgets were not affected by the reductions.
- At the beginning of SFY 2019, there were eighteen (18) Community Mental Health and Substance Abuse Centers (CMHC/SAC) across the state. Since that time, there has been one (1) closure, six (6) mergers, and one (1) center which, through a competing application, was not awarded a contract for SFY 2024 resulting in ten (10) contracted CMHC/SACs, covering all twenty-three (23) counties.
- 2021 HEA 56 requires a redesign of the public behavioral health system to serve specific priority populations through state funding. The framework for the system redesign was completed and agreed upon in SFY 2022. Workgroups convened in SFY 2023 to work through details and implementation of pilot projects.

Substance Abuse Residential Treatment

Program Core Purpose

The Substance Abuse Residential Treatment program provides access to community-based substance abuse treatment services for Wyoming residents in need of 24-hour intensive services to achieve and maintain recovery from alcohol and drug dependency.

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Utilization rate	85%	85%	91%	81%	72%	86%	83%
Treatment completion rate	60%*	60%	75%	75%*	71%*	73%*	68%

*Corrected from previous report. Metric target selection is currently being discussed as part of Behavioral Health Redesign efforts.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Number of persons served*	1,042	906	868	929	943	536	576	571	558
Number of persons admitted*	1,027	771	753	773	789	376	415	408	408
Number of persons discharged	976	819	726	770	810	385	405	430	417
Number of days residential services provided	69,417	61,582	53,105	61,313	59,465	29,676	31,637	30,404	29,061
EFFICIENCIES									
Average cost per client**	$11,545	$13,279	$14,093	$15,122	$16,272	N/A	N/A	N/A	N/A
Average cost per day**	$173	$195	$230	$229	$258	N/A	N/A	N/A	N/A

N/A indicates data not available on a quarterly basis.
**Persons served* indicates all persons who received any treatment, *persons admitted* indicates all new persons who began receiving treatment.
**Average cost per client for primary residential services only; does not include transitional group homes or social detox costs.
Note: Outputs may include duplicated and unduplicated (unique) persons, as individuals may be counted in multiple quarters or fiscal years.

Story Behind the Performance

- SFY 2023 showed a decrease in Substance Use Disorder (SUD) residential services. The decrease can be attributed to a variety of reasons, including outbreaks of COVID-19 and lice in residential facilities along with workforce shortages that limited the number of clients admitted. Residential length of stay also decreased, but coupled with an increase in the number of outpatient service hours shows that clients in residential were transitioned back into the community more quickly in SFY 2023 than the previous fiscal year.
- The Mental Health and Substance Abuse Services (MHSAS) section allowed the Community Mental Health and Substance Abuse Centers (CMHC/SACs) to determine how the Step Three budget reductions would be implemented for their contracts instead of taking an across-the-board cut. This method allows the CMHC/SAC providers to ensure the needs of their communities are met. However, unlike the budget units for outpatient services, substance use disorder residential services funding was increased by $560,990 as a result of shifts in funding from the outpatient budget units.
- Through the continuation of Behavioral Health Redesign work, it was determined that there would not be changes to current SUD residential services.

Division of Health Care Financing (Medicaid)

The following section contains HealthStat reports from the Division of Health Care Financing, organized by program as follows:

1. Wyoming Medicaid Overview
    a. Overall
    b. Financial Monitoring
    c. Health Outcomes
    d. Member Monitoring
2. Programs
    a. Care Management Entity (CME)
    b. Comprehensive Waiver
    c. Long Term Care Summary
    d. Medication Donation Program
    e. Patient Centered Medical Home (PCMH)
    f. Supports Waiver
    g. Wyoming Frontier Information Exchange (WYFI)
3. Benefits
    a. Behavioral Health
    b. Dental
    c. Pharmacy
    d. Psychiatric Residential Treatment Facilities (PRTF)
4. Administrative Functions
    a. Customer Service Center
    b. Medicaid Long Term Care Eligibility Unit
    c. Medicaid Long Term Care Summary
    d. Medicaid Third Party Liability
    e. Provider Network
    f. Program Integrity
    g. Program Integrity - Eligibility Review Unit

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 who 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

	2021	2022	2023
Total Claims Cost (millions)[1]	**$566.9M**	**$580.5M**	**$646.7M**
Average Monthly Enrollment	**68,438**	**77,642**	**85,062**
Cost per Person (PMPM)	**$681**	**$622**	**$620**

[1] 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. Revenue from rebate is also 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, 65% for former CHIP children
  - WINGS, HIE, WES and CSC technology and 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: 109 FT, 8 AWEC
- 34 FT in HCBS Unit
- 27 FT, 1 AWEC in Eligibility Unit
- 12 FT, 0 AWEC in Provider Services Unit
- 11 FT, 6 AWEC in Tech. and Bus. Oper.
- 11 FT in Program Integrity Unit
- 7 FT, 1 AWEC in Leadership & Admin.
- 5 FT in Medicaid Fiscal
- 2 FT in Health & Utilization Management

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 efficiencies such as administration cost, time to process claims, electronic versus paper processes, and error rates.
- Health care outcomes, emergency room usage, admission rates, and readmission rates.

Wyoming Medicaid - Overall

Events that Have Shaped the Program

- Federal COVID-19 aid expenditures from all bills allocating additional federal funds to states, including: the Coronavirus Preparedness & Response Supplemental Appropriations Act (3/6/20); the Families First Coronavirus Response Act (3/18/20); the Coronavirus Aid, Relief, and Economic Security (CARES) Act (3/27/20); the Paycheck Protection Program and Health Care Enhancement Act (4/24/20); the Coronavirus Response and Relief Supplemental Appropriations Act (12/27/20); and the American Rescue Plan Act (3/11/2021).

- Wyoming legislative studies, efforts, and changes to the program.

- Major technology efforts include the MMIS replacement project (WINGS), Wyoming Eligibility System, Eligibility Customer Service Center, and the Health Information Exchange (HIE).

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 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021[1]**	**SFY 2022[2]**	**SFY 2023**
Per Member Per Month (PMPM)		▶	$753	$808	$783	$681	$622	$620
Children PMPM	Children	▶	$350	$349	$314	$281	$271	$278
	Foster Care Children	▶	$690	$686	$584	$515	$465	$469
	Newborns	▶	$1,086	$1,200	$834	$743	$672	$572
Non-Disabled Adults PMPM	Family-Care Adults	▶	$505	$548	$527	$530	$492	$525
	Former Foster Care	▶	$389	$427	$405	$364	$370	$336
	Pregnant Women[3]	▶	$1,048	$1,175	$1,045	$743	$540	$515
Aged Individuals PMPM	Community Choices	▶	$1,679	$1,729	$1,729	$1,693	$1,818	$1,884
	Nursing Home[4]	▶	$4,426	$4,532	$5,006	$4,479	$4,556	$4,955
	PACE[7]	▶	$2,236	$2,409	$2,262	$2,364	N/A	N/A
Disabled Individuals PMPM	Acquired Brain Injury	▶	$3,897	$4,599	$4,550	$4,456	$4,119	$4,297
	Adults with ID/DD	▶	$5,133	$5,552	$5,457	$5,303	$5,227	$5,503
	Children with ID/DD	▶	$2,595	$2,946	$2,702	$2,401	$2,398	$2,403
	Suppl. Security Income (SSI)	▶	$791	$848	$797	$837	$874	$873
Benchmark PMPM[5]	CHIP (Plan A)[5]	▶	$267	$281	$281	$239	$274	$203
	Child Marketplace[6]	N/A	$452	$413	$415	$374	$374	$487
	Adult Marketplace[6]	N/A	$693	$690	$694	$625	$625	$742

[1] 12+ month claim lag
[2] 4 months claim lag, values are preliminary
[3] Excludes presumptive eligibility
[4] Excludes supplemental payments
[5] On October 1, 2020, the CHIP program transitioned to a Fee-For-Service program administered by the Department of Health. SFY 2020 and prior are the premiums paid to BCBS. The numbers for SFY 2021 and after are the PMPM for Medicaid CHIP.
[6] Kid-Care Chip premium Plan A. SFY 2023 child marketplace premium is for the lowest price gold plan with a $800 deductible and $9,100 max out of pocket. SFY 2023 adult marketplace premium is for a 40-year-old, non-smoker lowest price gold plan with a $800 deductible and $9,100 max out-of-pocket.
[7] The PACE program was terminated in 2021.

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023[1]**
OUTPUTS						
Recipients (unique count of members who received services)	70,307	67,077	64,055	65,643	70,174	75,914
Enrollment	79,300	76,035	76,036	78,300	86,034	94,791
Member Months	726,873	678,506	702,161	822,180	934,551	1,025,391
Claims Expenditures (by service date)	$547.1M	$548.1M	$549.6M	$559.7M	$580.8M	$635.3M
EFFICIENCIES						
% Enrolled Members that used services	88.7%	88.2%	84.2%	83.8%	81.5%	80.1%
Cost per recipient	$7,782	$8,171	$8,580	$8,526	$8,212	$8,369
Cost per enrolled member	$6,899	$7,209	$7,228	$7,148	$6,964	$6,702
[1] 12-month claim lag, values are preliminary						

Wyoming Medicaid - Financial Monitoring

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. The measure allows for better comparison of costs with other Medicaid programs, private insurance, and other premium-based programs.

- Per capita spending on healthcare in Wyoming was $10,989 in 2020. This equates to $915.75 per month per Wyoming resident. The national per capita figure was $10,191 in 2020. More recent data was not available at the time of reporting. (Source: http://kff.org/other/state-indicator/health-spending-per-capita/)

- On 10/1/2020, the CHIP program began processing fee-for-service claims in the Benefit Management System and Pharmacy Benefit Management System under an M-CHIP program.

Medicaid Health Outcomes

Program Description

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

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost[1]	$5,694,050	$5,596,181	$1,382,319[3]
People Served[2]	77,452	84,254	94,791
Cost per Person	$74	$66	$15

[1] Excludes Administrative Claims Costs.

[2] All Medicaid, All Ages.

[3] New vendor for Utilization Management with the scope of Health Management Services greatly reduced in the contract and brought in-house.

Program Cost Notes

- Health Management = $922,123 (50% Federal and 50% State funded)
- Seattle Children's Hospital = $448,100 (SGF)
- 24/7 Nurse Advice Line = $11,271 (SGF)
- Diabetes Incentives = $825 (SGF)

Program Staffing

- 1.5 FTE
  - Medical Director = 0.75
  - Contract Manager = 0.75

Program Metrics

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

Events that Have Shaped the Program

- Optum Healthcare Solutions was contracted to administer the WYhealth program and provide a total population program, disease management program, and complex care management program. The contract ended 6/30/22.
- Telligen, Inc. is the new vendor for Utilization Management with Health Management Services beginning 7/1/2022.
- The Wyoming Department of Health continues to provide disease management, complex care management, and population health support to Medicaid members through the WYhealth Program.
- Seattle Children's Hospital provides three different support services for our providers.
- The Patient-Centered Medical Home program requires practices to adhere to the best standards around patient care coordination and quality improvement.
- WYhealth continues to support Medicaid members with COVID-19 and an inpatient hospital visit. Upon meeting goals, the client is transitioned to another WYhealth program, as appropriate.

Program Core Purpose

The core purpose of these initiatives is to improve the prevention, screening, diagnosis, and management of acute and chronic diseases in Wyoming Medicaid members.

OUTCOMES								
Performance Metric		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (CMS 416 Report, Line 7)	Medicaid	▲	52%	52%	54%	53%	-	-
	National		58%	79%	68%	69%	-	-
Ambulatory Care: Emergency Department (ED) Visits Age 0-19 (AMB-CH)[1]	Medicaid	▼	47.1	47.84	47.6	29.07	20.23	34.68
	National		42.3	43.6	43.2	20.23	-	-
Follow-Up After Hospitalization for Mental Illness: Ages 6-17; Percentage with a 7-Day Follow-Up (FUH-CH)[1]	Medicaid	▲	58%	53%	54%	57%	53%	49%
	National		44.70%	41.90%	45.6%	46%	-	-
Follow-Up After Hospitalization for Mental Illness: Ages 6-17; Percentage with a 30-Day Follow-Up (FUH-CH)[1]	Medicaid	▲	83%	83%	82%	85%	80%	78%
	National		67.10%	66.3%	66%	66%	-	-
(PQI01-AD) Rate of Diabetes Inpatient Admits per 100,000 Member Months (Age 18-64)[1]	Medicaid	▼	17.54	15.31	28.01	15.55	14.23	0
	National		18	19.1	20.1	-	-	-
(OHD-AD) Percentage of High Dosage Opioids per 1,000 Opioids (Age 18-64)[1]	Medicaid	▼	35%	30%	23%	22%	25%	22%
	National		NA	NA	6.4%	-	-	-

(-) Indicates data not yet available
- Data is not yet available and will be reported in early 2024.
[1] These metrics are part of the CMS Core Measure set and are reported for the previous calendar year (i.e. values under CY2017 above are based on CY2016 data). The past year's measurements will not match what is reported to CMS but are re-run with the most recent year's logic. National Benchmarks represent the median. Online: https://www.medicaid.gov/state-overviews/stateprofile.html?state=wyoming
N/A indicates data not yet available due to the creation of a new metric
Retired indicates that this measure is no longer being reported to CMS.

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
Emergency Room Visits per 1,000 Member Months		62.7	61.9	53.4	42.6	45.9	45.6
Inpatient Admissions per 1,000 Member Months		11.1	15.7	14.2	11.7	9.6	9.8
Seattle Children's Hospital	# of Med Reviews	28	16	18	20	8	11
	# of Completed MDT[1]	153	95	108	97	108	122
	# of PAL Calls[2]	60	71	220	184	195	190
# of Clients Enrolled in the Diabetes Incentive Program		60	171	96	64	48	19
EFFICIENCIES							
PMPM	Age 0-20	$388	$393	$363	$326	$308	$323
	Age 21-64	$1,185	$1,280	$1,308	$1,193	$1,114	$1,002
	Age 65+	$1,572	$1,529	$1,635	$1,542	$1,034	$1,353
# of Unique Members	Age 0-20	48,465	47,617	45,874	40,220	45,901	50,522
	Age 21-64	22,043	22,094	22,341	19,095	20,691	23,105
	Age 65+	6,648	7,198	7,308	5,595	8,136	7,483

[1] MDT (Multi-Disciplinary Team)
[2] PAL (Provider Assistance Line)

Story Behind the Performance

WYHealth Functions

- **Total Population Health Management** - WYhealth provides education and support to Medicaid members for managing health and wellness. Engagement is limited to short-term support that may include direct outreach, mailing educational resources, social media push notifications, website support, and 24/7 Nurse Line support.
    - 24/7 Nurse Line - This is a 24/7 nurse line for Medicaid members where nurses will answer questions and advise clients on whether they should seek care immediately, visit the nearest urgent care, or schedule an appointment with their primary care physician. Nurses also assist members with understanding their medications and other health-related questions.
- **Care Management** - An important function of WYhealth is to support Medicaid members clinically through care management. Care Management is the practice of supporting clients in order to bridge gaps in care, provide health education and resources, as well as one-on-one support to address the needs of each unique member, meeting them where they are at in their health goals. The Registered Nurse Care Manager and the member work together to set goals, which are documented in a plan of care, and work through interventions to achieve health goals until the member "graduates" from the WYhealth program. The Disease Management Program and Complex Care Management Program fall under WYhealth Care Management.
    - **Disease Management** - Disease Management is a care management program aimed at clients with chronic disease states or other targeted conditions, such as diabetes and asthma, for outreach and prevention initiatives. Specific clients are identified through claims analysis and referral sources. While the Agency has defined certain conditions (including diabetes, asthma, cardiovascular pulmonary disease (COPD), and high-risk pregnancy), the Agency has the flexibility to care manage other conditions.
    - **Complex Care Management** - Complex Care Management is a clinical care management program 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 care management services.

Patient Incentives

- **Diabetes Choice Rewards (newly renamed Outsmart Diabetes)** - Choice Rewards is a client incentive program designed to call attention to a client's diabetes condition, support them to actively manage their diabetes, and engage clients in their health. Clients participating in the program can earn a twenty-five dollar ($25) gift card each quarter for up to four (4) quarters. The client participates by tracking and sharing their A1C Test Results and weight each month and reports these elements to their Registered Nurse Care Manager.

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 providers 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
- **The Current Iteration of Health Management** - Historically, care management is a high-touch and high-dollar initiative - not just for Wyoming, but across the country - and we have to keep asking how we can continue to improve the program for the population we serve and stay fiscally responsible. After reflection on the current scope of care management and the role it should play in the health of our Medicaid members, the Agency devised a hybrid care management approach to improve the quality of the program while also reducing expenses, beginning July 1, 2022. Before this, the Agency's health management program was defined by contractual requirements and outsourced to a vendor.

  Since mid 2022 a new contracted vendor, Telligen, is providing clinical and non-clinical staffing as well as a care management system for documentation purposes - with direct Agency oversight of all activities. The program's continued focus is on Medicaid members with complex cases, providing support for disease management, and improving population health. Within this hybrid model, Agency staff have more insight into the day-to-day happenings and flexibility to run pilot projects without having to do formal contract changes - all with oversight by the Medicaid Medical Director, Dr. Paul Johnson.

Program Core Purpose
Wyoming Medicaid provides health care coverage to qualified individuals.

OUTCOMES								
Performance Metric[1]		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Estimated % and # of Uninsured Children under Age 19, Under 138% of Federal Poverty Level (FPL)	Wyoming	▼	13.3% 3,734 (CY2017)	9.7% 2,609 (CY2018)	16.2% 3,961 (CY2019)	12.6% 2,817 (CY2020)	(-)	(-)
	Regional Average[2]	N/A	8.2%	8.7%	9.8%	8.9%	(-)	(-)
Estimated % and # of Uninsured Adults Age 18 to 64, Under 138% of FPL	Wyoming	▼	31.0% 16,515 (CY2017)	27.4% 14,087 (CY2018)	30.6% 14,905 (CY2019)	32.8% 14,913 (CY2020)	(-)	(-)
	Regional Average[2]	N/A	22.8%	22.8%	23.4%	23.3%	(-)	(-)
Estimated % and # of Uninsured Children under Age 19, All Incomes	Wyoming	N/A	8.8% 12,381 (CY2017)	6.8% 9,475 (CY2018)	11.1% 15,199 (CY2019)	8.0% 10,985 (CY2020)	(-)	(-)
	Regional Average[2]	N/A	5.4%	5.8%	6.3%	6.3%	(-)	(-)
Estimated % and # of Uninsured Adults Age 18 to 64, All Incomes	Wyoming	N/A	16.4% 56,134 (CY2017)	14.7% 49,923 (CY2018)	16.3% 54,899 (CY2019)	16.6% 55,957 (CY2020)	(-)	(-)
	Regional Average[2]	N/A	11.6%	11.8%	12.0%	12.2%	(-)	(-)

[1] All data pulled from US Census Small Area Health Insurance Estimates. https://www.census.gov/data-tools/demo/sahie/#/
[2] Region is defined as bordering states of Montana, Colorado, Idaho, South Dakota, Utah, and Nebraska, with Wyoming excluded from the calculation
(-) Data not yet available
N/A Does not apply to this metric

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS						
Enrolled Members (unique count, Total SFY)	79,300	76,035	76,036	78,300	86,034	94,791
% of State Population Enrolled in Medicaid[1]	13.7% (577,601)	13.2% (578,759)	13.1% (579,280)	13.5% (578,803)	14.8% (581,310)	16.3%
Member Months	726,873	678,506	702,161	822,180	934,551	1,025,391
Average Monthly Enrollment	60,542	56,505	58,469	68,438	77,642	85,062
Recipients (unique count of members who received services)	70,307	67,077	64,055	65,643	70,174	75,914

[1] For individuals enrolled at any time during the SFY compared to the population as of the start of the SFY (July 1). Population source (2015 to 2019) US Census: Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2019.
(-) Data is not available yet

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 these 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.
- The COVID-19 Public Health Emergency (PHE) created a maintenance of eligibility requirement, where Medicaid does not disenroll members during the term of the public health emergency. This requirement began January 1, 2020, and expires at the end of the month in which the PHE ends. The PHE is currently in effect and is forecast to end on either December 31, 2022, or March 31, 2022. This requirement led to a rapid increase in enrolled members and member months in SFY 2021 and SFY 2022.

Medicaid Care Management Entity (CME)

Program Description

Provide community-based alternatives to institutional care for Medicaid-covered youth (4 through 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" (HFW).

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$3,000,859	$3,108,441	$3,835,694
People Served	419	366	472
Cost per Person	$7,162	$8,493	$8,126

Program Cost Notes

- Funding is 50% federal & 50% state general funds
- SFY23 non-risk capitated payments were $1,885,642
- SFY23 FFS payment for TCM state plan services was $1,936,470

Program Staffing

- 1 FTE
- 17 FTE Contractor (Magellan Healthcare)
- Guidehouse Consulting

Program Metrics

Criteria for CME enrollment require that youth must be enrolled in Medicaid, 4 through 20 years of age, and at risk for out-of-home placement as defined by the clinical eligibility criteria components below:

- Meet the level of care (LOC) criteria, including clinical admission criteria similar to Medicaid prior authorization criteria utilized for Acute Psychiatric stabilization and Psychiatric Residential Treatment Facility (PRTF) services. The LOC is completed by a Qualified Mental Health Professional who attests that the youth can be safely served in the community with adequate services and support in place.
- Score within a specific range on the American Academy of Child & Adolescent Psychiatry's service intensity instruments (ECSII/CASII) that indicates a required service intensity equivalent to a 24-hour service setting with psychiatric monitoring. This service intensity level correlates with Acute Psych and PRTF LOCs.

Events that Have Shaped the Program

- Utilizing ARPA (sec. 9817), the 1915 b/c waivers and CME contract were amended to allow children and youth who with co-occurring challenges who are on the DD waiver waitlist to be served by the CME program. This change was implemented during the second quarter of SFY23.
- A CME FFS rate development study was completed during SFY23 to inform the payment methodology sections in the waiver renewals for SFY24. The study outlines the rate methodology and calculations behind a proposed rate increase which would be the first increase since the beginning of the CME program, July 1, 2015.
- CME network provider enrollment and member census have been steadily increasing from the declining enrollment numbers during SFY22.

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 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% and # of all youth served who were served for 6+ months		▲	47% (230/ 494)	42% (167/ 402)	50% (199/ 401)	54% (206/ 385)	43% (157/ 366)	43% (203/ 472)
% and # of all youth served who were served for 6+ months who graduated		▲	47% (107/ 230)	53% (89/ 167	40% (79/ 199)	28% (57/ 206)	39% (62/ 157)	46% (94/ 203)
# (%) of youth (with 6+ months enrollment) with an admit to:	Psychiatric Residential Treatment Facility (PRTF)	▼	6% (13/230)	13% (22/167)	13% (26/199)	10% (20/206)	3% (5/157)	4% (9/203)
	Juvenile Justice/ Detention Center	▼	4% (9/230)	1% (2/167)	1% (2/199)	1% (2/206)	0% (0/157)	2% (4/203)
	Acute Psychiatric Hospital	NA	8% (19/230)	8% (14/167)	18% (35/199)	14% (28/206)	3% (4/157)	11% (22/203)
	Overall[1]	▼	16% (36/230)	13% (21/167)	22% (43/199)	16% (33/206)	6% (9/157)	9% (29/203)

[1] 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.

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS						
% and # of youth discharged	60% (295/	61% (247/	53% (211/	57% (221/	46% (167/	51% (242/

Medicaid Care Management Entity (CME)

		494)	402)	401)	385)	366)	472)
# of CME youth served		494	402	401	385	366	472
# of Recipients using each CME service	Family Care Coordination	494	402	401	385	322	449
	Family Support Partner	219	162	196	203	160	247
	Youth Support Partner	26	37	5	0	5	15
	Respite Services	5	0	1	0	0	1
EFFICIENCIES							
# served and total Medicaid cost per youth[1]	all youth	494 $23,640	402 $20,072	401 $22,506	385 $19,058	366 $18,667	472 $18,047
	youth served 6+ months	230 $24,856	167 $24,647	199 $27,557	206 $24,961	157 $25,137	203 $23,508
	graduated youth[2]	107 $14,898	89 $11,445	79 $15,309	57 $19,769	62 $18,523	94 $13,035
# served and total Medicaid cost per PRTF youth (non-CME)[3]		228 $58,027	243 $48,892	174 $48,419	148 $58,557	133 $56,501	141 $60,725

[1] Total cost includes both CME and non-CME Medicaid costs
[2] Graduated youth is defined as those youth who have successfully transitioned from the CME program meeting all of their goals.
[3] Total cost includes both PRTF and non-PRTF Medicaid costs

Story Behind the Performance

- The CME program's enrolled providers rebounded from historic low numbers in the preceding year and CME member census increased as well as the two are closely tied together.
- Increase in JJ involved youth is driven by a couple of providers who specialize in working with JJ system-involved youth and their families. These specific providers have strong relationships with the DFS JJ staff in their service areas and receive referrals from those sources.
- The PHE-related Medicaid enrollment allowed some youth and their families to receive CME services who might not have otherwise. Or, who would have been served through the CMH.
- CME expansion into underserved areas continues to be a focus of the network development plan.

Program Description

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

Program Expenditures and People Served

	2021	2022	2023
Total Medical & Waiver Cost	$125,710,814	$118,002,077	$127,668,292
Total Waiver Cost	$114,499,001	$106,795,215	$116,992,552
Total Medical Costs	$11,211,813	$11,206,862	$10,675,740
Total People Served	1,892	1,867	1,840
Cost per Person (Medical & Waiver)	$65,886	$62,534	$68,235

Program Cost Notes

- Once funded on the waiver, the participant receives Medicaid medical and waiver services.
- Program staffing for the Comprehensive and Supports waivers is based upon the number of Home & Community Based Services (HCBS) Section staff proportional to the expenditures of the program.

Program Staffing

- 27 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of $5,802 per person in SFY23.
- The average cost per waiver participant in SFY23 was $63,583.
- 311 participants received some self-directed waiver services in SFY23.
- There were 576 providers, certified and monitored by the HCBS Section, that were available to provide services for the Comprehensive Waiver during SFY23.

Events that Have Shaped the Program

- **Federal Settings Rule.** Under the Home and Community Based (HCB) Settings Rule, 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 Rule also requires participants to have leases or residency agreements if receiving residential services. The Centers for Medicare and Medicaid Services (CMS) allow states, until March 2023, 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. In accordance with Wyoming's statewide transition plan, the HCBS Section completed all identified milestones and was in full compliance with the federal regulations by the March 17, 2023 deadline. Wyoming submitted their final compliance status to CMS on December 13, 2022.

- **COVID-19 Response.** CMS approved emergency flexibilities in response to the public health emergency, effective January 27, 2020. This included a temporary provider reimbursement rate increase of 12.5%, limited restrictions to visitor access of provider controlled settings, and service delivery via telehealth. The majority of the flexibilities offered during the PHE have been rescinded, or will expire on November 11, 2023. The HCBS continues to offer virtual support as a service delivery option for selected services. COVID-19 impacts on the program are still being explored, but widespread decreases in service utilization and provider closures do not appear to be supported by the data.

Program Core Purpose

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

OUTCOMES							
Performance Metric	**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
The number of participants ages 21+ living independently or semi-independently	▲	432/1695 (25.4%)	443/1631 (27.2%)	420/1635 (25.7%)	398/1623 (24.5%)	393/1677 (23.4%)	395/1680 (23.5%)
The number of participants ages 21+ working in competitive and community integrated settings earning at least minimum wage	▲	298/1683 (17.7%)	270/1591 (17.0%)	214/1593 (13.4%)	251/1609 (15.6%)	245/1633 (15.0%)	232/1635 (14.2%)
The number of individualized plans of care that pass quality review	▲	327/457 (72%)	757/1124 (67%)	744/1163 (64%)	1024/1805 (57%)	583/1189 (49%)	616/1542 (40%)

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS						
# of participants on waiver	1,962	1,959	1,932	1,892	1,867	1,840
# of waiver participants ages 21+ living in residential services or with family	1,177	1,128	1,185	1,195	1,255	1,265
# of participants ages 21+ using waiver supported employment services	229	227	225	203	179	165
EFFICIENCIES						
Average cost per participant (waiver and medical)	$54,580	$63,046	$63,866	$65,886	$62,534	$68,235
Average cost per participant (waiver only)	$47,941	$57,699	$58,900	$60,517	$57,202	$63,583

Story Behind the Performance

- **Rate Increases.** 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.

- The State of Wyoming Legislature appropriated $3.2 million dollars in 2022 to agency providers of developmental disability services that provided high-needs services, as defined in the Comprehensive and Supports Waivers SFY 2023 Provider Rate Study. This increase went into effect on September 1, 2022.

- The State of Wyoming Legislature appropriated a 2% rate increase for all providers of developmental disability services in an effort to restore previous rate cuts. Additionally, $12.6 million was appropriated ($25.2 million biennial) for agency providers to be added to the standard budget. These rate increases will go into effect October 1, 2023.

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) and Nursing Homes (NH).

Program Expenditures and People Served

SUMMARY	2021	2022	2023
Total LTC Expenditures[1]	$181,078,861	$189,491,318	$185,099,168
People Served	4867	4,684	4,614
Cost per Person	$37,205	$40,455	$39,445
COMMUNITY CHOICES WAIVER	**2021**	**2022**	**2023**
Total Program Cost (by service date)	$49,009,680	$52,390,415	$54,900,000
People Served	2,938	2,945	2,918
Cost per Person	$16,681	$17,790	$18,814
NURSING HOME	**2021**	**2022**	**2023**
Total Program Cost (by service date)[2]	$78,615,508	$77,968,171	$80,300,000
People Served	2,175	1,969	1,859
Cost per Person	$36,145	$39,597	$43,195
Total Provider Tax & Gap Payments[3]	$53,453,673	$59,132,732	$49,899,168
Cost Program with Tax and Gap Costs	$132,069,181	$137,100,903	$130,199,168
Cost per Person with Tax Gap & Costs	$60,721	$69,630	$70,037

[1] Includes CCW and NH (w/Tax and Gap).

[2] Costs include Nursing Facility & Swing Bed taxonomies, does not include Tax/Gap payments.

[3] Paid with 50% provider funding and 50% federal funding (i.e. no state general funds). Includes Provider Match.

Program Cost Notes

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

Program Staffing

CCW: 5 FTE NH: 0.25 FTE

Program Metrics

- Comparison of enrollment, expenditures, and member months between long-term programs.
- Comparison between LT101 scores, emergency room rates, and inpatient rates between long-term care programs.

Events that Have Shaped the 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 Waiver (CCW) program.
- In SFY 2021, the CCW program merged with the Developmental Disability Waiver program to form the Home and Community-Based Services (HCBS) Section.
- After an extensive public process, an updated nursing facility Rate Model was approved and implemented effective July 1, 2015.
- Effective July 1, 2021, a new rate methodology was implemented for the CCW program. This resulted in an average rate increase of approximately 9%.

Medication Donation Program

CY 2023 Program Snapshot

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 who lack adequate prescription insurance coverage while reducing medication waste.

Program Expenditures and People Served

	CY 2021	CY 2022	CY 2023 (Jan. – June)
Total Program Cost	$483,082	$519,597	$258,079
People Served[2]	1,975	2,246	1,121
Cost per Person	$244.60	$231.34	$230.22
Non-600 Series[1]	100%	100%	100%

[1]600 series is defined as direct service

[2] This is a combination of patients helped directly from the central location & from participating dispensing sites.

Program Cost Notes

- Revenue Source:
  Program costs paid 100% by the State's General Fund

- Return on Investment (Value of Rx's dispensed/program cost):
  - 2021 = $5.17
  - 2022 = $5.44
  - 2023 (Jan.-June) = $6.81

Program Staffing

- 1.5 FTE for pharmacists (RPh)
- 2.25 FTE for pharmacy technicians (CPhT)
- 0.75 FTE for AWEC CPhT

- Volunteer hours that supplement staffing costs:
  - 2021 = 41
  - 2022 = 119
  - 2023 (Jan.-June) = 63

Program Metrics

- Overall benchmarks include number of patients served, number of prescriptions filled, dollar value of donated medications (average wholesale price or AWP), donation usage rate, percentage of medication disposal, and ROI.
- Patient eligibility includes current Wyoming residency, low-income (at or below 200% federal poverty level), and uninsured or under-insured.

Events that Have Shaped the Program

- Drug Donation Program Act was passed in 2005 (W. S. § 35-7-1601 et seq.)
- The program began serving patients state-wide in 2011.
- In 2014, the program began receiving medications from the Dispensary of Hope to fill in gaps in donated inventory.
- In 2018, the Wyoming Legislature approved additional funding to support program expansion, allowing the program to move to a larger facility in the Hathaway building and double staffing by January 2019.
- By 2020, the program entered into agreements with SIRUM to start facilitating drug donation on a larger scale. SIRUM, a non-profit national charity platform, will help the program to get medications currently not being donated and will also allow the program to give non-usable donated drugs to other facilities instead of being turned into disposal.
- In 2020-2021, the program began addressing gaps in donated inventory and inconsistencies with drugs offered by Dispensary of Hope by supplementing with acquired drugs from secondary wholesalers.

Program Core Purpose

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

OUTCOMES							
Performance Metric	**Desired Trend**	**CY 2018**	**CY 2019**	**CY 2020**	**CY2021**	**CY2022**	**CY2023 (Jan. – June)**
Total patients served by re-dispensed medication[1,b]	▲	2,011	2,028	2,163	1,975	2,246	1,121
Total value of re-dispensed prescriptions[2]	▲	$2,337,156	$2,345,875	$2,190,542	$2,495,402	$2,828,748	$1,757,852
Patient medication adherence rate on mailed prescriptions[a]	▲	73%	87%	90%	92%	91%	92%
Return on Investment (ROI) (value of Rx's dispensed[2]/program cost)	▲	$6.70	$4.45	$4.45	$5.17	$5.44	$6.81

[1] Total number of patients served is an accurate count of unduplicated patients served via mail from the central location 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 one of several pricing benchmarks for drug pricing and calculating reimbursements for payments throughout the healthcare industry.
[b] see below for "story behind the performance".

OUTPUTS AND EFFICIENCIES							
Performance Metric		**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023 (Jan. – June)**
OUTPUTS							
Number of prescriptions filled using re-dispensed medication [1,b]		16,302	11,664	13,237	15,237	16,981	8,894
Rx's mailed[b]	Number	10,607	9,108	10,599	12,700	13,321	7,622
	AWP Value	$1,959,608	$1,522,887	$1,791,454	$2,133,485	$2,232,502	$1,424,558
	Percent	65%	78%	81%	83%	78%	86%
Donated Medications	Pounds[c]	5,947	5,726	6,190	5,599	6,960	3,427
	AWP Value	$3,464,516	$3,630,802	$6,213,764	$9,306,054	$11,989,701	$7,705,557
	Drug disposal[c]	43.5%	40.8%	30.5%	28.2%	32.3%	29.4%
Donated Med Exchange with SIRUM[d]	Pounds Donated (Outgoing)[3]	N/A	N/A	383	937	1,679	861
	AWP Value (Incoming)[3]	N/A	N/A	N/A	$24,756	$101,437	$53,057
EFFICIENCIES							
Average program cost per prescription dispensed[2]		$21.40	$45.21	$37.17	$31.70	$30.60	$29.02
Average AWP value per prescription dispensed		$143.37	$168.14	$165.49	$163.77	$166.58	$197.65
Medication usage rate (number of units incoming/number of units dispensed)[4]		83%	75%	68%	74%	68%	58%

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] Average program cost per prescription dispensed is rising due to loss of dispensing site participation. The program does not provide financial assistance to the dispensing sites, causing the cost per prescription to increase while the number of prescriptions dispensed has decreased.
[3] Incoming donations began June 2021. Outgoing donations began in August 2020.
[4] Number of units incoming and dispensed include items purchased as well as items donated to the program for re-dispensing.
[c,d] see below for "story behind the performance".

Story Behind the Performance

- Adherence rate calculation is based on how often a patient is requesting their refills on time and how often the program's central location is able to fill the prescription. Prescriptions can only be filled if the program has the medication in stock; otherwise the prescription goes on hold and it does not count positively toward a patient's adherence rate. Increased availability of drug items from other sources utilized by the program (purchased drug stock, drug exchange with SIRUM, and drug products acquired from Dispensary of Hope) has positively contributed to the patient adherence rate.

- The number of prescriptions filled from dispensing sites has continued to decrease. This is due to less participation from dispensing sites over time. In 2017, the program had 8 participating dispensing sites that re-dispensed 54% of the total prescriptions filled. Currently in 2023, the program has 5 participating dispensing sites that have re-dispensed just 14% of the total prescriptions filled.

- In January 2018 the program became more selective about what items are accepted for donation or disposal, resulting in a decrease in overall incoming donations. Donation criteria became more strict and the program provided education to the public (via the website, incoming phone calls, emails, etc.) and to donation sites about available disposal options, including drug disposal drop boxes across the state. The program began encouraging the use of these options to reduce costs and increase time/labor efficiency at the central location.

- Drug disposal occurring at the central location has decreased for several reasons. Along with the explanation from section "c" above, the 2020 implementation of the program's partnership with SIRUM, a non-profit that facilitates the movement of donated excess medications from donors to charity platforms (such as the Medication Donation Program) has also contributed to the decrease. Previously, overstocked medications at the central location were destroyed via drug disposal; now the program is able to ship these items to SIRUM for dispersal to other safety-net clinics and pharmacies. Alternatively, the program began acquiring donated drug items from SIRUM's platform to help supplement the program's current donated drug inventory. The Medication Donation Program's partnership with SIRUM has led to the creation of a drug exchange platform. The program can give excess inventory to SIRUM for use (instead of disposing of it). SIRUM will supply the program with items that are identified as in-need by the program to help supplement current donated inventory. The drug exchange will lead to better utilization of drugs by the program.

- In conjunction with the drug exchange between the program and SIRUM described in section "d" above, the program has been supplementing gaps in donated inventory and inconsistencies with drugs offered from Dispensary of Hope with acquired drugs from secondary wholesalers (which began in 2020-2021). This has led to a shorter waiting list (that current patients are placed on when the program is out of stock of a drug item) and better patient adherence rate.

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 and meeting the qualifications and standards of national health care accrediting bodies.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost[1]	$462,272	$301,196	$595,344
People Served	10,440	9,413	12,808
Cost per Person	$6 PMPM Recognized[2]	$6 PMPM Recognized[2]	$6 PMPM Recognized[2]

[1] By Paid Date

[2] Must be recognized by NCQA, URAC, AAAHC, or The Joint Commission

Program Cost Notes

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

Program Staffing

- 0.25 FTE divided among a team of 7 individuals

Program Metrics

- 10 practices are National Committee for Quality Assurance (NCQA) recognized and eligible to participate in the PCMH program; however, only 10 of NCQA recognized practices currently participate as of June 30th, 2023.
- These practices have 365 days to bill a clean claim and be paid for the PMPM, which has caused a lag and inaccurate 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 the quality of care, which is monitored through the CMS Core Measures.

Events that Have Shaped the Program

- 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

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 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
% of Eligible Medicaid & CHIP Recipients Served by a PCMH		▲	26%	25%	21%	14%	12%	14%
ER Visit Rate per 1,000 Member Months	PCMH	▼	79.48	77.49	63.87	55.48	61.11	56.95
	Non-PCMH (benchmark)[1]	N/A	66.99	68.02	57.94	57.66	57.10	60.29
Inpatient Admit Rate per 1,000 Member Months	PCMH	▼	15.81	16.26	13.34	13.10	9.36	9.32
	Non-PCMH (benchmark)[1]	N/A	13.86	14.30	13.63	10.79	8.64	7.07
SFY Average Percent for CMS Core Measures for All Participating Clinics	PCMH Early & Periodic Screening, Diagnostic & Treatment (EPSDT)	▲	56%	62%	58%	59%	54%	54%
	Non-PCMH EPSDT	N/A	37%	37%	34%	38%	34%	35%
	Cervical Cancer Screening - CCS - AD	▲	44%	45%	43%	44%	46%	47%
	Weight Assessment & Counseling for Nutrition & Physical Activity For Children BMI Assessment WCC-CH	▲	18%	20%	27%	44%	46%	45%
	Breast Cancer Screening - BCS-AD	▲	22%	26%	25%	33%	29%	22%
	Prenatal and Postpartum Care: Postpartum Care PPC-AD	▲	49%	45%	44%	52%	50%	60%

N/A indicates no desired trend

[1] Non-PCMH Benchmark is Medicaid members who have had at least one claim during the SFY.

CMS Core Measures versions are updated yearly and data is presented that way to stay in alignment with the measure.

Patient-Centered Medical Home

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
# of Practices Participating		19	20	12	10	10	10
% and # of Medicaid Eligible NCQA Practices Participating		85% (11/13)	79% (12/14)	79% (12/14)	77% (10/13)	77% (10/13)	77% (10/13)
% and # of Medicaid Providers in Participating Practices*		16% (168/1061)	15% (167/1148)	9% (107/1187)	9% (114/1248)	8% (118/1402)	7% (105/1602
# Clinics Connected to WY Frontier Information		0/19	6/20	2/12	5/10	10/10	10/10
EFFICIENCIES							
Eligible WY Accredited Clinics Participating /Total Clinics Participating in Program		13/19	12/20	12/14	10/13	10/13	10/13
Total # of Continuity of Care Documents (CCDs) Viewed		14,893	24,319	19,811	23,341	20,259	19,087
Per Recipient Per Month Cost (PRPM)	PCMH	$740.32	$752.85	$658.29	$656.38	$633.96	$704.47
	Non-PCMH (benchmark)	$892.96	$971.62	$980.51	$806.88	$692.95	$696.50

[1] 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.

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 Pull Continuum of Care Documents each month on clients that they are seeing. (before 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 currently has aligned with 6 of the CMS Core Measures to help improve Wyoming Medicaid's outcomes.

- Originally, 29 practices were interested in becoming recognized as a PCMH. Many practices have since dissolved, or have been acquired by larger practices.

- The State Agency continues to work with interested providers to discuss and assist with enrolling as a PCMH.

- 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 recognition are paid an additional $3 PMPM. The practices in the 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.

- On January 1st, 2020 the reporting measures were changed from Clinical Quality Measures to the CMS Core Measures for better accuracy and to remove clinic burden.

- On January 1st, 2020, the PCMH Program adopted the requirement that participating practices must be recognized by NCQA, URAC, AAAHC, or The Joint Commission to participate in the program. There is no longer a 1 year grace period. This has resulted in a decrease in participating practices since SFY 2020.

- On January 1st, 2021 the Children's Health Insurance Program's (CHIP) Members were included in the PCMH program. PCMH clinics can bill the PCMH PMPM for the CHIP members that they serve, since Wyoming Medicaid now manages CHIP.

- 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."

Program Description

The Supports Waiver is a stipend-based program for those with intellectual/developmental disabilities or acquired brain injuries. The Supports Waiver is designed to reduce the Medicaid Waiver waitlist by providing services so individuals can remain living in their home as safely as possible and live according to their own choices and preferences.

Program Expenditures and People Served

	2021	2022	2023
Total Medical & Waiver Cost	$12,092,809	$12,644,452	$15,318,627
Total Waiver Cost	$8,285,270	$8,440,356	$10,457,616
Total Medical Costs	$3,807,538	$4,204,096	$4,861,012
Total People Served	674	725	809
Cost per Person (Medical & Waiver)	$17,731	$17,110	$18,302

Program Cost Notes

- Once funded on the Waiver, the participant receives Medicaid medical services in addition to Waiver services.
- Program staffing for the Comprehensive and Supports waivers is based upon the number of Home & Community Based Services (HCBS) Section staff proportional to program expenditures.

Program Staffing

- 3 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Waiver recipients received Medicaid medical services at an average cost of $6,216 per person in SFY23.
- The average cost per Supports Waiver participant in SFY23 was $12,927.
- 202 participants self-directed some of their waiver services in SFY23.
- 362 eligible individuals were on the waiting list for the Supports Waiver as of June 30, 2023. This is a decrease of 45.3% from 526 in SFY22.

Events that Have Shaped the Program

- **Federal Settings Rule.** Under the Home and Community Based (HCB) Settings Rule, 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 Rule also requires participants to have leases or residency agreements if receiving residential services. The Centers for Medicare and Medicaid Services (CMS) allow states, until March 2023, 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. In accordance with Wyoming's statewide transition plan, the HCBS Section completed all identified milestones and was in full compliance with the federal regulations by the March 17, 2023 deadline. Wyoming submitted their final compliance status to CMS on December 13, 2022.

- **COVID-19 Response.** CMS approved emergency flexibilities in response to the public health emergency, effective January 27, 2020. This included a temporary provider reimbursement rate increase of 12.5%, limited restrictions to visitor access of provider controlled settings, and service delivery via telehealth. The majority of the flexibilities offered during the PHE have been rescinded, or will expire on November 11, 2023. The HCBS continues to offer virtual support as a service delivery option for selected services. COVID-19 impacts on the program are still being explored, but widespread decreases in service utilization and provider closures do not appear to be supported by the data.

Program Core Purpose

The Supports Waiver is a stipend-based program for individuals with intellectual/developmental disabilities or acquired brain injuries. The Supports Waiver is designed to reduce the Medicaid waiver waitlist by providing services so individuals can remain living in their homes according to their own choices and preferences.

OUTCOMES							
Performance Metric	**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Average utilization of individual budget amount for Supports Waiver participants	▲	50.7%	61.7%	54.7%	63.6%	67.0%	58.4%

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
# of participants	# of participants of all ages using community support services	51	51	60	56	56	62
	# of participants of all ages using supported living services	179	160	159	146	158	165
	# of participants ages 21+ using waiver-supported employment services	21	19	24	20	17	20
	# of total participants	565	569	644	674	725	809
Average cost per participant (waiver and medical)		$16,474	$16,538	$15,810	$17,731	$17,110	$18,302
Average cost per participant (waiver only)		$10,424	$11,429	$11,133	$12,293	$11,642	$12,927

Story Behind the Performance

- Rate Increases. 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 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.

- The State of Wyoming Legislature appropriated $3.2 million 2022 to agency providers of developmental disability services that provided high-needs services, as defined in the Comprehensive and Supports Waivers SFY 2023 Provider Rate Study. This increase went into effect on September 1, 2022.

- The State of Wyoming Legislature appropriated a 2% rate increase for all providers of developmental disability services to restore previous rate cuts. Additionally, $12.6 million was appropriated ($25.2 million biennially) for agency providers to be added to the standard budget. These rate increases will go into effect October 1, 2023.

Wyoming Frontier Information Exchange (WYFI)

Program Description

The Wyoming Frontier Information (WYFI) is a Wyoming statewide Health Information Exchange (HIE) that shares patient healthcare information between providers in a secure environment to improve patient care and reduce system inefficiencies.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$2,375,827	$1,035,942	$668,069
People Served[1]	357,349	452,915	556,602
Cost per Person	$7	$2	$1

[1] Wyoming Covered Lives

Program Cost Notes

- The program and administrative costs are funded with 100% Federal Funds as of 2/17/22 - 5/31/2024.
- The program and administrative costs will be funded with 90% Federal and 10% State General Funds.

Program Staffing

- 3.25 FTE
- 0 AWEC
- 2.5 Vendor Staff

Program Metrics

- As of June 30, 2023, 22 Hospitals, 15 Rural Health Clinics, 9 Federally Qualified Health Centers, and 12 trading partners have connected to WYFI as data contributors.
- 678,739 patient records exist in the WYFI.

Events that Have Shaped the Program

- 2016 Budget Session WY Senate Enrolled Act 19 Section 48 Footnote 2. $1,000,000.00 from General Funds and $9,000,000.00 Federal matching funds. To build out a multi-payer, statewide Health Information Exchange (HIE).
- As a part of the ARRA 2009 HITECH Act, the Division of Healthcare Financing was awarded funding to request for proposals for a statewide HIE in SFY 2016.
- In January 2017 the contract was executed with Health Catalyst, Inc. (formally Medicity)
- On October 21, 2019, the WYFI system certificate of acceptance was signed and designated as live.
- On July 1st, 2021, Wyoming Statute § 9-2-131 WY health information exchange became effective. Authorizing the Wyoming Department of Health to administer and maintain the HIE and promulgation of fees for services provided.
- On February 17th, 2022, the CDC COVID-19 & Health Disparities Grant Awarded funds allocated for the WYFI as a grant activity which ends May 31, 2024.
- On June 10th, 2022 the WYFI became Center for Medicare and Medicaid Services Certified.
- May 18th-19th, 2023, the strategic planning sessions with the Executive Steering Committee took place.
- WYFI Contract Amendment Five which includes the KPI Ninja Universe upgrade was executed May 26, 2023. This will improve overall system capabilities.

Program Core Purpose

The WYFI Health Information Exchange (HIE) core purpose is to promote a healthier Wyoming by developing a secure, connected, and coordinated statewide health IT system that supports effective and efficient healthcare.

OUTCOMES								
Performance Metric		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Facilities	Data Contributing	▲	0	54	92	189	217	227
	View Only	▲	0	15	100	157	165	123
	Total WY Potential[1]	▲	N/A	1,214	1,331	1,474	1,593	1,766
Community Health Record Users	Unique Providers	▲	0	27	386	3,556	3,551	3,486
	Total Users	▲	0	170	939	5,446	5,552	5,555
Covered Lives in the HIE	WY Covered Lives (Year over Year change)	▲	N/A[2]	N/A[2]	271,741 (+271,741)	357,359 (+85,609)	452,915 (+95,566)	556,602 (+103,687)
	All Covered Lives (Year over Year change)	▲	N/A[2]	N/A[2]	303,541 (+303,541)	402,304 (+98,763)	550,651 (+148,347)	678,739 (+128,088)
# of Patient Encounters in the HIE		▲	N/A[2]	N/A[2]	2,485,938	3,668,561	5,525,435	7,927,907
[3] Notify Users - Admit, Discharge, Transfer Notifications (ADTs)		▲	0	0	8	62	63	69

Total WY Potential[1] is based on Medicaid enrolled Provider Groups and Facilities
N/A[2] Reporting tool was not available until SFY 2020
N/A Indicates no data since the program did not start until late SFY 2018
[3] Notify is the system that is utilized by providers to check ADTs for their patients. Providers may sign up for specific types of notifications.

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS						
# of WY Hospitals Connected (Data Contributors)	0% (0/27)	11% (3/27)	30% (8/27)	59% (16/27)	78% (21/27)	81% (22/27)
# of WY Federally Qualified Health Centers Connected (Data Contributors)	0% (0/15)	7% (1/15)	20% (3/15)	27% (4/15)	73% (11/15)	60% (9/15)

Wyoming Frontier Information Exchange (WYFI)

# of WY Rural Health Clinics Connected (Data Contributors)	0% (0/25)	0% (0/25)	36% (9/25)	56% (13/25)	56% (13/25)	60% (15/25)
# of State & Federal Trading Partners Connected	0	1	2	8	8	12
# of Boarding State HIEs Connected to WYFI	0% (0/6)	0% (0/6)	50% (3/6)	50% (3/6)	50% (3/6)	50% (3/6)

EFFICIENCIES						
Total # of Charts Viewed	N/A	N/A	263,807	980,895	713,797	1,000,868
Total # of Continuity of Care Documents (CCDs) Viewed	N/A	63	23,711	65,043	686,045	317,619
Total # of Notifications ADTs sent to Providers from Notify	N/A	0	13,081	26,685	50,863	66,668
N/A Indicates no data since the program did not start until late SFY 2018						

Story Behind the Performance

- This program is funded by the COVID-19 Health Disparities Grant that ends on 05/31/2024.
- The State of Wyoming released a Request for Proposal for an HIE solution in October 2016 and was awarded a vendor in May 2017. The contract was signed on December 29, 2017, and approved by the Centers for Medicare and Medicaid Services (CMS) in January 2017, totaling $9,162,002 over three years. The HIE project is set to be completed in three phases:
  - Phase I focuses on the technical infrastructure build- COMPLETED ON 10/21/2019
  - Phase II focuses on onboarding hospital data contributors - ONGOING
  - Phase III focuses on connecting ambulatory and other providers and trading partners- ONGOING
- The WYFI upgrade will take place over the next year. The upgrade will include:
  - KPI Ninja Universe
  - Analytics and Population Health Solutions Dashboards
  - Amazon Web Services Cloud infrastructure
- Current State and Federal Connections:
  - WYhealth - Medicaid Health Management Case Notes
  - Wyoming Emergency Medical Services - Public Health
  - Public Health Nursing - Webchart Electronic Health Record
  - Wyoming Department Corrections - Correcktek Electronic Health Record
  - Colorado Regional Health Information Organization - Health Information Exchange
  - Utah Health Information Network - Health Information Exchange
  - South Dakota Health Link - Health Information Exchange
  - Social Security Administration
  - Aledade Inc.
  - Wyoming Medicaid Eligibility File - Department of Healthcare Financing
  - Change Health Care Pharmacy Claims - Department of Healthcare Financing
  - Vital Statistics Services

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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost[1]	$19,735,358	$17,028,801	$15,695,869
People Served	16,186	16,670	17,434
Cost per Person	$1,219	$1,022	$900

[1] Includes claims expenditures based on BH procedure codes by service date

Program Cost Notes

- 50% Federal / 50% State Funded
- Utilization Management Contractor (Telligen)

Program Staffing

- 0.6 FTE

Program Metrics

- All Medicaid enrollees are eligible for behavioral health coverage. Approximately 19% of enrollees received behavioral health services in SFY 2022, while approximately 18% received behavioral health services in SFY 2023.
- Behavioral Health services were approximately 2.8% of total expenditures in SFY 2022 and 2.7% of total expenditures in SFY 2023.

Events that Have Shaped the Program

- 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.

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

OUTCOMES									
Performance Metric			**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit **Ages 6-17**[1]	7 Days	National	▲	45%	42%	42%	46%	48%	(-)
		Wyoming		57% (259/ 455)	53% (215/ 407)	54% (204/ 379)	57% (204/ 361)	55% (215/ 390)	(-)
	30 Days	National		67%	66%	66%	66%	70%	(-)
		Wyoming		83% (377/ 455)	84% (340/ 407	82% (309/ 379)	85% (307/ 361)	80% (312/ 390)	(-)
Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit **Ages 18-64**[1]	7 Days	National	▲	38%	32%	33%	33%	39%	(-)
		Wyoming		44% (136/ 311)	41% (132/ 321)	40% (119/ 297)	40% (120/ 300)	33% (101/ 279)	(-)
	30 Days	National		59%	55%	55%	55%	52%	(-)
		Wyoming		69% (215/ 311)	64% (206/ 321)	61% (180/ 297)	63% (190/ 300)	52% (178/ 279)	(-)

(-) Indicates data not yet available
N/A indicates data not available due to creation of new metric or re-definition of metric methodology
[1]These metrics measure follow-up visits within 7 or 30 days of discharge of hospitalization for mental illness. These metrics are part of the CMS Core Measure set, and are reported for the previous calendar year (i.e. values under SFY2018 above are based on CY2017 data). National Benchmarks represent the median. Online: https://data.medicaid.gov/browse?category=Quality&limitTo=datasets&sortBy=newest

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
Rate of BH visits per recipient[1] (# of visits / # of people)	Children	18.8 (190,005/ 10,112)	17.5 (179,924/ 10,302)	16.9 (167,786/ 9,951)	14.7 (153,952/ 10,507)	12.3 (130,732/ 10,666)	11.5 (128,802/ 11,194)
	Adult	14.7 (85,663/ 5,814)	12.7 (68,977/ 5,424)	13.4 (65,759/ 4,918)	13.7 (69,757/ 5,079)	13.6 (72,854/ 5,340)	13.3 (74,836/ 5,608)
Outpatient BH service expenditures[1]	Total	$25,634,726	$22,804,541	$21,218,025	$19,735,358	$17,028,801	$15,695,869
	Children	$19,326,424	$18,316,732	$17,185,204	$15,367,841	$12,319,536	$10,791,356
	Adult	$6,308,303	$4,487,810	$4,032,821	$4,367,877	$4,709,265	$4,904,513
% of enrolled clients w/ mental health diagnosis[4]	Children	18.6% (7,788/ 41,872)	18.2% (7,593/ 41,624)	16.8% (7,314/ 43,524)	16.7% (7,722/ 46,293)	15.7% (8,200/ 51,971)	15.4% (8,781/ 57,032)
	Adult	19.4% (7,638/ 39,360)	20.4% (7,403/ 36,392)	21.2% (7,266/ 34,327)	22.9% (7,660/ 33,470)	22.6% (8,103/ 35,879)	21.4% (8,324/ 38,954)
% of clients w/ MH or SUD diagnosis who received BH outpatient treatment[1]	Children	86.7% (6,899/ 41,872)	87.0% (6,766/ 41,624)	86.9% (6,502/ 43,524)	84.9% (6,681/ 46,293)	83.6% (6,991/ 51,971)	82.7% (7,415/ 57,032)
	Adult	61.6% (5,368/ 39,360)	60.2% (5,077/ 36,392)	56.8% (4,677/ 34,327)	55.9% (4,828/ 33,470)	55.6% (5,056/ 35,879)	57.7% (5,327/ 38,954)
# of unique BH providers[2]	In-State	2,021	2,061	2,024	2,155	2,297	2,553
	Out-of-State	460	508	526	579	652	821
	Out-of-State Telehealth	2% (11/ 460)	6% (33/ 508)	42% (220/ 526)	38% (222/ 579)	31% (201/ 652)	24% (199/ 821)
EFFICIENCIES							
% of total BH expenditures paid to Community Mental Health Centers and/or Substance Abuse Treatment Centers[3]	CMHC	23%	21%	18%	15%	16%	16%
	SATC	12%	13%	15%	12%	13%	13%
PMPM for BH services[1]		$36	$34	$31	$24	$18	$15

% of prior authorization requests approved (# approved / # reviews)[5]	Adult	87% (3,267/ 3,752) CY2018	92% (5,456/ 5,928) CY2019	92% (4,735/ 5,173) CY2020	98% (2,440/ 2,497) CY2021	95% (4,500/ 4,727) CY2022	(-)
	Children	N/A	N/A	N/A	96% (4,429/ 4,618) CY2021	93% (4,149/ 4,439) CY2022	(-)

[1] BH procedure codes by service date
[2] Providers by BH taxonomies
[3] Providers by procedure code and taxonomy
[4] 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.
[5] The State started reviewing for medical necessity on 01/01/2021 for Medicaid children.

Story Behind the Performance

- 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.
  - 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.
- 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. This table is defined by ABA procedure codes only.

SFY	Expenditures	Clients	Providers
2018	N/A	N/A	N/A
2019	$239,369.06	46	4
2020	$888,167.57	75	7
2021	$1,661,510.68	71	6
2022	$1,445,297.12	53	7
2023	$474,900.21	47	6

- 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. Starting January 1, 2020, there was an increase to 30 dates of services due to the approval rates from the clinical reviews.
- Starting January 1, 2020, rehabilitative services for adults changed from 20 dates of service to 30 dates of service before requiring a prior authorization.
- Starting January 1, 2021, rehabilitative and habilitative services for children under 21 years with more than 30 dates of service require prior authorization to determine if additional services are medically necessary.
- During the PHE, Medicaid wasn't disenrolling members resulting in an increase in members receiving behavioral health benefits as compared to previous years.

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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$11,898,535	$11,879,599	$13,220,860
People Served	27,800	28,577	30,544
Cost per Person	$428.01	$415.71	$432.85

Program Cost Notes

- Dental is a 50/50 cost share between state general funds and federal match.

Program Staffing

- 0.2 FTE
- 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 the Program

- Many providers are no longer accepting new Medicaid clients due to the reimbursement rates, which have not increased in at least a decade.
- Legislation approved a 25% increase for all dental services effective 4/1/2023.
- Quarterly advisory group meetings act as a sounding board for both state workers and providers to discuss concerns, industry standards of care, and best practices.
- 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 situations.

OUTCOMES								
Performance Metric		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Actively Enrolled Providers		▲	485	464	442	478	485	522
Recipients per Enrolled Provider		▼	59.3	59.0	56.0	58.2	59.4	58.5
Unique Recipient Count for Teeth Cleaning	Children (0-20)	▲	44% 20,101	36% 19,352	38% 17,224	41% 19,284	39% 19,844	36% 21,246
	Adults (21+)	▲	8% 2,980	7% 2,733	8% 2,342	10% 2,607	9% 3,083	8% 3,040
Tooth Extraction Count	Children (0-20)	▼	3,672	3,275	2,998	3,625	3,506	3,760
	Adults (21+)	▼	2,120	2,008	1,859	2,080	2,019	2,053
Emergency Care Event Count	Children (0-20)	▼	47	67	41	50	82	86
	Adults (21+)	▼	278	257	242	247	272	288

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS						
# of unique children (0-20) served (any dental service)	23,303	22,370	20,293	22,448	23,308	25,032
# of unique adults (21+) served (any dental service)	5,380	5,033	4,461	5,007	5,751	5,660
Children Expenditures	$10,406,122	$9,888,879	$8,768,122	$10,297,440	$10,326,901	$11,633,596
Adult Expenditures	$1,421,135	$1,308,779	$1,192,650	$1,432,847	$1,552,698	$1,587,263
EFFICIENCIES						
Expenditures per Recip Children	$446	$447	$442	$432	$459	$465
Expenditures per Recip Adult	$460	$264	$260	$267	$266	$280
Per Member Per Month	$17.84	$15.77	$15.58	$14.19	$14.12	$13

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

	2021	2022	2023
Total Program Cost (Before Rebate, All Pharmacies)	$68,502,831	$83,199,373	$98,527,611
Total Program Cost (Before Rebate, Excludes IHS)	$53,204,073	$60,047,306	$68,527,901
Total Program Cost (Net of Rebate, Excludes IHS)	$19,680,155	$21,410,888	$25,470,990
People Served	35,393	43,228	47,515
Cost Per Person	$1,503	$1,389	$1,447

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 reimbursements that included State funds (excludes IHS claims paid by 100% federal funds).
- The third row of data reflects the program cost once the collected rebate is factored in. This number is derived by subtracting rebate dollars 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 58% of enrollees used the pharmacy benefit in SFY 2022, while approximately 50.2% used the pharmacy benefit in SFY 2023.
- Pharmacy expenditures were approximately 14.3% of total expenditures in SFY 2022 and 15.7% of total expenditures in SFY 2023.

Medicaid Pharmacy Program

Events that Have Shaped the Program

- As of SFY 2020, there are four in-state pharmacies that are classified as Indian Health Service (IHS) or tribal pharmacies submitting their Medicaid pharmacy claims to the Pharmacy Point of Sale system. These pharmacies are reimbursed per prescription at the All Inclusive Rate (AIR) published annually in the Federal Register. This rate was $640 in calendar year 2022 and is $654 in calendar year 2023. The State program is a pass-through for these claims as they are paid at 100% FFP.

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 habit by Medicaid Providers.[1]

OUTCOMES								
Performance Metric		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Short-Term Outcomes – Cost-Effective Coverage								
Rebate Savings	Mandatory	▶	$27,973,723	$26,868,678	$24,763,484	$30,230,501	$32,837,403	$37,901,449
	Supplemental		$2,440,555	$2,412,419	$2,415,980	$3,293,417	$5,799,015	$5,360,462
	Total Rebate Savings		$30,414,278	$29,281,097	$27,179,464	$33,523,918	$38,636,418	$43,261,911
Savings generated by Preferred Drug List and Prior Authorization[a,2]		▲	$10,756,339	$10,562,232	$10,444,793	$11,656,160	$13,506,785	$15,261,164
# of Claims Paid at State Maximum Allowable Cost/ % of total claims[b,2]		▶	N/A	N/A	N/A	N/A	333,322 / 68%	358,305 / 67%
Intermediate Outcomes – Clinically Sound Treatment								
# of Prior Authorizations approved / # reviewed (% approved)		▶	4,757/ 11,797 (40.3%)	4,830/ 12,056 (40.0%)	4,888/ 11,990 (40.8%)	5,873/ 13,339 (44%)	6,798/ 15,198 (44.7%)	9,704/ 20,242 (47.9%)
# of prescriptions that changed due to Drug Utilization Review (DUR) edits / # that hit DUR edits (% of prescriptions changed)		▶	9,751/ 45,743 (21.3%)	11,618/ 44,202 (26.3%)	10,610/ 44,345 (23.9%)	10,574/ 45,944 (23%)	14,299/ 57,437 (24.9%)	16,810/ 63,418 (26.5%)

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

[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.

[a-e] Indicates that further explanation can be found in the "Story Behind the Performance" on page 3.

Medicaid Pharmacy Program

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
# of Clients Served		43,455	40,717	36,807	35,393	43,228	47,515
# of Prescriptions Paid		515,395	489,626	446,816	452,974	531,080	581,229
Average # of prescriptions per client per month		2.95	2.98	3.02	2.95	2.86	2.81
#/$ of claims recovered by program integrity[d]		753[c]/ $280,937	374/ $79,311	600/ $54,951	625/ $236,322	322/ $48,504	223/ $43,202
EFFICIENCIES							
Average cost	Per client served before rebate[2]	1,144	$1,163	$1,256	$1,503	$1,389	$1,447
	Per client served net of rebate[2]	$444	$443	$518	$556	$495	$536
	Per prescription[2]	$100.93	$103.44	$110.38	$125.00	$122.42	$128.56
Rebate Collected for Physician-administered drugs		$5,747,677	$5,726,005	$5,362,381	$6,467,105	$5,170,809	$5,437,956
Program Integrity Cost Avoidance[e]		$1,092,461	$1,638,099	$2,118,998	$1,497,585	$1,451,583	$2,261,904

[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.
[a-e] Indicates that further explanation can be found in the "Story Behind the Performance" on page 3.

Story Behind the Performance

- 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.

- Pharmacy claim reimbursement methodology is based on "lesser of" logic which compares multiple price points and reimburses the pharmacy provider at the lowest price point available. Of the price points used, State Maximum Allowable Cost (SMAC) is the only price point that the State Medicaid Agency sets and can modify. Pharmacy providers do have the ability to dispute claims paid at the SMAC rate if this rate causes the pharmacy to be reimbursed at less than cost. A high percentage of claims-paying at the SMAC rate demonstrates that the Agency is using this tool effectively for fiscal management while the dispute process ensures that pharmacies are not underpaid for their services.

- Claims from the Wind River Family and Community Pharmacy and the Wind River Service Unit account for 457 of these claims.

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

- In SFY17, these figures include cost avoidance achieved by corrections that avoid filling prescriptions too soon or too often as well as 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 Facilities

SFY 2023 Program Snapshot

Program Description

Wyoming Medicaid covers inpatient psychiatric 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

	2021	2022	2023
Total Program Cost[1]	$7,325,970	$6,072,857	$6,377,861
People Served*	186	155	161
Cost per Person	$39,313	$39,180	$39,614

[1] Medicaid and State General Fund costs/members combined

Program Cost Notes

- 50% SGF / 50% FF Medicaid costs:
  - SFY 23 - $6,377,861
  - SFY 22 - $6,072,857
  - SFY 21 - $7,312,281
- 100% SGF costs for non-medically necessary claims:
  - SFY 23 - $3,807
  - SFY 22 - $0.00
  - SFY 21 - $13,689

Program Staffing

- 0.35 FTE
- Other - Contractor, Telligen

Program Metrics

- Number of unique clients served in SFY 2023: 156 (Medicaid funds); 1 (State General funds)
- Number of PRTFs currently enrolled:
  - in-state: 2
  - out-of-state: 8
- Average length of stay in SFY 2023: 155 days

Events that Have Shaped the Program

- Enrolled Act No. 57, House of Representatives became effective July 1, 2013. This specifies that any order regarding potential placement at a PRTF shall not specify a particular PRTF or level of care for the placement of the child.
- Payment is no longer made using 100% SGF for any clients with an incorrectly worded court order after July 1, 2013.
- SGF are only used after a clinical review and determination that the PRTF placement no longer meets medical necessity, a transition period of up to thirty (30) days may be authorized permitting time for the necessary court hearings, multidisciplinary team meetings and court orders to be updated. Upon expiration of an approved transition, no further reimbursement shall be authorization.

Medicaid Psychiatric Residential Treatment Facilities

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 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
% of PRTF admits with a previous PRTF admit[1]	Past 12 months	▼	15% (33/224)	18% (41/227)	26% (46/178)	25% (40/155)	25% (28/113)	18% (21/118)
	Past 5 years	▼	31% (70/224)	30% (68/227)	39% (70/178)	46% (72/155)	51% (58/113)	29% (34/118)
Average length of stay (days)[2]		►	200	147	133	134	148	155
% of discharged recipients with 6+month length of stay (LOS)/# of recipients		▼	57% 114	26% 38	21% 28	29% 39	20% 31	35% 36

[1]All data is based on Medicaid Chart A client information; Medicaid only
[2]Based on individuals discharged during the SFY

OUTPUTS AND EFFICIENCIES

Performance Metric		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
OUTPUTS							
# of new PRTF admits reviews vs. # of PRTF continued stay reviews completed		213 1,316	225 1,072	152 906	178 840	138 751	219 640
# of recipients	Medicaid	288	289	259	184	155	161
	SGF[3]	1	11	19	2	0	1
	Discharged w/6+ month LOS	98	51	27	35	31	36
# of placements [1]	In-State	190	186	184	152	131	103
	Out-of-State	114	39	46	34	20	15
# of Medicaid covered/paid days		39,259	31,288	23,406	23,939	18,961	17,885
# of reported incidents		149	192	105	106	148	64
EFFICIENCIES							
% of PRTF placements	In-State	63%	75%	85%	84%	90%	87%
	Out-of-State	37%	25%	15%	16%	10%	13%
Average cost per client [2]		$43,394	$35,205	$28,716	$39,313	$39,180	$39,614

[1] Will not equal total served as the same client can be placed in both in-state and out-of-state in the same SFY or were admitted the prior year.
[2] Costs only include PRTF expenditures, excludes non-PRTF Medicaid costs.
[3] After a determination that the PRTF placement no longer meets the medical necessity criteria, a transition period of up to thirty (30) days may be authorized and paid for with the State General Funds.

Story Behind the Performance

- A PRTF is a non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient psychiatric services benefit to Medicaid-eligible individuals under the age of 21. The facility must be accredited by the Joint Commission or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements in §441.151 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)
    - Average OSCR Score: Year 5 (SFY 2020) = 2.88 - Admin, 2.74 - Records (5 visits)
    - Average OSCR Score: Year 6 (SFY 2021) = 2.95 - Admin (3 reviews), 2.76 - Records (5 reviews, 2 were re-audits of records only)
    - Average OSCR Score: Year 7 (SFY 2022) = 2.93 - Admin (2 reviews), 2.78 - Records
    - Average OSCR Score: Year 8 (SFY 2023) = No reviews completed

WDH Customer Service Center

Program Description

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

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost[1]	$4,194,481	$4,182,250	$6,427,113
People Served	69,194	75,331	77,473
Cost per Person	$60.62	$55.52	$82.96

[1] Total Contract Cost

Program Cost Notes

- 75% Federal match on the cost of staffing the Customer Service Center (CSC) and State staff.
- The CSC Operations Costs was $288,457 per month from October 2020 - September 2021, $306,993 from October 2021 - April 2022, and $527,053 from May 2022 - June 2022. The CSC Operations Cost was $535,592.76 per month from July 2022 - June 2023.

Program Staffing

- 1 FTE - two ½ time state staff
- Contractor (AHS)
  - 74 FTE

Program Metrics

- SFY 2023 average total call volume: 8,468 calls per month. The highest average call volume was 10,265 in May 2023.
- SFY 2023 average speed to answer: 1:92 minutes. The slowest monthly average speed to answer was 3:61 minutes in January 2023. The fastest monthly average speed to answer was 0:36 minutes in September 2022.
- SFY 2023 average application processing time: 14.25 days. The slowest monthly average processing time was 23.68 days in December 2022. The fastest monthly average processing time was 10.35 days in July 2022.

Events that Have Shaped the Program

- Northrop Grumman was the original vendor for the CSC which opened in 2013. Northrop Grumman was replaced by Maximus in 2016. Automated Health Systems (AHS) took over CSC operations in 2020.
- AHS initially proposed a staffing model of 28 FTEs that incorporated key and operational personnel.
- After a Contract Amendment was executed on May 7, 2022, AHS increased the key and operational personnel staff to 74 FTEs per month.
- Under the contract, AHS agreed to assume an additional call volume in October 2021 that was previously handled by the fiscal agent when the new fiscal system, Benefits Management System (BMS), went live. The CSC Interactive Voice Response (IVR) provides extra navigation functionality for customer service assistance. The number of calls after unification is a total of 52,701 from October 2021 through June 2023, or an average of 518.46 self-service calls being routed through the IVR each week.
- AHS is contractually obligated to meet designated Service Level Agreement (SLA) metrics. WDH reviews compliance with the SLAs on a monthly basis. If SLAs are not met, penalties are assessed, notification is provided, and an invoice for liquidated damages is sent to AHS.

Program Core Purpose

The Wyoming Department of Health's Customer Service Center processes Medicaid and KidCare CHIP applicationrenewalsandchanges,timelyandaccurately,whileprovidingexcellentcustomerservice.

OUTCOMES							
Performance Metric	**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Average Speed to Answer (minutes)	▼	4.75	11.18	7.33[1]	32.49	22.55	1.92
Client Satisfaction Survey Results (1 to 5, with 5 Being Most Satisfactory).	►	4.62	4.16	3.99	4.05	4.10	4.39
Average Processing Time for Application (days)[2]	►	15.11	7.58	6.07	7.30	11.57	14.25
Quality Eligibility Error Rate > 3.00	▼	12.82	5.46	7.08	30.21	39.67	37.76
First Call Resolution < 60 Seconds	►	96.46	92.58	96.36	98.18	98.42	100

OUTPUTS AND EFFICIENCIES						
Performance Metric	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS						
New Applications	18,858	15,245	17,520	25,044	15,926	17,205
Renewals (ongoing cases)[3]	38,875	40,947	32,922	32,389	9,601	9,025
Total (Applications & Renewals)	54,733	56,192	50,442	57,433	25,527	26,230
Total Call Volume[4]	145,939	142,612	140,465	133,415	119,204	101,620
EFFICIENCIES						
Average Handle Time (minutes)	13.86	17.92	22.20	24.52	20.28	14.37
Number of Abandoned Calls	12,740	27,467	29,615	21,026	16,533	687
Abandonment Rate	8.74%	19.26%	11.83%	15.76%	11.36%	0.47%

[1] Transition period score included three months of Maximus and the initial months of the Automated Health Systems contract.
[2] The Federal application processing deadline is 45 days.
[3] Renewals resumed for Wyoming Medicaid on 4/1/2023.
[4] Total Call Volume includes taking new applications, renewals, checking status of application/renewal, adding a newborn to the case,

verifying eligibility and ordering new Medicaid cards, updating client address, phone or members in the family, and checking on the status of a case or application.

Story Behind the Performance

- The Wyoming Department of Health Customer Service Center (CSC) opened on October 1, 2013. There have been three (3) contracted CSC vendors since 2013. Automated Health Systems (AHS) was awarded the contract in 2020 and is the current vendor.
- Normal business hours of the CSC are 7:00 AM to 6:00 PM (MTN) 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 KidCare CHIP), adults with Medicaid eligible children, and pregnant women.
- As of February 2014, all of the Medicaid and KidCare CHIP eligibility determinations are processed through the CSC and the Medicaid Long Term Care Unit (LTC). These functions transitioned from 29 DFS field offices to centralized Medicaid eligibility processing to promote consistent policy decisions.
- Eligibility rules for Medicaid and KidCare CHIP (KCC) programs are built into the rules engine of the Wyoming Eligibility System (WES) which is utilized by the CSC.
- The WES/CSC Contract Managers closely monitor both vendors to verify that deliverables are of high quality and all SLAs are met or exceeded; if the SLAs are not met then penalties are assessed.
- The State staff participates in quality assurance reviews, provides specialized Medicaid training for CSC staff, and works proactively to address issues.
- WDH Quality Assurance (QA) staff and contract staff work with AHS QA staff to review eligibility errors, provide instruction, and assist with training and coaching.
- The CSC vendor and the Wyoming Eligibility System (WES) vendor work in collaboration by attending joint Change Control Board (CCB) meetings, creating and sharing training documents, and participating in system Design and Requirement sessions, and User Acceptance Testing (UAT) when system changes or updates affect case processing.
- In October 2021, the CSC added additional call center duties which are related to the new Benefits Management System (BMS). The unification of the client call centers has improved customer self-service options through Interactive Voice Response (IVR) system selections and streamlined customer service interactions.
- WDH encourages clients to use the Client Web Portal (https://www.wesystem.wyo.gov) to manage their cases. Clients can use self-service tools to make case changes (e.g. name, address, income, etc.), renew applications, or to complete a new application.
- The CMS expiration of the continuous enrollment condition and unwinding with a return to regular eligibility operations after COVID-19 on March 31, 2023 meant the return to the restarting of full Medicaid and KidCare CHIP eligibility renewals. Wyoming elected to stagger renewals over a full 12 months as allowed by CMS.

Medicaid Long Term Care Eligibility Unit

SFY 2023 Program Snapshot

Program Description

The Medicaid Long Term Care Eligibility Unit determines financial eligibility for the Community Choices Waiver, Comprehensive Waiver, Support Waiver, Children's Mental Health Waiver, 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

	2021	2022	2023
Total Program Cost	$1,714,219	$1,889,188	$2,091,987
People Served	7,192	7,279	7,134
Cost per Person[1]	$19.86	$21.63	$24.44

[1] Cost per person is derived by dividing the Total Program Cost by the People Served (number of cases for SFY 2022) and then dividing that number by 12 so that a cost per person per month is determined.

Program Cost Notes

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

Program Staffing

- 17 FTE (SFY 2021)
- 17 FTE (SFY 2022)
- 17 FTE (SFY 2023)

Program Metrics

- SFY 2023 caseload percent:
  - Waiver programs - 79.5%.
  - Nursing Homes - 20.12%.
    - Hospice - 0.18%.
  - Inpatient Hospital - 0.2%.

Events that Have Shaped the 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. Centralizing the unit has reduced case processing time and provided consistency statewide.
- The unit is co-located with other WDH entities allowing for face-to-face coordination on cases.
- In March 2020, the Federal Public Health Emergency (FPHE) changed the policy for closing individuals who are not completing renewals or who no longer qualify at renewal. Our Federal partners mandated that we continue eligibility in order to receive a 6.2% Federal Matching increase.
- The Consolidated Appropriations Act of 2023, uncoupled continuous enrollment in Medicaid and CHIP from the Federal Public Health Emergency.
- The Federal Public Health Emergency officially ended on May 11, 2023.
- The LTC Unit began closing cases effective May 1st, for reasons such as no longer financially eligible and no longer receiving waiver or nursing home services.

Medicaid Long Term Care Eligibility Unit

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 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Community-based Program (CCW & PACE)	% of LTC Member Months	▲	58%	60%	63%	64%[3]	63%	64%
	% of LTC Expenditures	▲	24%	26%	26%	28%	28%	30%
Total Cost for Extraordinary Care Clients (% of total NH tax & gap costs)[1]		▼	$840,239 (0.6%)	$1,792,789 (2.0%)	$1,688,807 (1.1%)	$1,757,632 (1.3%)	$1,531,597 (1.2%)	$2,580,295 (3.3%)
Average LT101 Score[2]	CCW	N/A	23	22.4	20.0	22.9	23.0	22.9
	Nursing Home	N/A	32.4	31.6	31.2	31.6	31.4	31.6
Rate of ER Visits (per 1,000 member months)[3]	CCW	▼	130.2	127.8	119.4	109.3	107.9	113.4
	Nursing Home	▼	42.8	42.4	40.6	37.5	40.6	58.4
Rate of inpatient admits (per 1,000 member months)	CCW	▼	52.5	48.6	45.9	45.4	29.1	33.9
	Nursing Home	▼	23.0	30.2	26.9	24.6	17.5	27.4

LTC (Long Term) CCW (Community Choice Waiver) NH (Nursing Home) ER (Emergency Room)
[1] These are NH clients only - this number could have increased due to the use of the revenue code 0101 for COVID rate extraordinary care.
[2] A higher LT-101 score indicates a need for a greater level of care.
[3] PACE was included in years from SFY2017 to SFY2021; not included after that date.
N/A indicates data not available due to the creation of a new metric or re-definition of metric methodology

Medicaid Long Term Care Eligibility Unit

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
# of Unique Served	CCW	2,622	2,763	2,870	2,938	2,945	2,918
	Nursing Home	2,413	2,419	2,246	2,175	1,969	1,859
Member Months	CCW	24,911	26,872	27,588	28,966	28,573	29,166
	Nursing Home	20,860	20,521	18,860	17,561	16,827	16,206
Expenditures as % of Total Medicaid	CCW	8.1%	8.6%	8.8%	10.1%	8.1%	8.9%
	Nursing Home (w/o tax & gap)	15.9%	17.1%	14.1%	15.0%	15.9%	13%
	Nursing Home (w/tax & gap)	24.4%	25.3%	22.2%	24.5%	24.4%	20.0%
EFFICIENCIES							
Per Member Per Month (PMPM) total costs	CCW	$1,623	$1,660	$1,722	$1,691	$1,610	$1,883
	Nursing Home (w/o tax & gap)	$4,228	$4,249	$4,994	$4,472	$4,097	$4,957
	Nursing Home (w/tax & gap)	$6,790	$6,971	$7,858	$7,521	$8,148	$8,034
PMPM Index to NH (w/tax & gap)	CCW (waiver & medical)	24%	24%	22%	22%	20%	23%

Story Behind the Performance

- **Community Choices Waiver (CCW)**
  - In July 2021, 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 transitioned to the CCW program.
  - The PACE program was eliminated effective April 1, 2021. As of June 2022, 53% of PACE participants were being served on the CCW program while 9% were served in a nursing home. The remainder of PACE participants no longer receive any long term care services or are deceased.
- **Nursing Home (NH)**
  - The Nursing Home Reform Act (1987) 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 intellectual disability. 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 SFY21, the acuity score was 0.95.
  - Effective January 2020, a budget reduction of 2.5% was implemented which included nursing facilities. In July of 2020, Wyoming Medicaid was able to increase nursing facility rates by 5% until December 2021. This increase came from the extra FMAP received from the American Rescue Plan Act. This 5% increase was applied after the 2.5% reduction in budget. The 5% increase was discontinued in January 2022 but was restarted in February 2022. The 5% increase continued through June of 2023.
  - Extraordinary Care (ECC) 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. In March 2020, Wyoming Medicaid began to pay an Extraordinary Care rate for individuals in the Nursing Facilities that contracted COVID. This ECC rate is for a period of 14 days which is the quarantine period. The ECC rate for COVID was discontinued at the end of the public health emergency.
  - 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.

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 payment.

Program Expenditures and Total TPL Dollars Recovered

	2021	2022	2023
Total Program Cost[1]	$1,164,121	$1,080,160	$876,739[1]
Total TPL Dollars Recovered[2]	$5,384,999	$9,120,152[3]	$5,598,533[4]

[1] Beginning in May 2021, the Attorney General's Office experienced turnover/attrition in staff, including their paralegal and their attorneys. The paralegal changed twice and the attorneys changed twice. Since February 2023, the paralegal position has been fully staffed. Since July and August 2023, the attorney positions became fully staffed. In order to bridge the gap with the loss of institutional knowledge, the Division of Healthcare Financing's Legal Analyst and TPL & Estate Recovery Specialist have been meeting with the Attorney General's Office to discuss and attempt to resolve opened and referred TPL and estate cases. The Attorney General's Office has been reviewing all opened cases to determine next steps as well as creating a desk manual.

[2] Includes estate recovery and TPL recovery.

[3] The dollars recovered may have been impacted by COVID-19, the transition to a new vendor with a subcontractor, and a couple of large recoveries from special needs trusts.

[4] The dollars recovered may have been impacted by COVID-19, the continued transition to a new vendor with a subcontractor, and turnover/attrition at the Attorney General's Office, the vendor, and their subcontractor.

Program Cost Notes

- The Attorney General's Office performs legal services for TPL and estate recovery.
- Beginning October 25, 2021, performance of TPL services transitioned from Medicaid's MMIS Fiscal Agent, Conduent, to the Fiscal Agent of CNSI/Acentra Health who subcontracts with HMS/Gainwell Technologies. In this joint venture and collaboration, both entities conduct cost avoidance, pay and chase recoveries, disallowance for Commercial Insurance, Medicare, and Workers' Compensation, pursue small personal injury recoveries, including medical payments coverage, tort recovery from criminal restitution and products liability, and conduct preliminary research for 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 the TPL recoveries be returned at the FMAP rate used when the claim was originally paid.

Program Staffing

- 1 FTE
- 2 Part-time attorney and 1 part-time paralegal at the Attorney General's Office
- Contractual (Conduent) Staff 10 FTE for TPL
- HMS/Gainwell Technologies Staff

Program Metrics

- Dollar amount of cost avoidance, pay and chase recoveries/disallowance collections, estate recoveries, and TPL recoveries.

Medicaid Third Party Liability (TPL)

Events that Have Shaped the Program

- The Social Security Act and the United States Code mandate third party liability and estate recoveries.
- The Wyoming Statutes §§ 42-4-201 - 42-4-207 - Medicaid Benefit Recovery.
- The Wyoming Medicaid Rules, Chapter 35 - Medicaid Benefit Recovery.
    - Bipartisan Budget Act of 2018 - Prenatal services must be cost avoided beginning 02/09/2018.

Medicaid Third Party Liability (TPL)

Program Core Purpose

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

OUTCOMES

Performance Metric		Desired Trend	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022[5]	SFY 2023[5]
Total TPL	Excluding Cost Avoidance[1]	▲	$5,128,958	$6,038,575	$6,318,210	$5,384,999	$9,120,152	$5,598,533
	Including Cost Avoidance[2]	▲	$16,541,242	$16,024,407	$16,477,194	$15,973,661	$36,648,389	$33,330,011
% of Medicaid Claim Expenditures Offset by Total TPL	Excluding Cost Avoidance[3]	▲	0.90%	1.09%	1.17%	0.80%	1.57%	0.89%
	Including Cost Avoidance[3]	▲	2.91%	2.89%	3.04%	2.36%	6.31%	5.29%
Estimated Return on Investment	Excluding Cost Avoidance[4]	▲	$6 to $1	$7 to $1	$6 to $1	$5 to $1	$9 to $1	$6 to $1
	Including Cost Avoidance[4]	▲	$18 to $1	$17 to $1	$17 to $1	$14 to $1	$35 to $1	$38 to $1

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 also may be inflated. For example, if a provider submits the same claim multiple times and it denies each time for TPL.

[1] These figures include estate recovery and third party liability recoveries by deposit date.

[2] These figures include estate recovery, third party liability recoveries, and cost avoidance by deposit date for recoveries and by paid date for cost avoidance.

[3] SFY2023 figures are through 06/30/2023 for recoveries (deposit date) and for cost avoidance (paid date).

[4] For SFY 2018, 2019, 2020, 2021, 2022, and 2023 per BPO for Medicaid claims expenditures.

[5] The dollars collected and cost avoided may have been impacted by COVID-19, transition to a new vendor with a subcontractor, and a limited staff at the Attorney General's Office.

OUTPUTS AND EFFICIENCIES

Performance Metric		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023**
OUTPUTS							
Total	Estate Recovery	$3,603,406	$3,853,730	$5,295,675	$4,434,249	$8,226,838	$5,076,811
	Third Party Liability – Pay and chase and disallowance	$1,525,552	$2,184,827	$1,022,535	$950,749	$893,314	$521,722
	Cost Avoidance[1]	$11,412,314	$9,985,850	$10,158,983	$10,588,662	$27,528,237	$27,731,478

Medicaid Third Party Liability (TPL)

# of Estate Recovery Cases	Opened[3]	1391	1428	1302	1526	2138	2248
	Closed[4]	1189	1359	1442	1513	497	3947
Average # of Days From Case Opened Date to Case Closed Date – Estate[5]		216	212	347	538	Not[6] Available	2488
# of TPL Cases	Opened[3]	599	527	449	342	90	252
	Closed[4]	483	419	652	499	58	186
Average # of Days from Case Opened Date to Case Closed Date – TPL *****		584	503	943	874	Not[6] Available	1201
EFFICIENCIES							
% of recovered estate recovery cases to open cases		12.01%	14.22%	20.35%	16.78%	Not[6] Available	12.60%
% of recovered TPL cases to opened case – Pay and chase		52.25%	56.16%	65.26%	72.22%	Not[6] Available	61.51%
% of Medicaid clients with other health insurance coverage identified (related to TPL recoveries and cost avoidance potential), excludes Medicare		5.38%	4.61%	3.85%	4.05%	4.04%	5.92%

[1] 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 through 10/06/2021. Beginning 10/25/2021, for denied claims cost avoidance is calculated based on the billed charges from the provider; however, paid claims are based on the Medicaid allowed amount for the services. These numbers do not include pharmacy cost avoidance.
[2] Recoveries are through 06/30/2023 by deposit date. The numbers do not include pharmacy pay and chase recoveries.
[3] 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 special needs trust, a pooled trust, or an income trust.
[4] Closed cases are cases that may be opened and closed within a year, closed during a year, but have been open for several years. Examples of closure reasons are: maximum recovered from estate, no liable third party, no payment or resource identified, no related claims in 1 year, not cost effective to pursue, received payment in full, and receive all available payment.
[5] The average is for the number of days a case is opened to the number of cases closed during SFY 2023. This is for cases closed during the SFY.
[6] Data not available due to transition from incumbent vendor, Conduent, to a new vendor, CNSI and CNSI's Third Party Liability subcontractor, HMS.

Story Behind the Performance

- **Estate recovery** – Wyoming Medicaid has an aggressive estate recovery program. Wyoming has elected to use the expanded definition of estate that extends beyond probate actions. Wyoming is a lien state and has the ability to impose a lien on real property. Wyoming is able to recover from any real or personal property that the client had legal title or interest in at the time of death or when s/he took their last breath to the extent of that interest, including such assets conveyed to a survivor heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship life estate, living trust or other arrangement.
- **Third party payer** is a person, entity, insurer, or government program that may be liable to pay, or that pays pursuant to the client's right of recovery arising from an illness, injury, or disability for which funds were paid or are obligated to be paid on behalf of the client. Third party payers may be Medicare, health insurance companies, worker's compensation, casualty insurance companies, a spouse or parent court ordered to carry health insurance, or a client's estate.

- **Cost avoidance** recognizes the existence of other insurers' responsibility and requires the insurer to pay prior to Medicaid payment.
- **Pay and chase/direct bill** involves TPL staff and systems 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.
- **Commercial and Medicare Disallowance** involves TPL Staff attempting to collect Medicaid funds by recouping/voiding Medicaid claims from Medicaid providers when Medicare or commercial insurance should have been the primary payer.
- TPL began imposing liens on properties when a Wyoming Medicaid client passes away and is survived by a spouse. Wyoming Medicaid will not require repayment of the lien or enforce the lien until the surviving spouse passes away. By imposing the lien, Wyoming Medicaid has received voluntary payments from surviving spouses and has helped to prevent improper transfers of property.

Upcoming Events That Will Impact Performance

The Wyoming Department of Health, the Division of Healthcare Financing, contracted with a new Fiscal Agent/contractor (Client Network Service Incorporated/CNSI/Acentra Health) for Wyoming Medicaid claims processing who subcontracted with Health Management Services, Inc./HMS/Gainwell Technologies. HMS/Gainwell Technologies is a specialty contractor focusing their efforts on third party liability. DHCF has been working with HMS since March 2020 for DDI and transitioned to CNSI/ Acentra Health and HMS/Gainwell Technologies on 10/25/2021. HMS has developed a national enrollment database with health insurance carriers, and third party administrators, pharmacy benefits managers to assist with locating and identifying Wyoming Medicaid clients with other health insurance. HMS has engaged with Wyoming specific health insurance carriers to receive their eligibility/member enrollment files. By having access to additional and national member eligibility or enrollment files from health insurance carriers, the DHCF anticipates enhanced cost savings and recoveries of payments previously made by Wyoming Medicaid that should have been considered by a primary payer in the next several state fiscal years.

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								
Performance Metric		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Physicians	% of In-State Licensed, Eligible, and Enrolled	▶	99%+ (est.)	99%+ (est.)	99%+ (est.)	99%+ (est.)	99%+ (est.)	99%+ (est.)
	# In-State Enrolled	N/A	2,167	2,220	2,243	2,347	2,582	2,921
	# Out-of-State Enrolled	N/A	7,914	8,350	8,474	9,387	10,933	12,742
Nursing Facilities	% of In-State Licensed, Eligible, and Enrolled	▶	100%	100%	100%	100%	100%	100%
	# In-State Enrolled	N/A	37	39	39	38	36	37
	# Out-of-State Enrolled	N/A	19	17	15	15	16	17
Hospitals	% of In-State Licensed, Eligible, and Enrolled[1]	▶	97%	94%	97%	97%	94%	91%
	# In-State Enrolled	N/A	30	30	29	29	29	29
	# Out-of-State Enrolled	N/A	213	192	185	197	237	277
Pharmacies	% of In-State Licensed, Eligible, and Enrolled	▶	93%	93%	91%	90%	77%	76%
	# In-State Enrolled	N/A	128	130	132	131	116	114
	# Out-of-State Enrolled	N/A	94	84	89	95	92	90
Dentists	% of In-State Licensed, Eligible, and Enrolled	▲	94%	96%	96%	97%	60%	63%
	# In-State Enrolled	N/A	343	345	349	359	370	387
	# Out-of-State Enrolled	N/A	137	118	116	119	139	165

Includes providers enrolled for at least one day in the SFY
(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
[1] Excludes private hospitals such as VA Medical Centers, WBI, SageWest HealthCare

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Physician rates as a % of the regional average		116%	110%	117%	123%	100%	98%
Nursing facilities % cost coverage with the upper payment limit (UPL)[1]		90%	86%	84%	80%	84%	83%
Hospital % cost coverage with the qualified rate adjustment (QRA)[2]	Inpatient	100%	100%	100%	100%	101%	103%
	Outpatient	99%	99%	99%	100%	99%	106%
Dental rates as a % of the estimated provider cost^ or private pay rates^^		79%^	82%^	79%^	NA	NA	46%^^
% of Nursing Facility days paid by Medicaid		64%	64%	65%	64%	66%	65%
EFFICIENCIES							
ALL Claims Processing Time (days)	Service to Bill	35.7	45.4	33.6	26.6	60.4	61.5
	Turnaround Time, Receipt to Payment	6.9	6.7	6.9	7.1	13	7.7
	Service to Payment	39.6	49.2	37.6	30.8	73.4	69.2
% of all claims denied		12.70%	16.49%	16.16%	14.69%	29.46%	19.78%

(-) Indicates data not yet available. Wyoming Medicaid Benchmarking Report is currently in draft form for SFY 2022.
N/A indicates data not available on a quarterly basis.
[1] UPL implemented mid-year 2011; data is collected by FFY. Percentages are with share of Supplemental Payment only.
[2] In-state hospitals only

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.
- Starting January 1, 2021 Wyoming Medicaid was required to reduce its General Fund by $46,550,796 for the 21/22 biennium causing a 2.5% reduction in provider rates, services covered and added thresholds on some Behavioral Health services.

Program Integrity

Program Description

Program Integrity is dedicated to identifying, and coordinating the mitigation of provider and member: fraud, waste, and abuse in the Medicaid program. The duties of Program Integrity include detection; prevention; investigation; education; auditing; recovery of improper payments, and coordination with law enforcement partners (e.g. FBI, AUSAs, MFCU, OIG).

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost[1]	$761,840	$819,923	$1,062,142[2]
Medicaid Providers	21,162	24,324	28,170
Medicaid Members	78,300	86,034	94,635

[1] 100 series only Salary/Benefits

[2] Additional Resources added and FTEs

Program Cost Notes

- Includes Program Integrity Administration Cost
- 50% SGF / 50 % FFP

Program Staffing

- 11 FTE

Program Metrics

- Program Integrity is responsible for reviewing Medicaid claims data and associated member and provider records to identify potential: fraudulent, wasteful, and abusive spending practices.
- Program Integrity may impose adverse actions (Chapter 16) against providers and members, navigate administrative hearings, and draft recommendations on needed policy changes to mitigate potential program vulnerabilities.
- Cases are referred to the Medicaid Fraud Control Unit, Office of Inspector General, County Attorneys, and other law enforcement partners if criminal activity is suspected.
- Program Integrity coordinates auditing and investigation efforts with the CMS assigned Unified Program Integrity Contractor (UPIC).

Events that Have Shaped the Program

- Fraud, Waste, and Abuse Contract re-procurement (11/2023), design and development (02/2024-01/2025), production deployment (02/2025)
- Transition of investigation activities of Medicaid client FWA from DFS - EIU to PI Section (10/2022).
- Transition of the Eligibility Review Unit (3 FTE) and associated duties: Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) into the Program Integrity Section (04/2022)
- Medicaid Rule Chapter 16 - Program Integrity, updated and promulgated (04/2020); and Medicaid Rule Chapter 4 - Administrative Hearings, updated and promulgated (03/2020)
- Fraud, Waste, and Abuse Contract procurement (05/2018), design and development (06/2018-04/2019), production deployment (05/2019), and system acceptance (02/2020) of the program integrity dedicated Fraud, Waste, and Abuse solution
- Reorganization and redesign of the Program Integrity Unit's essential functions (10/2018)
- The Social Security Act provides overall guidance of program integrity and 42 C.F.R. 455 provides general guidance on Program Integrity actions.
- The Deficit Reduction Act of 2005 established the Medicaid Integrity Program.

Program Core Purpose

To safeguard the integrity of the Medicaid program by detecting and preventing fraud, waste, and abuse through coordination with State and Federal partners, and the performance of audits, reviews, and investigations of Medicaid members and service providers.

OUTCOMES

Performance Metric		Desired Trend	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
# Cases Initiated		►	267	279	320	169	186	298
Case Source Distribution[1]	Proactive	▲	80	67	NA	9	8	29
	Reactive	►	187	212	NA	160	178	269
# Preliminary Case Studies		▲	NA	28	21	35	15	129
% Cases w/ Preliminary Case Studies		▲	NA	10%	6.5%	20%	8%	43%
% Cases Reaching a Disposition[2]		▲	100%	100%	100%	99%	99%	70%

[1] A "proactive" case source prompts case initiation from the use of data mining or analytics by PI staff. A "reactive" case source prompts case initiation from referrals for allegations of FWA to the PI section.
[2] "Cases Reaching a Disposition" is defined as an outcome where a decision point is reached for an initiated case (see also "Case Dispositions" within Outputs table). This metric is not static and will change over time as cases move through PI processes.

OUTPUTS AND EFFICIENCIES

Performance Metric		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
OUTPUTS							
Cases by Case Type	# Provider	261	270	313	163	150	230
	# Member	NA	NA	NA	NA	34	65
	# Global Settlements	6	9	7	6	2	3
Case Dispositions	# w/ Adverse Action	140	25	178	49	23	53
	# w/ Program Recommendation	NA	3	20	3	5	16
	# w/ No Actionable Findings	93	155	80	49	61	87
	# Pending a Disposition	0	0	0	2	3	91
Case Referrals	# to Unified Program Integrity Contractor	4	1	1	11	2	1
	# to County Attorneys	NA	NA	NA	NA	NA	0
	# to Law Enforcement[4]	9	6	2	3	4	0

EFFICIENCIES							
Performance Metric		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Expenditures vs Expenditures Identified As At Risk	$ Total Medicaid Expenditure	$574,806,172	$560,115,024	$551,125,682	$579,016,451	$595,328,559	$664,483,559
	$ Identified As At Risk[2]	$3,191,840	$1,758,571	$6,618,360	$1,085,228	$1,071,296	$835,356
Return On Investment (x 100)[3]		4.29	2.51	10.78	1.42	1.30	0.78
$ Payments Processed		$647,126	$551,660	$363,582	$725,522	$1,685,587	$457,665

[1] This value represents the total dollars in scope for cases where an adverse action was imposed. Not all dollars in scope for a case will be "Identified As At Risk".
[2] "Identified As At Risk" represents all Medicaid funding that has been identified through Program Integrity activities as recoverable through administrative actions, funding that was ordered payable to Wyoming Medicaid as part of a Civil False Claims Settlement Agreement, or criminal prosecution resulting in court ordered restitution, fine, or penalty.
[3] Return On Investment = ("$ Identified As At Risk" / "SFY 100 Series Expenditures"). NOTE: Return On Investment and $ Identified As At Risk are not static values, they can change over time as cases progress through PI processes.
[4] Law Enforcement referrals comprises various law enforcement partners: Medicaid Fraud Control Unit (MfCU), Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), and Assistant United States Attorneys (AUSAs).

Story Behind the Performance

- SFY 2023 - The above metrics are a snapshot into Program Integrity"s role as an investigative entity within the Medicaid program, but PI's initiatives and FWA mitigation activities extend beyond investigations. In addition to reviews, audits, and investigations of Medicaid providers/members, the PI Section is also responsible for managing: Payment Error Rate Measurement (PERM), Medicaid Eligibility Quality Control (MEQC), Quality Assurance reviews of Medicaid member eligibility determinations, coordination and execution of the Deficit Reduction Act (2005) Attestation process, and Medicaid's component of the Statewide Single Audit. In November 2022, the PI Section formally kicked-off activities towards re-procurement of its Fraud, Waste, and Abuse platform (FWA2). The current (FWA1) contract was executed in May 2018 and is set to expire in April 2024. The future FWA2 contract will be in effect for up to 10 years (7 base years + 3 Option years). As of August 2023, the procurement activities have been finalized and an "intent to award" has been issued. Effective Design, Development, and Implementation of this software will enable further automation and increased efficiency of business processes. The public health emergency has made it challenging for member fraud investigations as there was a continuous eligibility requirement. Many of the referrals received for allegations of member fraud have resulted in no findings due to this requirement. The reduction in referrals to the UPIC is a result of managing their workload to drive efficiency. Cases reviewed/investigated by the UPIC have a propensity to extend for lengthy periods of time, and the referrals made in SFY 2021 are beginning to near their end in 2023.

- SFY 2022 - October 2021, the PI section entered into an agreement to become a full partner with CMS's Healthcare Fraud Prevention Partnership (HFPP). HFPP is designed to connect and evaluate combined data sets from: private insurance companies, SMAs, Tricare, Medicare, and law enforcement partners (i.e. DEA). The PI Section receives data study results that may prompt additional case generation and expand Wyoming Medicaid's fraud detection and prevention activities. January 2022, the Audit and Investigation Unit within the PI Section experienced the resignation of an Investigative Analyst, but this vacancy was quickly filled. As part of this change, the A&I Unit conducted extensive training and strategic planning activities. TheProgram Integrity Section assumed the responsibility of investigating FWA of Medicaid client cases in April 2022, previously conducted by the Department of Family Services, Eligibility Integrity Unit.

Program Integrity - Eligibility Review Unit

Program Description

The Eligibility Review Unit (ERU) manages the Agency's internal quality assurance review process identifying errors in eligibility determinations within the Customer Service Center, the Long Term Care Unit, and Tribal Eligibility. The ERU manages the federally required Medicaid Eligibility Quality Control (MEQC) Pilot and Payment Error Rate Measurement (PERM) Pilot addressing vulnerabilities within Medicaid's eligibility processes through collaboration with Agency staff and the development of corrective and preventive actions. The ERU is responsible for oversight into Medicaid Member Fraud.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$321,416	$230,373	N/A[1]
People Served[2]	3,671	3,147	2,089
Cost per Person[3]	$87.56	$73.20	N/A[1]

[1] This figure is not available as the ERU is now located in PI and our program cost is included within PI's program cost.This number is derived from the number of people served divided by the total program cost.

[2] People Served reflects the total number of Cases Reviewed. A reviewed case, in most cases, will have multiple people within a case.

[3] Cost per person actually reflects the Cost per Case Review. A reviewed case, in most cases, will have multiple people within a case.

Program Cost Notes

- 50% Federal match on the cost of employees completing ERU work.
- The primary costs are employee salaries, benefits, and general administrative costs.

Program Staffing

- 3 FTE

Program Metrics

- Case samples for monthly review are chosen from a random sample. Once a case is chosen all factors on a case are evaluated against eligibility requirements, processes and policies. The comprehensive review includes everything from data input to supporting documentation. The ERUs work on projects that are area specific, that do not include a full case review, are not included in the presented data.

Program Integrity - Eligibility Review Unit

Events that Have Shaped the Program

- The ERU was started in February 2012 to move the MEQC (now ERU) program from DFS to Medicaid Eligibility. The Unit has continued to grow since then, adding the PERM program and additional types of reviews. In previous PERM years, eligibility reviews were contracted out for $540,000. Currently PERM reviews are conducted by federal contractors with support from state staff.
- The ERU gained two reviewers in 2014 with the implementation of ACA.
- MEQC regulations are in 42 CFR 431 Subpart O. New MEQC regulations were published July 5, 2017.
- PERM regulations are part of the Improper Payment Information Act (IPIA) of 2002, amended in 2010 and 2012 to be the Improper Payments and Elimination and Recovery Improvement Act (IPERIA) which evolved into the PERM. New PERM regulations were published July 5, 2017.
- Medicaid has been under a Public Health Emergency (PHE) since SFY 2020. Medicaid eligibility must remain continuous through the PHE. The PHE has affected case reviews, MEQC and PERM allowing several exceptions to errors.
- Effective May 2022 the ERU is now part of the Program Integrity Section.
- Effective September 2022 ERU took over Medicaid Member Fraud investigations from DFS.
- Effective April 2023 the PHE ended and Medicaid began unwinding the flexibilities put in place during that time. Unwinding affects most aspects of case review, MEQC and PERM allowing continued flexibility during the 14 month period of unwinding.
- MEQC federal guidance updated in 2019 affected the RY2022 cycle requiring a payment error review on all deficiencies cited.
- ERU faced management turnover late 2022 and filled the position mid March 2023. ERU was also down a staff member for a few months in mid 2023. These staffing issues impacted QA reviews and Medicaid Member Fraud investigations.

Program Integrity - Eligibility Review Unit

Program Core Purpose

The purpose of the Eligibility Review Unit is to manage the Agency's internal quality assurance review process for eligibility determinations, manage federally mandated audits, and to address vulnerabilities within Medicaid's eligibility processes through collaboration with Agency staff and the development of corrective and preventive actions.

OUTCOMES								
Performance Metric		**Desired Trend**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Eligibility Error Rate		▼	22%	16%	11%	14%	28%	31%
Case Error Rate	Case Error Rate	▼	34%	25%	17%	27%	17%	15%
	Scanning Error Rate	▼	2%	3%	1%	3%	4%	4%
	Notice Error Rate	▼	29%	11%	11%	26%	28%	28%

OUTPUTS AND EFFICIENCIES							
Performance Metric		**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
OUTPUTS							
# of case reviews		2,816	2,628	3,816	3,671	3,147	2,089
# of eligibility errors		631	415	452	510	883	645
Case Errors	Overall Case Errors	954	662	658	983	1417	952
	Scanning Errors	59	65	39	95	136	84
	Notice Errors	805	303	420	951	873	591
EFFICIENCIES							
Cost per case reviewed		$121.09	$126.43	$83.12	$87.56	$73.20	N/A[1]

[1] This figure is not available as the ERU is now located in PI and our program cost is included within PI's program cost. This number is derived from the number of cases reviewed divided by the total program cost.

Story Behind the Performance

- Effective 10/01/2020 the Wyoming Customer Service Center had a new vendor processing Medicaid applications.
    - We have been in a Public Health Emergency (PHE) for the full SFY 2021 and full SFY 2022 which requires Medicaid eligibility to be continuous. A notice explaining the PHE and the Family First Act (FFA) was mailed out when a client was no longer eligible for benefits, but needed to maintain benefits during the PHE which explained that they would maintain Medicaid at this time and be re-evaluated at a later date. The increase in notices errors relates to this PHE.
    - During the unwinding of the PHE many flexibilities are still allowed.

- Another important data point is PERM & MEQC results. PERM is conducted every 3 years. MEQC is conducted in cycles during the years the state is not in an active PERM cycle. The MEQC program allows the states to choose specific focus areas to review. The ERU chooses to focus the majority of MEQC reviews on our Long Term Care program areas as they are not heavily sampled in PERM.

- ERU faced management turnover late 2022 and filled the position mid March 2023. ERU was also down a staff member for a few months in mid 2023. These staffing issues impacted the work of the ERU.

Public Health Division

The following section contains HealthStat reports from the Public Health Division, organized by program as follows:

1. Community Health Section
    a. Children and Youth with Special Health Care Needs Program
    b. Chronic Disease Prevention Program
    c. Immunization Unit
    d. Injury and Violence Prevention
    e. Public Health Nursing (PHN) Program
    f. Public Health Nursing (PHN) Home Visitation Program
    g. Substance Use Prevention Program
    h. Tobacco Prevention and Control Program
    i. Women and Infant Health Program
    j. Women, Infants, and Children (WIC) Program
    k. Wyoming Cancer Program
    l. Youth and Young Adult Health Program
2. Health Readiness and Response Section
    a. Community Services Program
    b. Healthcare Preparedness Program (HPP)
    c. Healthcare Workforce Recruitment, Retention, and Development
    d. Medicare Rural Hospital Flexibility Program
    e. Emergency Medical Services
    f. Public Health Preparedness and Response (PHPR)
    g. Trauma Program
3. Public Health Sciences Section
    a. Communicable Disease Prevention
    b. Communicable Disease Treatment
    c. Infectious Disease Epidemiology
    d. Public Health Laboratory

Children and Youth with Special Health Care Needs Program

SFY 2023 Program Snapshot

Program Description

The Children and Youth with Special Health Care Needs (CYSHCN) 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 all children, ages 0-21, including those with special health care needs. The CYSHCN Program also strives to foster the engagement of parents and other caregivers across the state.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$1,018,117	$1,180,641	$1,142,115
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	49%	57%**	51%

* 600 series is defined as direct service contracts or direct client services

** Many CYSHCN funds are directed to 900-series contracts that support client benefits (e.g., Newborn Screening Courier services).

Program Cost Notes

- The CYSHCN Program is funded through the Title V Maternal and Child Health Services Block Grant, Trust and Agency funding, and State General Funds used as Title V match and maintenance of effort.
- The Newborn Screening (NBS) Program is supported through a Trust and Agency account funded through the payment of fees from birthing hospitals as outlined in Wyo. Stats. §§ 35-4-801 – 802.
- Program expenditures increased significantly in 2021 due to internal restructuring that shifted staff and funding for the NBS program to the CYSHCN program.

Program Staffing

- 4.0 FTE
- 0 AWEC
- 0 Other

Program Metrics

- 40.3% of Wyoming children 6-11 years old are physically active 60 minutes per day, compared to 26.3% nationally (National Survey of Children's Health [NSCH], 2020/2021 combined).
- 47.3% of Medicaid-enrolled Wyoming children ages 1-9 years received an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen in 2021 compared to 45.4% in 2020 and 64.6% in 2019. Nationally, 62.2% of 1-9 year olds received an EPSDT screen, compared to 59.6% in 2020 and 67.4% in 2019 (Centers for Medicaid Services 416 Report, 2021). The 2022 data is not yet available. EPSDT screenings occur during child well visits. Well-visit rates dropped nationally in 2020, likely due to the impact of the COVID-19 pandemic.
- In Wyoming, 19.7% of children ages 0-17 are estimated to have a special healthcare need (NSCH, 2020/2021 combined).

Events that Have Shaped the Program

- In 2022, an Emergency Preparedness Plan (EPP) to mitigate risks and delays in NBS collection, testing, and follow-up was developed.
- In 2021, Wyoming and Colorado were jointly awarded a Health Resources and Services Administration (HRSA) grant to implement a long-term follow-up program for newborn screening.
- In 2020, the NBS Program revised the rules under Wyo. Stats. §§ 35-4-801 – 802 to add Spinal Muscular Atrophy (SMA), Pompe, X-Linked Adrenoleukodystrophy (X-ALD), and Mucopolysaccharidosis type 1 (MPS1) to the newborn screening panel.
- In 2020, the MCH Unit integrated the Child Health and CYSHCN programs to better coordinate efforts and improve staff capacity. Current program priorities include: 1) promoting healthy and safe children and 2) improving systems of care for CYSHCN through the promotion of medical homes.

Program Core Purpose

The purpose of the Children and Youth with Special Health Care Needs (CYSHCN) Program 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 health care with engaged caregivers.

OUTCOMES							
Performance Metric	**CY 2023 Target**	**CY 2024 Target**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
% and # of births that occur in Wyoming with first newborn screen completed[1]	99%	99%	98.4% 5,827/ 5,923	98.8% 5,552/ 5,622	98% 5,537/ 5,648	99% 5,368/ 5,336	(-)
% of Medicaid enrolled children (1-9 years) that received at least one recommended EPSDT screen in the past 12 months[2]	66.6%	66.6%	64.6% 67.4% US	45.4% 59.6% US	47.3% 62.2% US	(-)	(-)
% of children ages 6-11 who are physically active at least 60 minutes per day[3]	40.7%	40.7%	35.8% WY 28.3% US (2018/2019)	38.7% WY 26.2% US (2019/2020)	40.3% WY 26.3% US (2020/2021)	26.5% WY 25.2% US (2022)	(-)
% of parents reporting their child's doctor or health care provider always helped them feel like a partner in their child's care[4]	75%	80%	66% WY 73.4% US (2018/2019)	71.7% WY 73.9% US (2019/2020)	75.5% WY 75.0% US (2020/2021)	(-)	(-)

[1] Newborn Screening Database/Vital Statistics Services (VSS)
[2] Medicaid 416 Report, Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) – 2021 data not yet publicly available.
[3] N/AtioN/Al Survey of Children's Health (NSCH). Data for 2022 is a single year data point, as that is what is currently available. This will be replaced with the two-year combined data (2022/2023) once available, for a more reliable estimate to compare to the previous years.
[4] NSCH "Child and Family Health Measures," from which the fifth metric is derived, are not yet available for the 2022/2023 combined years.
(-) Indicates data not yet available.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of women served in MaterN/Al High Risk (MHR) Program	~	24	18	16	18†	N/A*	N/A*	N/A*	N/A*
# of infants served in the Newborn Intensive Care (NBIC) Program	~	83	60	26	30†	N/A*	N/A*	N/A*	N/A*

# of children served in the Children's Special Health (CSH) Program	~	277	394^	367	323†	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Cost per 1st & 2nd newborn screens (# of screens completed)††	$45.63 (11,014)	$49.31 (10,487)	$53.05 (10,327)	$49.26 (10,059)	N/A	N/A*	N/A*	N/A*	N/A*

N/A - Data not yet available.
N/A* - Data not available on a quarterly basis.
~ Denotes removal of data points that reflected prior data methodology focused on referrals and not numbers served.
^ More evaluation is needed to determine the direct cause for the increase in the # served but anecdotal data suggests that the initial impact of COVID-19 eased, allowing for greater contact with Wyoming families in 2021.
† Current through September 30, 2023.
†† This measure reflects SFY data instead of CY.

Story Behind the Performance

Trends

- EPSDT rates for children ages 1-9 were steadily increasing until CY2020, at which time it decreased likely due to the impacts of COVID-19. As of the preparation of this report, 2021 is the most recent publicly available CMS 416 report. Because 2022 data is not yet available, the program does not yet know if EPSDT rates will return to prior levels.
- The decrease in childhood physical activity from 2020/2021 to 2022 may or may not reflect a true decrease. When the 2022/2023 combined data point is available, the program will have a more reliable estimate.
- Parents reporting that their child's doctor or healthcare provider made them feel like a partner in their child's care has steadily increased in the last three years, closing the gap between Wyoming and N/AtioN/Al proportions.

Changes

- Program outputs are new due to recent restructuring of the program and only reflect three years of total individuals served. Prior years data are not available as they reflect total referrals received not total individuals served. The new outputs more accurately represent program impact.
- As the program integrated CSH, Child Health, Newborn Screening, and Genetics it was necessary to identify previously unreported outputs for the CYSHCN program. To maintain consistency in output measures, it was only possible to report on three years of data for total people served.

Chronic Disease Prevention Program

SFY 2023 Program Snapshot

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 CDPP is dedicated to promoting and supporting the health and wellbeing of Wyoming's residents through cross-sector partnerships and collaborative efforts, health systems improvement, and continuous quality improvement.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$1,106,428	$1,635,153	$1,767,835
People Served	576,851	578,803	581,381
Cost per Person	$1.92	$2.83	$3.04
Non-600 Series*	70%	66%	55%

* 600 series is defined as grants.

Program Cost Notes

- 100% federally funded from the Centers for Disease Control and Prevention's (CDC) Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke cooperative agreement.
- The CDC limits the use of grant funds for policy, systems, and environmental strategies and does not provide funding for client-level education or services.
- Increased program spending was in-part due to CDPP's value based payment program where recognized lifestyle change programs in the state were compensated per participant per session they attended.

Program Staffing

- 2.15 FTE
- 1 AWEC

Program Metrics

- 75.7% of Wyoming adults have modifiable risk factors for chronic disease. These risk factors are smoking, sedentary lifestyle, diabetes, obesity, depression, and/or sleeping for other than 7-8 hours (WY BRFSS, 2022).
- 5.9% of Wyoming adults have been told by a provider that they have had a heart attack or angina (WY BRFSS, 2022).
- In Wyoming, the prevalence of diabetes in adults is 9.3% (WY BRFSS, 2022).
- In Wyoming, the prevalence of pre-diabetes is 8.4% (WY BRFSS, 2022).
- In 2022, 69.9% of Wyoming adults were considered overweight or obese (WY BRFSS, 2022).
- Hospital discharge data shows 19,142 patients were treated for heart disease, diabetes, and stroke (WY Hospital Discharge Data, 2022).

Chronic Disease Prevention Program

Events that Have Shaped the Program

- 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 with adult populations.
- In SFY2021, COVID-19 became a barrier for clinic level work. Many grant partners were overwhelmed with acute patient care and did not have the time or resources to commit to chronic disease prevention and management.
- SFY2023 was the last grant year of CDC's Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke five year cooperative agreement.
- CDPP has successfully applied for and has been funded through CDC's National Cardiovascular Health Program and CDC's A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes five year cooperative agreements. Both grants start in SFY2024.
- Statutes governing program responsibilities are Wyo. Stats. §§ 35-25-301 and 35-25-203(g)(iv).

Program Core Purpose

The purpose of the Chronic Disease Prevention Program (CDPP) 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	2023 Target	2024 Target	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Number of people with diabetes with at least one encounter at an American Diabetes Association-recognized or Association of Diabetes Care and Education Specialists -accredited diabetes self management and education (DSME) program[1]	4,836	1,500	N/A	2,042	1,636	1,414	1,477
Total number of enrolled participants in a CDC- recognized diabetes prevention program (DPP)[2]	300	500	133	992	406	354	752
% of people with self-reported hypertension[3] (national average)	30.0%	30.0%	N/A*	30.2% (32.3%)	N/A*	29.7% (32.3%)	N/A*
% of people with self-reported diabetes[3] (national average)	8.2%	8.0%	8.7% (10.9%)	7.7% (10.6%)	8.5% (8.2%)	8.4% (11.5%)	(-)

[1] Data Source: CDC DSME State Data Report (The first release of this data was in August 2021).
[2] Data Source: CDC DPP State Data Report.
[3] Data Source: Wyoming Behavioral Risk Factor Surveillance System; data is weighted.
N/A indicates data not available due to new metric in SFY19.
N/A* indicates data not available annually.
(-) Data not yet available.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	2023 Q1-2	2023 Q3-4	2023 Q1-2	2023 Q3-4
OUTPUTS									
# of patients in health care systems implementing new or enhanced team-based approaches or policies to address blood pressure control[4]	12,149	20,436	45,927	27,493	67,939	N/A*	N/A*	N/A*	N/A*
# of pharmacists who provide medication therapy management (MTM) services to promote medication self-management and lifestyle modification for patients with high blood pressure, high blood cholesterol, and diabetes[4]	4	11	20	20	20	N/A*	N/A*	N/A*	N/A*

# of patients served within health care organizations with systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs[4]	N/A	93,129	32,207	38,372	41,876	N/A*	N/A*	N/A*	N/A*
# of health care systems with electronic health records (EHRs) appropriate for treating patients with diabetes and cardiovascular disease[5]	8	10	10	9	9	N/A*	N/A*	N/A*	N/A*
# of patients with known high blood pressure who have achieved blood pressure control[4]	N/A	5,868	6,950	7,860	8,767	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
# of CDC-recognized DPPs available in Wyoming[6]	6	12	14	12	9	N/A*	N/A*	N/A*	N/A*
% of patients within health care systems that have policies or systems to encourage self-measured blood pressure monitoring (SMBP) with clinical support for patients with hypertension[4]	30.30%	59.11 %	67.20 %	72.90 %	79.52 %	N/A*	N/A*	N/A*	N/A*

[4]Data Source: Wyoming Chronic Disease Assessment Tool
[5]Data Source: Mountain Pacific Quality Health 2019 1815 Project Report
[6]Data Source: Diabetes Physician Recognition Program (DPRP) Registry
N/A indicates data not yet available due to the creation of a new metric
N/A* indicates data not available on a quarterly basis

Story Behind the Performance

- The CDPP supports state initiatives to implement and evaluate evidence-based strategies that prevent and manage diabetes, cardiovascular disease, and stroke in high-risk populations.
- According to the Centers for Disease Control and Prevention, approximately 21.4% of people who have diabetes are undiagnosed nationally and the number of people with prediabetes is on the rise. In addition, those with prediabetes often do not know they have it. Prevention strategies, early diagnosis, and intervention are critical in promoting better management, reducing complications, and reducing costs for those living with diabetes. In SFY2022, the CDPP created a statewide media campaign funded by the CDC's Health Disparities Grant to promote awareness of prediabetes and the Diabetes Prevention Programs (DPP). This campaign led to 9,631 residents taking the CDC pre-diabetes risk assessment to know their risk of developing type 2 diabetes.
- According to the National Institute for Health's National Center for Biotechnology, training in evidence-based protocols and a team-based approach to health care for all chronic conditions results in earlier diagnoses and improved treatment as well as reduced costs due to decreased hospitalizations and need for treatment of complications.
- The CDPP continued to provide grant funds through value based payments to support the sustainability of DPP and SMBP across the state. These programs support team based care and early intervention for chronic diseases. Each year-long program should contribute to the successes and efficiencies of the program.

- The CDPP continued to provide technical assistance to provider offices and worked with Medicaid to find innovative options for billing chronic disease prevention services. Sustainability of this grant work is a priority.
- In SFY2021 and SFY2022, the CDPP faced significant challenges navigating the COVID-19 pandemic as a majority of grant work and partner development was on the clinical and pharmacy level. In addition, many evidence- based lifestyle change programs were either shifted to online delivery modes or paused completely.
- In SFY2022, the CDPP invested in an online DPP platform that was available at no-cost to any Wyoming resident with prediabetes. The online offering significantly boosted the number of people enrolled in a CDC-recognized DPP. The program successfully reached some of Wyoming's most rural residents. SFY2022 numbers were lower than SFY2023 because they did not include the number of enrolled participants from the Omada DPP program offered through the state health plan.
- In SFY2023, the CDC lifted their special COVID-19 recognition rules that allowed DPPs to maintain their program recognition without the required data submission. Three of Wyoming's DPP programs fell off the CDC recognized list once those special rules were lifted because they were unable to offer a program during the pandemic. CDPP is actively working with those three sites to get their recognition restored.
- In SFY2023, the number of health care systems with electronic health records (EHRs) appropriate for treating patients with diabetes and cardiovascular disease were updated to reflect the numbers included in CDPP's final evaluation submission to the CDC.

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 the 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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost*	$3,492,962	$3,285,299	$2,316,035
People Served**	315,684	316,405	412,837
Cost per Person	$11.06	$9.63	$5.61
Non-600 Series***	45%	45%	90%
COVID-19 Response Cost	$542,432	$2,793,530	$7,037,193

*Traditional, non-COVID-19-related program costs. These are considered typical costs. The cost per person served is calculated based on this total.

**Number of people served is the number of patients who received a vaccine administration reported to the WyIR by providers.

*** 600 series is defined as direct service (vaccine purchases).

Program Cost Notes

- Operational funding for the Public Vaccine Program in SFY23 consisted of 82% federal and 18% state. COVID-19 vaccination efforts are funded with 100% federal funds.
- Standard budget general funding was reduced by $4,384,605 in BFY 2020/2021. Funding reductions in the WyVIP Program resulted in fewer vaccine purchases for SFY 2022/2023. Additional budget reductions passed in the supplemental budget for BFY 2020/2021 were biennialized and reduced an additional $879,011 in BFY 2022/2023, resulting in fewer vaccine purchases. Vaccine purchases are made in bulk and in advance to ensure availability when needed by providers. As a result fewer vaccine purchases were needed in SFY2023. This resulted in lower program costs and a higher percentage of non-600 series expenditures. Program costs and 600 series expenditures are expected to increase in SFY24.
- Federal funding awarded increased in SFY23 by approximately $574,906.
- One-time CDC COVID-19 Federal Response Funding of $39,316,971 was awarded during SFY2021 through SFY2025 for vaccination efforts.

Program Staffing

- 8 FTE: 1 state-funded, 7 federally-funded
- 2 AWEC, state-funded
- 1 ASTHO Fellow
- 7 AWEC COVID-19 Response Expanded Workforce

Program Metrics

- As of November 15, 2023, 113 public and private healthcare providers receive state-funded, federally-purchased vaccines, or both, from Public Vaccine Programs operated by the Immunization Unit.
- Approximately 74,166 doses of pediatric and 1,690 adult doses were distributed to enrolled providers through the Public Vaccine Programs during SFY23. Approximately 99,200 COVID-19 doses were distributed to program-enrolled providers in Wyoming in SFY23.
- As of November 20, 2023, the WyIR contained information for 11,464,933 vaccinations.

Events that Have Shaped the 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 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.
- 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, reporting of all immunization information became required and pneumococcal and rotavirus vaccination became mandatory for children attending schools and child caring facilities.
- COVID-19 vaccines became available in December 2020.
- In January 2021, due to budget reductions, the WyVIP Program was limited to only Public Health Nursing offices, health departments, federally qualified health centers, and rural health centers.
- In December 2022, the WyIR connected to the Veterans Health Administration (VHA) system via an electronic interface connection to allow for submission of vaccines administered at the Veteran Affairs (VA) locations in Wyoming. This was essential to providing more comprehensive vaccination records in the WyIR for those patients who received vaccinations at VA locations in Wyoming. In August 2023, the interface connection with the WyIR and VHA added query functionality to allow the VA to query current vaccination status of patients seen at VA locations in Wyoming.

Immunization Unit

Program Core Purpose

The purpose of the Immunization Unit is to reduce the risks associated with vaccine-preventable diseases in Wyoming.

OUTCOMES							
Performance Metric	**CY 2023 Target**	**CY 2024 Target**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
7-Vaccine Series Coverage Estimate (19 - 35 mos.)[1]	80%	80%	64%	64%	64%	62%	(-)
School Vaccination Coverage Estimate (7 years)[2]	75%	75%	68%	69%	72%	67%	(-)
Influenza Vaccination Coverage Estimate (6 mos. – 17 yrs.)[3]	80%	80%	45.7%	59.1%	46.3%	37.8%	40.3%
HPV 2-doses Coverage Estimate (13 -17 yrs.)[4]	40%	40%	34%	37%	36%	36%	(-)
COVID-19 series completion vaccine coverage for 18+ yrs[11]	70%	70%	N/A	N/A	52.5%	55.6%	63.3%*

(-) Indicates data not yet available.
N/A indicates data not available due to new metric.
* Indicates data through 05/11/2023.

Footnotes
1 - 11 denotes further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Number of PVP Providers Receiving IQIP[5]	73	35	43	39	33	N/A*	N/A*	N/A*	N/A*
Number of Program-purchased Doses Shipped to PVP Providers[6]	141,822	133,288	106,736	71,561	75,856	41,928	29,633	42,546	33,310
Number of PVP Program Providers[7]	124	121	113	112	113	113	112	112	113
COVID-19 Enrolled Program Providers[8]	N/A	N/A	260	139	134	260	139	136	134

Percent of PVP Providers also enrolled in the COVID-19 Vaccination Program	N/A	N/A	82%	79%	80%	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Percent of PVP providers with less than 5% waste*[9]	72%	71%	46%	40%	46%	N/A*	N/A*	N/A*	N/A*
WyIR Cost per Organization[10]	$952 ($357,147/ 375)	$1,111 ($420,913/ 379)	$2,156 ($625,467/ 290)	$1,904 ($696,689/ 366)	$4,015 ($1,617,941/ 403)	N/A*	N/A*	N/A*	N/A*

N/A* indicates data not available on a quarterly basis
* indicates calendar year (CY) data

Footnotes
1 - 11 denotes further explanations provided in the Story Behind the Performance.

Story Behind the Performance

Coverage estimates are reported by Calendar Year from the Wyoming Immunization Registry (WyIR) with the exception of influenza coverage which is obtained from the National Immunization Survey (NIS) and COVID-19 vaccination coverage which is obtained from the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker.

- 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 School Vaccination Coverage Estimate is measured at seven years of age and includes: 5 DTAP, 4 Polio, 2 MMR, 3 Hep B, 3 Hib, 2 Varicella and 4 Pneumococcal vaccines. The current school requirements allow children to complete the required vaccines between ages four to six, meaning they should be fully vaccinated by age seven.
- Coverage rates are from NIS FluVaxView and are measured from July 1st-June 30th. The national coverage rate for this age group is 49.3% (NIS 2022-2023). Measure was updated to align with NIS FluVaxView age range.
- This measure is reported at 13-17 years for two doses. Note that HPV vaccine is not provided by the Wyoming Vaccinates Important People (WyVIP) Program, nor mandatory for school entry. The national rate is 62.6% while the HHS Region 8 rate is 61.8% (NIS 2022).
- Immunization Quality Improvement for Providers (IQIP) is the CDC's quality improvement program for Vaccine For Children (VFC) providers. The IQIP process includes an initial site visit, and check-ins at two, six, and 12 months. IQIP components include assessing clinic immunization workflow, clinic specific immunization coverage data, and selecting core strategies to improve upon. Provider quality improvement site visits have shown to significantly impact coverage rates, decrease missed opportunities and implement best practices. Fifty percent of eligible providers are eligible to receive an IQIP site visit annually.
- 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). PVP-enrolled providers noticed a decreased demand for regularly scheduled vaccinations starting in SFY22, which aligned with national trends. In addition, in January 2021, the WyVIP program budget was significantly decreased which restricted program providers eligible to order WyVIP vaccine to only Public Health Nursing offices, federally qualified health centers, and rural health centers. PVP-enrolled providers noticed an increase in demand and have increased vaccine ordering throughout SFY23. This does not include COVID-19 vaccine.

- The number of providers enrolled in a Public Vaccine Program (PVP). This metric includes all PVP providers and is not limited to VFC providers.
- The number of providers enrolled in the COVID-19 Vaccination Program.
- 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 5%. The Immunization Unit continued to see a decrease in the number of providers with less than 5% waste in CY21. Per CDC's guidance in early 2020, compliance site visits were put on hold due to the pandemic until January 2022, at which time the Immunization Unit began to conduct compliance site visits virtually. 100% of providers were brought up-to-date on compliance site visits in SFY23. Restitution continues to be suspended. In addition, PVP-enrolled providers continue to see a decreased demand for regularly scheduled vaccinations, which aligns with national trends. These factors contributed to the significant increase of wasted vaccines in SFY21 and SFY22, but the number of wasted vaccine is trending down in SFY23. Education related to vaccine inventory management and vaccine ordering continue to be provided to PVP-enrolled providers in an effort to continue decreasing waste.
- WyIR cost per organization is calculated by taking the costs associated with the WyIR (maintenance, annual technical assistance, and product subscriptions) and dividing it by the number of organizations as listed on the provider contact report in the WyIR. In SFY23, WyIR costs also included a pandemic cost parity, increased cost adjustment for maintenance, annual technical assistance and product assistance, modernization costs to align with CDC requirements, WyIR Tier 1 help desk services, and costs for a dedicated service desk ticket priority process.
- As of 12/2022, data includes doses administered by the US Department of Veteran Affairs; however, does not include US military data. The national data for series completion as of 05/11/2023 is 69.5% (CDC). Baseline for COVID-19 series completion vaccine coverage for 18+ yrs after 05/11/2023 is reported as COVID-19 up to date for 18+ yrs:14.2% for Wyoming; 17% for national average.

Injury and Violence Prevention Program

SFY 2023 Program Snapshot

Program Description

The Wyoming Injury and Violence Prevention Program (WIVPP) coordinates state and local efforts to prevent unintentional and intentional injury and violence by promoting public awareness and providing training.

Program Expenditures and People Served

	2021	2022	2023
Total Program Cost	$1,667,390	$1,993,189	$1,676,914
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	22%	51%	32%

* 600 series is defined as direct service contracts.

Program Cost Notes

- The WIVPP is funded through the CDC Preventive Health and Health Services Block Grant, the Wyoming Department of Transportation (WYDOT) ThinkFirst for Teen Driver Grant, State General Funds (SGF), and Tobacco Settlement Funds (TSF).
- In 2022, Senate File 66 provided the program with $200,000 in ARPA funds to be spent specifically on Mental Health First Aid (MHFA) training.

Program Staffing

- 3.0 FTE
- 0 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 injury mortality rates are consistently higher than U.S. rates.
- The leading causes of fatal injury in Wyoming are suicide by firearm, unintentional motorvehicle crashes, unintentional poisoning, and unintentional falls (WY VSS).
- In Wyoming, the unintentional injury mortality rates are over two times higher than suicide rates and nineteen times higher than homicide rates (WY VSS).
- In 2021, the Wyoming suicide rate was more than twice the national rate and the highest suicide rate of all fifty states (National Center for Health Statistics).
- On average, one Wyoming resident dies by suicide every two days.

Events that Have Shaped the Program

- The Wyoming Injury Prevention Program (WIPP) was created in June 2014 and changed to Wyoming Injury and Violence Prevention Program (WIVPP) when suicide prevention was moved to the program in 2017.
- As of SFY 2019, funding for community prevention grants for substance use, tobacco prevention and control and suicide prevention is distributed to county governments. A majority of suicide prevention funding ($1 million annually) is allocated to the local level through this grant.
- In 2020, the Wyoming State Legislature designated SGF to support the establishment and operation of an in-state suicide prevention call center. Oversight of this transitioned to the Behavioral Health Division (BHD) in 2021.
- Since 2021, the WIVPP participates in the Wyoming Governor's Challenge to Prevention Suicide Amongst Veterans, Service Members, and Their Families.
- In 2022 and 2023, WIVPP applied for and was awarded funding from WYDOT to provide state-wide education on teen motor vehicle safety and helmet safety.
- The WIVPP hosts a bi-annual suicide prevention conference that brings multidisciplinary stakeholders together for two days to discuss data trends and provention strategies.

Injury and Violence Prevention Program

Program Core Purpose

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

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Crude injury mortality rate per 100,000 population (National Rate)[1]	90	90	100.91 (74.96)	101.15 (84.48)	100.7 (92.2)	101.3 -	-
Older adult unintentional injury mortality rate per 100,000 population age 65+ (National Rate)[1]	125	125	154 (112.01)	142 (112.82)	143 (123.56)	156.9 -	-
Total drivers involved in injury crashes under 20 years old[2]	532	532	609	527	552	559	-
Crude suicide rate per 100,000 population (National Rate)[1]	22	25	29.4 (14.5)	31.1 (14)	32.5 (14)	26.3 -	-

- Data not yet 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 year is preliminary data from Vital Records and subject to change as data is validated and rates finalized. Data is reported on the calendar year.
[2]Data Source: Annual Wyoming Report on Traffic Crashes from the Wyoming Department of Transportation (WYDOT). Data is reported on the calendar year.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of Wyoming participants in a fall prevention course[3]	233	220	961	1,820	*	792	1,028	*	*
# of people trained in evidence-based suicide prevention (gatekeeper) supported by program[4]	945	876	1,156	6,858	753	4,430	2,428	408	345
# of people participating in postvention activities supported by program[5]	N/A	N/A	N/A	N/A	76	NA	NA	38	38
# current or future teen drivers reached by ThinkFirst Program	N/A	N/A	N/A	N/A	1,298	NA	151	1,165	133

EFFICIENCY									
Suicide prevention training cost per trainer[6]	N/A	N/A	N/A	$1,659	$2,678	$1,900 ($66,500/ 35	$1,411 ($48,000/ 34)	$3,125 ($25,000/ 8)	$2,500 ($50,000/ 20)

N/A Data not available due to creation of a new metric.
[3] Includes individuals who participated in some of the course, even if they did not complete the full course. New ThinkFirst for Falls Prevention presentations to begin 2024.
[4] Includes individuals trained through Community Prevention Grant suicide prevention activities and available virtual QPR. Figure obtained from Prevention Reporting and Evaluation System (PRES) data.
[5] Includes individuals trained through Community Prevention Grant suicide postvention activities (support groups and presentations for loss survivors etc.). Figure obtained from PRES data.
[6] Includes only individuals trained by WIVPP sponsored training for trainer courses (ASIST, safeTALK, MHFA and YMHFA). Only accounting for attendees that passed the course.
* Metric was not captured in 2023 but will continue in 2024.

Story Behind the Performance

- 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.
- Several outcome measures used to track progress for the program, including participant numbers, 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. The program will continue to monitor program acceptance, barriers, and health outcomes to improve WIVPP work.
- In 2020, the Wyoming State Legislature designated SGF to support the establishment and operation of an in-state suicide prevention call center. Oversight of this transitioned to the Behavioral Health Division (BHD) in 2021. The metrics related to answered calls and call volume will no longer be reported on the WIVPP Healthstat documents.

Performance Notes:

Through a collaborative effort with the Tobacco Prevention and Control and Substance Use Prevention Programs, the WIVPP provides funding to Wyoming counties for alcohol, tobacco, substance use, and suicide prevention activities. Starting July 1, 2023, the county prevention grant program recipients began inputting their data into a new Prevention Reporting and Evaluation System (PRES) which provides metrics on gatekeeper trainings (ASIST, QPR, etc.) and postvention support (loss and survivor support groups etc.). County programs have autonomy to choose which suicide prevention strategies fit community needs, so these metrics do not always capture the full scope of suicide prevention work.

In 2022, through the Community Prevention Grant (CPG), each county was able to train individuals in suicide prevention gatekeeper training at a local level. Through data collection related to the CPG, the number of trainees substantially increased. This is due to training being pushed out to students district-wide in some counties, as well as focusing on industries and workplaces to improve coverage areas. In 2023, these communities scaled back their gatekeeper training efforts.

In 2021, the WIVPP received CARES funds for the purpose of Mental Health First Aid (MHFA) training for trainers (T4T) and to purchase lethal means safe storage devices. These funds have been expended and the program can no longer support purchasing bulk safety devices, therefore the metrics related to personal safety devices will no longer be reported by WIVPP. However, to address the need for safe storage the program has been partnering with the Veterans Administration and the Firearm Research Center to connect communities to free locking devices and safe storage education. In 2022, WIVPP received $200,000 for MHFA T4T. These trainings will be hosted in partnership with the Wyoming Department of Education's (WDE) Project AWARE throughout 2024. Recruiting trainers for these opportunities has been challenging.

Classes are a set cost but due to non-completion of paperwork or late attrition, classes are not filled. WIVPP is working with WDE to mitigate some of these issues and increase recruiting efforts.

The unintentional injury portion of the program is transitioning focus toward preventing teen motor vehicle crashes while restrategizing falls prevention activities. In 2024, the program will be implementing ThinkFirst for Falls Prevention, (audience to include caregivers, families, and senior center staff) with plans for library pilot programs. Future HealthStat documents will pivot to include the new Think First for Falls Prevention attendees.

In 2022, WIVPP received new grant funding from WYDOT to reach teen drivers and provide education on distracted driving and their potential for injury and death due to motor vehicle crashes. The teen drivers who took the course have shown an increase in knowledge post presentation and school districts are continuing to welcome the presentation throughout 2023 and 2024.

Public Health Nursing Program

SFY 2023 Program Snapshot

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 contracts 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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost*	$7,928,272	$8,168,998	$8,225,438
People Served	235,813	141,877	114,485
Cost per Person	$33.62	$57.58	$71.85
Non-600 Series**	85.9%	82.9%	79%
COVID Response Cost***	$0	$0	$0

*Traditional, non-COVID-related program costs.

**600 series is defined as direct service contracts.

***Although PHN was directly involved in COVID response activities, these associated costs are reported through other programs.

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.
- 98% of total program costs are personnel costs; this does not include other expenses paid by counties. It also includes state general funds for Natrona, Sweetwater, and Laramie counties' contracts.
- Number of participants represents direct care services, classes, and outreach provided through PHN.
- The significant increase in people served during SFY2021 was due to COVID-19 vaccine response.

Program Staffing

- 76 State PHN positions in 19 counties and PHN administration (66 FTE, 10 PT)
- 2 AWEC positions
- ~74 other county PHN positions, including PHN staff from the 4 independent counties
- ~79 temporary county staff were hired to assist with the COVID-19 response at the local level

Program Metrics

- Public health infrastructure and services are provided to Wyoming residents through the Wyoming Department of Health, Public Health Division, State PHN, and locally through county PHN offices and health departments.
- In SFY23, PHN provided direct services to 4,345 clients in 23,081 visits. Clinics, classes, and outreach efforts were provided to 110,140 participants (some clinic/class participant numbers may be repeat participants).
- In SFY23, 10,176+ hours of PHN time were spent on COVID-19 response work.
- Each $1 spent on public health programming generally returns $5.06 in savings (APHA, 2013). Approximately $41,620,716 in future savings to the State of Wyoming's social and health care systems may be realized from SFY2023 PHN services alone.

Public Health Nursing Program

Events that Have Shaped the Program

- State statutes pertaining to Public Health Nursing are Wyo. Stats. §§ 35-1-240; 35-1-305, 35-1-306; 35-27-101 through 104 and 35-1-243.
- PHN staff continue to spend a significant amount of time on COVID-19 response and prevention activities at the community level, educating partners and the public on current recommendations, performing testing, and administering vaccines.
- 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 Program

Program Core Purpose

Promote, protect, and improve health and 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 2023 Target	SFY 2024 Target	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
# of adult residents reached through outreach activities*	14,071	8,510	12,792	10,274	N/A	N/A	7,736
# visits for Children with Special Health needs receiving case management services through PHN	650	990	672	533	591	879	976
# of communicable disease screens conducted by PHN**	6,172	7,136	10,853	5,611^	4,577^	5,492^	6,487
% of Ryan White-eligible, HIV-infected Wyoming residents receiving PHN case management	100%	100%	95% (206/218)	90% (226/250)	97% (202/208)	99% (214/217)	99% (229/232)
% of referred clients assessed for long-term care Medicaid waivers through PHN***	95%	95%	88.2% (6,185/7,011)	89.3% (6,092/6,818)	89.4% (4,770/5,337)	89.5% (4,757/5,316)	88.8% (4,136/4,658)

*NA indicates data not available due to shift of focus to COVID-19 response.
** includes screenings for sexually transmitted diseases (N=3,398) and tuberculosis (N=3,089). 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.
^ Decrease likely due to COVID-19 and limitations on services.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	2022 Q1-2	2022 Q3-4	2023 Q1-2	2023 Q3-4
OUTPUTS									
% of chronic disease clinic visits with diabetes focus	21% (852/4,046)	14.3%* (212/1,478)	14.2%* (386/2,711)	20.7% (600/2,897)	23.1% (342/1,478)	27.9% (377/1,351)	14.4% (223/1,546)	27.4% (178/650)	19.8% (164/828)
% and # of Wyoming adult immunizations administered by a PHN office	19.2% (68,541/356,199)	23.4% (38,848/165,711)	35.7% (199,459/558,000)	25.6% (109,591/427,400)	21.6% (53,458/246,013)	25.4% (85,127/335,106)	26.5% (24,464/92,294)	22.1% (44,037/199,180)	20.1% (9,421/46,833)
Average # of state PHN vacancies and average vacancy rate	13.3/76 17.5%	13.5/76 17.7%	16.7/76 22.0%	19.1/76 25.1%	16.4/76^ 21.6%	18.2/76 23.9%	19.5/76 25.7%	18.7/76 24.6%	14.0/76 18.4%

EFFICIENCIES									
% of PHN hours spent on Maternal Child Health services for Temporary Assistance for Needy Family clients	61.8%	71.8%	49.8%*	52.9%*	61.3%	53.3%	52.5%	62.4%	60.3%
% of PHN immunization hours spent on COVID-19 vaccination efforts	--	--	67.4%	61.2%	38%	63.4%	57.6%	42.4%	29.7%

* Decrease likely due to COVID-19 and limitations on services
-- Data not available
^ It was discovered that PHN positions from county offices transitioning to Independent had not been removed from the position count on vacancy reports, and the wrong denominator was previously used.

Story Behind the Performance

- State PHN is a partnership between the State and County governments for the provision of public health nursing services in 19 counties. In four counties these services are provided independently by county governments and three independent counties receive funding for public health nursing services through contracts with PHN. PHNs in the counties are the "boots on the ground," comprised of 76 direct care state nurse positions and 74 direct care county nurse positions.
- Performance of independent counties is included in the overall picture of PHN outputs and efficiencies.
- PHN played a significant role in the COVID-19 response and prevention at the community level. In SFY23, PHN spent 7,564 hours administering COVID-19 vaccinations.
- In SFY23, PHN received 4,658 Medicaid long-term care assessment referrals. An assessment was completed on 88.8% of the referrals. The remaining referrals were not assessed due to the following reasons: client discharged from nursing facility, unable to reach client by phone or mail, or client declined the assessment.
- Outreach activities were minimal during SFY21 and SFY22, as staff time was prioritized to focus on the pandemic response and capacity was limited, but have resumed in SFY23.

Public Health Nursing Home Visitation Program

SFY 2023 Program Snapshot

Program Description

The Public Health Nursing (PHN) Home Visitation Program, Wyoming Hand in Hand (WHH), provides perinatal home visiting services for women to improve pregnancy outcomes and infant health outcomes from pregnancy to child's second birthday. WHH uses the evidence based Maternal Early Childhood Sustained Home Visiting (MECSH) model.

Program Expenditures and People Served

	2021	2022	2023
TANF Expenditures (SFY)	$1,014,453	$1,192,373	$734,971.32
TANF Families Served (SFY)	1,559	1,984	1,456
Cost per TANF Family	$651	$601	$505
Non-600 Series*	14.8%	11.5%	5.84%

*600 series is defined as direct service contracts

Program Cost Notes

- WHH uses two funding sources: (State General Funds (SGF) and Federal Funds from Temporary Assistance for Needy Families (TANF). Only TANF expenditures are reported in the total program cost in this Snapshot. SGF funds are reported on the Women & Infant Health Program Snapshot.
- Non-600 Series has decreased due to reduction in MECSH contract amount and ability to move funds from one county to another to support staff salary.

Program Staffing

- 0 FTE

Two Public Health Nursing (PHN) staff oversee Maternal and Child Health (MCH) services provided by PHN, including the Home Visitation Program. Those FTEs and associated costs are reported on the PHN Snapshot.

Program Metrics

- MECSH goals are to:
  - Improve transition to parenting by supporting mothers through pregnancy;
  - Improve maternal health and wellbeing by helping mothers to care for themselves;
  - Improve child health and development by helping parents to interact with their children in developmentally supportive ways;
  - Develop and promote parents' aspirations for themselves and their children; and
  - Improve family and social relationships and networks by helping parents to foster relationships within the family and with other families and services.
- TANF funding is used to provide the following MCH services to TANF-eligible families: home visitation, lactation consultation, parenting and childbirth classes, community baby showers, and presumptive eligibility.
- WHH information:
  - 1,271 clients enrolled since March 2021. 514 clients enrolled during SFY 2023.
  - 106 PHN staff trained in the MECSH model since March 2021. 55 of these are currently fully trained MECSH staff with caseloads.
  - Excelling in WHH Patient Satisfaction with a score of 88.0% out of 100% (target is at least 80%)
  - In SFY 2023, 641 clients were screened for a perinatal mood or anxiety disorder using a validated tool and 152 (24%) of these clients had a positive screen and were able to receive a nursing intervention and/or referrals. This means that 24% of clients were identified as "at risk" for a perinatal mood or anxiety disorder. National data estimates only 15-21% of caregivers experience a perinatal mood or anxiety disorder, which lends to the importance of early and frequent screening.
  - In SFY 2023, 400 clients were screened for intimate partner violence using a validated tool and 23 (6%) of these caregivers disclosed current intimate partner violence and 100% of these caregivers received nursing interventions and/or referrals.

Public Health Nursing Home Visitation Program

- In SFY 2023, 591 clients were screened for substance use and 77 (13%) of these clients disclosed substance use.

Events that Have Shaped the Program

- In 1990, the Maternal Child Health (MCH) Unit began providing grants to counties to implement MCH services including home visitation.
- In 1996, Nurse Family Partnership (NFP), an evidence-based home visiting model for first-time mothers, was implemented in Wyoming, in addition to Best Beginnings (BB) home visiting model.
- PHN Home Visiting Programs are delineated in Wyo. Stats. §§ 35-27-101 – 104.
- In 2018, an electronic health record (EHR) system was implemented for PHN services. Data reporting was severely limited and unable to meet MECSH fidelity reporting needs until February of 2023.
- From spring 2020 to March of 2022, the COVID-19 pandemic impacted PHN by requiring an all-hands-on-deck response and significantly reduced the ability to serve Wyoming's home visitation families. Home visitation services continued during this time but were significantly decreased and modified.
- In March of 2021, PHN began implementation of the WHH home visitation program and phased out both the NFP and BB programs. WHH uses an evidence-based model and, as of July 1, 2021, is the sole home visitation program in all 23 counties.
- Nurse turnover, retention, and capacity is a significant concern. In SFY 23, 64% of referrals to home visitation were unable to be contacted/enrolled due to nurse shortage. Twelve out of 23 counties report nurse shortage as the main reason families cannot be served.
- In FFY 2022 and 2023, the entirety of the TANF grant was expended. The majority of the grant is used to support nurse salaries. Increased diligence and appropriate distribution of the TANF grant has led to a significant decrease in non-600 series spending.

Public Health Nursing Home Visitation Program

Program Core Purpose

The Public Health Nursing (PHN) Home Visitation Program, Wyoming Hand in Hand (WHH), provides perinatal home visiting services for birthing people to improve prenatal and infant health outcomes from pregnancy to child's second birthday. WHH is Wyoming's program name for the evidence-based Maternal Early Childhood Sustained Home Visiting (MECSH) model.

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
1. % and # of referrals to WHH contacted[1] versus total home visitation referrals received	75%	75%	61% 2,683/ 4,368	67% 3,234/ 4,809	50% 1,771 / 3,540	47% 1,935/ 4,107	43% 2,016/ 4,670
2. % and # of clients offered WHH that enrolled in the program	75%	75%	--	--	95% 227 / 238	33% 565 / 1,670	31% 514/ 1,648
3. WHH Patient Satisfaction Questionnaire (PSQ) score[2]	80%	80%	--	--	92.8%	92%	88%
4. % of clients that meet 1 or more of the statutory priority populations	70%	70%	--	--	--	79%	67%

[1] 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. Data updated for previous years to increase accuracy by removing vital statistics "refusal to be contacted" removed numbers.
[2] PSQ is a brief, confidential survey taken by all WHH enrolled clients that explores their satisfaction with the program/nurse.
-- indicates data not available due to new evidence-based home visiting model implementation and identification of new metrics.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1+Q2**	**2022 Q3+Q4**	**2023 Q1+Q2**	**2023 Q3+Q4**
OUTPUTS									
1. % and # currently employed WHH nurses versus total WHH nurse positions available[1]	--	--	84.4% 49/58	89.6% 52/58	74.1% 43/59	N/A*	N/A*	78.8% 46.5/ 59	75.4% 44.5/ 59
2. % and # of prenatal WHH clients enrolled in the program[2]	--	--	43% 52/122	42% 236/ 562	33% 173 / 521	36% 92/ 257	47% 144/ 305	32% 87/ 271	34% 86/ 250
3. % and # of postnatal[3] WHH clients enrolled in the program[2]	--	--	57% 70/122	58% 326/ 562	67% 348 / 521	64% 165/ 257	53% 161/ 305	68% 184/ 271	66% 164/ 250
EFFICIENCIES									
1. Average TANF cost to train a Maternal Child Health (MCH) nurse	$5,986.70	$2,732.70	$4,723.30	$3,787.95	$4,500	N/A*	N/A*	N/A*	N/A*
2. % of the average # of current WHH clients versus current staff caseload capacity**	--	--	--	--	80% 539/674	--	--	79.3% 537/676.5	80.5% 541/671.5

Public Health Nursing Home Visitation Program

[1]All MCH staff until SFY 2022 when MECSH launched. Then some staff are MCH only and do not provide MECSH HV services.
[2]# Prenatal and Postnatal enrollments may include duplicates
[3] Postnatal period is considered birth to 8 weeks post-infant discharge from hospital.
N/A* indicates data not available on a quarterly basis
-- indicates data not available due to new evidence-based home visiting model implementation
** new efficiency to breakdown capacity issues in any given quarter.

Story Behind the Performance

In accordance with Wyo. Stats. §§ 35-27-101 – 104, the PHN Unit provides a statewide home visitation program that is available in all 23 counties. These services are provided by specially trained public health nurses located in local PHN offices and health departments.

Wyoming Hand in Hand (WHH), also known as Wyoming Maternal Early Childhood Sustained Home Visiting (MECSH), began a staggered rollout beginning March 1, 2021 with full statewide implementation occurring by July 1, 2021. As of July 1, 2021, WHH became the sole home visitation model, replacing both Nurse Family Partnership (NFP) and Best Beginnings. MECSH is an approved HomVEE (Home Visiting Evidence of Effectiveness) evidence-based model developed by Western Sydney University in Australia. Wyoming was the third state, out of four, in the U.S. to implement MECSH.

Performance Notes:

For outcome 1, the target continues to be unmet in SFY 2023 due to the following reasons: nurse shortage (64%), no client response or unable to reach (10%), contacted with previous referral (19.8%). Continued nurse shortage is of particular concern as there are several counties with frequent turnover. There are two counties that have had open MCH nurse positions for more than a year and have been unable to provide home visiting services in those communities.

For outcome 2, the target is a fidelity measure set by Western Sydney University. In 2021, the percentage was high due to the large number of clients that were transferred into MECSH from the previous Best Beginnings model. In 2022 and 2023, there has been a static decline. The reasons for not meeting this target are multifaceted and dependent on community. PHN does not have adequate staff capacity to enroll 75% of the referral population. Maximum client capacity with all positions fully staffed and trained is 873 but referrals for eligible clients far exceed this.

For outcome 3, the PSQ measures the client's satisfaction with WHH in five combined areas to create an overall average. The target is a range of ≥ 80%. Areas assessed are: communication between the nurse/client (98%), general program satisfaction (97%), interpersonal manner (88%), times spent (96%), and accessibility and convenience (96%).

For outcome 4, the priority populations are directly from the PHN home visiting statute (Wyo. Stats. §§ 35-27-101 – 104). The 2024 Target is set at 70% to support nursing staff capacity and fidelity to the MECSH model by serving a variety of families. Nurses that service the majority of high risk and high intensity families are at higher risk of experiencing burnout and compassion fatigue.

For output 1, staffing and turnover are monitored annually via PHN MCH mentorship. Turnover rates were not tracked quarterly until SFY 2023.

Output 2 and 3 should be looked at in conjunction with each other. The MECSH target for prenatal enrollments is 80%, leaving 20% for postnatal. It is a desired change to see prenatal enrollments increasing, resulting in postnatal enrollments decreasing. Most referral sources are postnatal lending to the majority of families enrolling postnatally.

Efficiency 1, numbers are monitored via the MCH mentorship in conjunction with the MECSH dashboard provided by Western Sydney University. Training for home visiting nurses includes MCH mentorship, lactation counselor training and MECSH program training. Costs are determined by calculating the following: average nurse salary, MECSH training costs, mentorship per hour cost, and lactation training costs.

Efficiency 2 is a new metric to better capture the average current caseload versus the average caseload maximum capacity.

Substance Use Prevention Program

Program Description

The Substance Use Prevention Program (SUPP) uses evidence-based strategies to prevent excessive alcohol use, opioid misuse, and other drug misuse.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$3,932,666	$3,276,787	$3,610,006
People Served	576,851	578,803	581,381
Cost per Person	$6.82	$5.66	$6.21
Non-600 Series*	37%	34%	34%

* 600 series is defined as direct service contracts.

Program Cost Notes

- Funded by Federal Funds and Tobacco Settlement Funds.
- Federal Funds make up a majority of the budget and include the Substance Use Prevention, Treatment and Recovery Block Grant, and the Strategic Prevention Framework Partnership for Success.
- SUPP received an additional $786,881 in COVID-19 Relief and an additional $679,580 in ARPA funding through the Substance Abuse Prevention and Treatment Block Grant. This funding is being used to expand substance use prevention in communities, to support strategic planning for the program, and to increase data collection and reporting.
- SFY2021 and 2022 costs are updated in this snapshot. Prior year snapshots mistakenly included non-SUPP related funding provided to communities through the Community Prevention Grant. Expenditures above are specific to the SUPP only.

Program Staffing

- 2 FTE
- 1 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 over the course of their lives. Cost savings like this happen every year showing that prevention in Wyoming is successful in avoiding future alcohol use disorders.

Substance Use Prevention Program

Events that Have Shaped the Program

- As part of the reorganization of the Community Prevention Unit in 2021, the Substance Use Prevention Programs and the Tobacco Prevention and Control Programs were merged into the Substance Use and Tobacco Prevention Program.
- As of SFY 2019, funding for community prevention grants for substance use, tobacco prevention and control, and suicide prevention is distributed to county governments.
- Since 2001, Wyoming communities have pursued a comprehensive approach to preventing underage alcohol use, adult overconsumption of alcohol, and other substance abuse through evidence-based strategies with preference given to strategies that impact the entire population.
- An epidemiologist began supporting the program in SFY 2019.
- 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.
- Wyo. Stats. §§ 35-4-901–906 allows pharmacists to prescribe an opiate antagonist, like naloxone, and allows standing orders for opiate antagonists.

Substance Use Prevention Program

Program Core Purpose

The Substance Use Prevention Program (SUPP) uses evidence-based strategies to prevent overconsumption of alcohol, opioid misuse/abuse, and other drug use in Wyoming.

OUTCOMES							
Performance Metric	**2023 Target**	**2024 Target**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
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)	17%	16%	17.7% (16.8%)	16.4% (15.7%)	15.9% (15.4%)	18.4% (-)	(-)
Adult Heavy Drinking Percentage of Wyoming adults who report drinking 2 or more drinks per day (1 or more drink for woman) per week[1](national prevalence)	7%	6%	6.5% (6.5%)	6.3% (6.7%)	6.7% (6.2%)	8.1% (-)	(-)
Alcohol Fatal Crashes Percentage of fatal crashes with a blood alcohol content (BAC) of .08 or higher[3] (national rate)	25%	25%	25% (28%)	29% (30%)	34% (31%)	(-)	(-)
Youth Prevalence Percentage of Wyoming high school students who have consumed alcohol within the past 30 days[2]	24%	24%	(-)	27.78% **	(-)	25.4%	(-)
Opioid Overdose Death Crude rate per 100,000 of overdose deaths from prescription and illicit opioids[4] (national rate)	12	12	7.9 (15.0)	10.4 (20.6)	11.9 (24.0)	13.9 (24.5*)	(-)
Opioid ER Rate Crude rate per 100,000 of opioid overdose emergency room discharges from prescription, illicit, and unspecified opioids[5]	18	18	18.3	18.5	20.9	(-)	(-)

(-) Indicates data not yet available.
*Provisional National Vital Records Data.
[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. Due to incomplete reporting, caution should be used when comparing 2020 to other years..
**The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted.

Substance Use Prevention Program

OUTPUTS AND EFFICIENCIES									
Performance Metric	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023 YTD**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4 YTD**
OUTPUTS									
Beverage server trainings - # of people Training for Intervention Procedure (TIPS) certified (3 year certificate)	4,401	2,350	1,505	1,899	1,914	1,094	805	1,307	607
Alcohol compliance checks with no infractions	87% (1,068/ 1,222)	88.4% (882/ 999)	85.6% (887/ 1,036)	88.7% (987/ 1,113)	89.5% (905/ 1,011)	N/A*	N/A*	N/A*	N/A*
Number of participants reached through the Community Prevention Grant (SFY) as reported through PERC (ended June 30, 2023)	885	2,314	2,964	8,106	9,970	4,113	3,993	9,970	N/A
Number of participants reached through the Community Prevention Grant (SFY) as reported through PRES - launched July 1, 2023)	N/A	N/A	N/A	N/A	26,624	N/A	N/A	N/A	26,624 ***
Number of Community Prevention Grant recipients reporting on number of participants reached **	15	10	14	22	23	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
Prevention Needs Assessment Survey, cost per school district	(-)	$8,097 [$283,400 /35]	(-)	$6,441 [$283,400 / 44]	(-)	N/A*	N/A*	N/A*	N/A*
Community Prevention Grant, cost per person served as reported	BFY19/20 $1,104.32 ($3,532,706.42/ 3,199)		BFY21/22 $369.42 (4,089,469/ 11,070)		(-)	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.
^TIPS was recently bought by 360 Training and has a new data reporting system. The data now indicates the number of people trained in one year.
** Reworded due to change in reporting system
*** As of 11/15/23

Tobacco Prevention and Control Program

SFY 2023 Program Snapshot

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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$3,596,071	$3,109,617	$3,344,981
People Served	576,851	578,803	581,381
Cost per Person	$6.23	$5.37	$5.75
Non-600 Series*	78%	61%	68%

*600 series is defined as direct service contracts.

Program Cost Notes

- Total program cost varies from year to year due to differences in federal funding awarded and community prevention grant spending.

Program Staffing

- 3 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Smoking costs the state $258 million in direct healthcare costs (Preventive Medicine, 2021).
- 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).
- Wyoming currently has high rates of youth vaping that are greater than the national trend. In 2022, 24.4% of Wyoming high school students vaped in the past 30-days (Prevention Needs Assessment).

Events that Have Shaped the Program

- As part of the reorganization of the Community Prevention Unit in 2021, the Substance Use Prevention Programs and the Tobacco Prevention and Control Programs were merged into the Substance Use and Tobacco Prevention Program.
- Tobacco is the leading preventable cause of death and chronic disease in the United States, leading to more than 800 Wyoming deaths annually.
- Wyo. Stats. §§ 9-4-1203 – 1204 require the Wyoming Department of Health 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 and Prevention'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 SFY 2019, funding for community prevention grants for substance use, tobacco prevention and control, and suicide prevention is distributed to county governments.
- An epidemiologist began supporting the program in SFY 2019.
- In December 2019, the federal minimum age to purchase tobacco products was raised from 18 to 21. During the 2020 Budget Session, Wyo. Stat. § 14-3-302 was updated to prohibit the sale of nicotine products to any person under the age of 21 years.

Tobacco Prevention and Control Program

Program Core Purpose
To reduce tobacco use in Wyoming.

OUTCOMES

Performance Metric	2023 Target	2024 Target	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
% of Wyoming employed adults surveyed who report that smoking is never allowed in indoor areas of their workplace[2]	90%	91%	87%	*	89%	*	-
% of Wyoming adults surveyed who currently smoke[1] (national average)	15%	14%	18.4% (16.0%)	18.5% (15.5%)	16.4% (14.4%)	15.5% (-)	-
% of Wyoming high school students surveyed who smoked cigarettes on one or more of the past 30 days[5]	4%	3%	*	7.6%**	*	4.1%	*
% of Wyoming high school students surveyed who vaped on one or more of the past 30 days[5]	24%	22%	*	31.2%**	*	24.4%***	*

- Indicates data not yet available.
* Intervening years between survey dates, or periods for which there is no data.
** The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted. Caution should be used when making comparisons between 2020 and previous survey years.
***Due to the impacts of COVID-19 in CY2020 and a change in wording on survey questions for vaping in CY2020, caution should be used when comparing CY2022 to previous survey years.

Footnotes
[1]BRFSS – Behavioral Risk Factor Surveillance System (Adults)
[2]ATS – Adult Tobacco Survey
[5]PNA – Prevention Needs Assessment (Youth – Wyoming specific)

OUTPUTS & EFFICIENCIES

Performance Metric		CY 2019	CY 2020	CY 2021	CY 2022	CY 2023 YTD	2022 Q1+Q2	2022 Q3+Q4	2023 Q1+Q2	2023 Q3+Q4 YTD
OUTPUTS										
WQT [3] (Wyoming Quit Tobacco) Enrollments	Total	2,634	2,116	2,364	1,886	1,961	1,056	812	1,151	802

	Pregnant Women (Opted into Pregnancy Program)	20	10	7	7	8	4	3	3	5
	American Indian Commercial Tobacco Program	17	11	12	18	24	8	10	12	12
# of Healthcare Provider Referrals to WQT [3*]		758	451	458	273	276	159	114	87	189
Media Impressions[4] (mass, digital, social) (SFY)		34.6M	42M	11M	23M	14.2M	NA*	NA*	NA*	NA*
# of policies implemented in communities[6]		13	6	3	6	5	0	6	4	1
EFFICIENCIES										
Average cost per WQT enrollee		$316 ($833,273 /2,634)	$394 ($833,273 /2,116)	$352 ($833,273 /2,364)	$441 ($833,273 /1,886)	(-)	NA*	NA*	NA*	NA*

(-) Data is currently unavailable
NA* indicates data not available on a quarterly basis
*Numbers reported are higher than previous years as we are now including e-referrals and have switched to date closed

Footnotes
[3]NJH – National Jewish Health WQT enrollment reports
[4]Warehouse Twenty-One – Media analytics and metrics reports
[6]PERC – Reporting system for County Prevention Grant work

Story Behind the Performance

- Through a collaborative effort with the Injury and Violence Prevention Program, the Substance Use and Tobacco Prevention Program provides funding to Wyoming counties for alcohol, tobacco, substance, and suicide prevention activities. The grant program is in its third two-year grant cycle. Metrics in future HealthStat documents will be updated to reflect outcomes for this grant program as data becomes available.

Trends:

- The percentage of Wyoming adults who report that smoking is never allowed in indoor areas of their workplace has remained above 80% (2006-2019)[2]. In 2021, 18% of Wyoming adults reported being exposed to second-hand smoke at their workplace (men, adults aged 25 - 34, and those without higher education were most likely to be exposed to secondhand smoke at work).[2.]
- The percentage of Wyoming high school students who smoked cigarettes on one or more of the past 30 days has decreased from 26% in 2001 to 4.1% in 2022.[5]
- The majority of Wyoming adults support smoke free laws for indoor workplaces (84%) and restaurants (82%). Additionally, 77% of adults support banning smoking in all indoor workplaces (2021 ATS).[2]

- Youth use of emerging tobacco products, such as e-cigarettes, have been an increasing concern. Wyoming high school students who have vaped one or more times in the last 30 days has decreased from 36.11% in 2018, to 24.4% in 2022.[5]

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 are obtained through the PNA, which is Wyoming-specific, and there is no longer a national comparison.
- While the youth smoking rate is 4.1%, the youth e-cigarette use rate is 24.4% (2022 PNA).
- The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted. Caution should be used when making comparisons between 2020 and other survey years.

Value added to the WQT:

- The WQT has been able to sustain offering up to twelve (12) weeks of free Nicotine Replacement Therapy (NRT) to any Wyomingite that seeks cessation through the quitline.
- Protocols specific to Native Americans, pregnant women, and those with behavioral health issues (anxiety, depression) are available to address disparities in smoking rates in these populations.

Current Efforts:

- In 2021, strategic marketing utilizing digital, radio, and newspaper media was used to promote the WQT and a youth vape prevention campaign, kNOw vape.
- Collaboration with Medicaid for ongoing reimbursement of coaching calls Medicaid clients receive from the WQT.
- WQT was rebranded to be more modern and inclusive of a more diverse audience.
- WQT continues to provide services tailored to certain populations including American Indians, pregnant women, youth, and those with behavioral health conditions.

Sources:

[2]ATS – Adult Tobacco Survey
[5]PNA – Prevention Needs Assessment (Youth – Wyoming specific)

Women and Infant Health Program

SFY 2023 Program Snapshot

Program Description

The Women and Infant Health Program (WIHP) facilitates access to care and promotes the health of women (15-44 years old) and health of infants (0-1 year old). The program strives to improve outcomes related to safe sleep, well woman visits, maternal mortality, maternal smoking, pre and early term birth, and infant mortality.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$1,067,024	$1,156,933^	$1,487,518^
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	15%	20%	8.55%

^ The increased expenditures between 2022 and 2023 are most likely due to consistent staffing in the program and the implementation of program grants and contracts.
* 600 series is defined as direct service contracts.

Program Cost Notes

- The program is funded by State General Funds, Title V Maternal and Child Health Services Block Grant funds, and Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant funds. State general funds are used as required state match and maintenance of effort for the Title V grant.
- The program provides funding and technical assistance to support Public Health Nursing (PHN) implementation of the Wyoming Hand in Hand Home Visitation Program. People served, performance metrics for the Hand in Hand Visitation Program, and additional federal funding are reported through the PHN Home Visitation HealthStat documents.
- The program provides leadership and funding for the Wyoming Perinatal Quality Collaborative (WyPQC), a multi-disciplinary, statewide network that seeks to improve perinatal health care and access for women and infants in Wyoming.

Program Staffing

- 2.0 FTE
- 0 AWEC
- 0 Other

Program Metrics

- From 2010 to 2021, the prevalence of pregnant women smoking has decreased from 19.1% to 9.8%. This prevalence remains higher than the national prevalence for all years.
- From 2010 to 2021, the prevalence of women who received an annual preventive visit from a provider increased from 54.2% to 67.6%. This prevalence remains lower than the national prevalence for all years.
- From 2016 to 2021, the prevalence of infants placed to sleep without soft objects or loose bedding increased from 28.6% to 50.1%. This prevalence remains lower than the national prevalence for all years.

Events that Have Shaped the Program

- In 2020, the Maternal and Child Health (MCH) Unit completed the Title V Needs Assessment leading to the development and adoption of 2021-2025 MCH priorities. The priorities which directly relate to the Women and Infant Health Program include: (1) Prevent Maternal Mortality and (2) Prevent Infant Mortality.

- In 2020, an internal restructure moved Newborn Screening/Genetics to the Children and Youth with Special Health Care Needs Program, where the process of testing and then referral to case management could be streamlined within one program.

- In 2019, Wyoming partnered with Utah to conduct a joint Maternal Mortality Review Committee (MMRC) which reviews all Maternal Mortality cases, this includes all deaths during pregnancy and up to one year postpartum. Currently, the MMRC has finished reviewing cases from 2018-2021 and is now working on cases from 2022.

- In 2023, the first Wyoming MMRC report and recommendations was released. The report looks at all MMRC data collected for 2018-2020 cases, including contributing factors and preventability.

Women and Infant Health Program

Program Core Purpose

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

OUTCOMES							
Performance Metric	**2023 Target^**	**2024 Target^**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
% of women, ages 18-44, with a preventive medical visit in the past year[1]	66.5%	68.9%	64.6% (US: 72.8%)	65.1% (US: 71.2%)	67.6% (US: 69.7%)	(-)	(-)
% of infants placed to sleep on a separate approved sleep surface[2]	34.4%	35.3%	30.4% (US: 35.9%)	31.4% (US: 36.9%)	32.6% (US: 37.8%)	(-)	(-)
% of infants placed to sleep without soft objects or loose bedding[2]	59.0%	62.0%	37.1% (US: 50.9%)	45.7% (US: 52.5%)	50.1% (US: 55.8%)	(-)	(-)
% of women that smoked at anytime during pregnancy[3]	6.5%	5.5%	13.6% 855/ 6,266	12.5% 735/ 5,894	9.8% 583/ 5,949	9.3% 545/ 5,862*	(-)
% and # of infants born preterm (<37 weeks)[4]	9%	9%	9.8% 642/ 6,535	10.0% 610/ 6,103	10.8% 669/ 6,190	10.3% 618/ 6,012	(-)

(-) Indicates data not yet available.
*This data is provisional and subject to change once finalized.
^ These targets represent the trajectory of change over time the programming is moving toward and the same yearly targets reported to Title V.
[1] Data from the Behavioral Risk Factors Surveillance System (BRFSS).
[2] Data from the Pregnancy Risk Assessment Monitoring System (PRAMS).
[3] Data from National Vital Statistics Services (NVSS).
[4] Data from Wyoming Vital Statistics Services (WYVSS).

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of pregnant women enrolled in Wyoming Tobacco Quit Line*	20	10	7	7	8 (YTD)	4	3	3	5 (TD)
Cumulative # of women ages 18-44 enrolled in the Maternal and Child Health (MCH) & Wyoming Cancer Program	N/A*	N/A*	N/A*	N/A*	8	N/A*	N/A*	1	8
# of hours spent on case abstraction for Maternal Mortality Review (MMR)	N/A*	N/A*	113	226	196	N/A**	N/A**	N/A**	N/A**
EFFICIENCIES									
Average cost per MMR case abstracted[1]	N/A*	N/A*	$2,15^	$1,346	$1,544	N/A**	N/A**	N/A**	N/A**

(-) Indicates data not yet available.
N/A* indicates data not available due to new metric.
N/A** data not available on a quarterly basis.
* The Quitline data is reported per Calendar Year by the Quitline provider and Tobacco Prevention and Control Program.
^ Initial cost of case abstraction for SFY 2020 was due to training and onboarding.
[1]Due to small numbers in relation to maternal mortality cases the numerator and denominator are not shared.

Story Behind the Performance

- In 2020, the MCH Unit completed a new five-year needs assessment. This document reflects new performance measures that align with the 2021-2025 priorities developed based on the needs assessment. Current measures include % of women ages 18-44 receiving a preventive medical visit in the last year, % of infants placed to sleep on a separate approved sleep surface, and % of infants placed to sleep without soft objects or loose bedding.
- WIHP funds and supports the Public Health Nursing Hand in Hand home visiting program's current efforts to improve smoking cessation of pregnant and postpartum women through referrals. Home visitors, in every county, are supplied with pamphlets, quit kits, and motivational interviewing training to better support this effort. Successful referrals of pregnant women to the Quitline are reflected in outcome #4.
- The WIHP supported efforts to improve safe sleep outcomes through distribution of an evidence-based safe sleep book *Sleep Baby, Safe and Snug*. Books are currently available in every county through the Women, Infants, and Children (WIC) Unit, Hand in Hand Program, and Parents as Teachers. Since 2022, over 3,500 books have been distributed.
- The WIHP collaborates with and provides funding support to the Wyoming Cancer Program. This joint effort aims to increase the rate of women of reproductive age (ages 15-44) completing an annual preventive visit

by paying for life saving screening services for women that are either underinsured or uninsured, this is reflected in outcome #1.

- The WIHP partners with the Utah Department of Health to review maternal deaths as part of a cross-state maternal mortality review committee (MMRC). As of April 2023, all cases from 2018-2021 were abstracted and reviewed by the MMRC. As of 2022, all maternal mortality cases will be reviewed within one year of identification date.

Women, Infants, and Children (WIC) Program

SFY 2023 Program Snapshot

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

	2021	2022	2023
Total Program Cost	$8,435,060	$9,123,550	$10,836,940
People Served*	11,658	11,612	11,749
Cost per Person	$726.12	$785.70	$922.37
Non-600 Series**	18%	19%	21%

* People served is an unduplicated count of individuals served in the federal fiscal year.
** 600 series is defined as direct service contracts.

Program Cost Notes

- Total BFY 23 budget of $24,601,764 includes 7% GF, 73% FF, and 20% infant formula rebates.
- 2023 program cost increased due to the additional Cash Value Benefit for fruits and vegetables authorized and required by USDA/FNS, increase in participants, and increased food costs. The FFY 2023 benefits increased from $9 to $25 for children, and from $11 to $44 and $49 for women (higher amount for fully breastfeeding women).

Program Staffing

- 44 Total FTE (12.5 state office, 31.5 local agencies)
  - 39 state positions: 18 FT; 9 PT; 12 AWEC
  - 11 county positions: 4 FT; 7 PT
  - 8 hospital positions: 4 FT; 4 PT

Program Metrics

- From 2020-2022, an average of 6,980 pregnant, postpartum, and breastfeeding women, infants, and young children were served each month by WIC. In SFY2023, an average of 7,154 pregnant, postpartum, and breastfeeding women, infants, and young children were served each month by WIC.
- Approximately half of all babies born in Wyoming, and the nation, are eligible to receive WIC services.
- Seventy-five retail grocers are contracted in Wyoming to redeem WIC participant food benefits.
- Wyoming WIC received the U.S. Department of Agriculture (USDA), Food and Nutrition Services's (FNS) WIC Breastfeeding Performance Bonus Award for outstanding achievements in sustaining high breastfeeding rates among WIC participants during fiscal year 2022.
- National WIC Breastfeeding Data for states indicates that Wyoming WIC had the 7th highest fully breastfeeding rate in FFY22.

Women, Infants, and Children (WIC) Program

Events that Have Shaped the Program

- Wyoming was the first state to implement electronic benefit transfer (EBT) for delivery of food benefits, which is now mandated for all WIC programs (statewide by January 1, 2002).
- 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.
- Participation remained stable during the COVID-19 pandemic, despite having to issue benefits and provide education in a different manner.
- The 2022 infant formula recall had profound implications for the Wyoming WIC Program and its participants, leading to a series of adaptive and responsive measures. The recall created an increased workload for staff, who had to navigate the challenges of the shortage while continuing to effectively support participants. This involved finding alternative formula options, providing guidance to participants on safe feeding practices during the shortage, and liaising with manufacturers and other state agencies to ensure a steady formula supply. These adaptive measures highlighted the program's resilience and commitment to public health in challenging circumstances.

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

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% and # of survey respondents who said WIC breastfeeding information they received met their needs[1]	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	92.8% 1,218
% of cash value benefits spent on fresh fruits and vegetables by WIC participants[2]	70%	70%	71.3% ($485,031/ $679,842)	67.84% ($439,888/ $647,959)	63.11% ($461,971/ $733,443)	63.74% ($1,155,672/ $1,813,078)	70.43% ($1,408,657/ $2,000,195)
% of WIC infants who were ever breastfed (initiation)[3]	81%	81%	80%	81%	81%	79%	77%
% of WIC infants who are exclusively breastfeeding at 3 months[5]	45%	45%	32%	30%	25%	39%	49%

N/A* Indicates data not available due to new metric.

Footnote
Numbers 1 - 5 denote further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Average # of women served/month[4]	1,836	1,711	1,603	1,498	1,647	1,496	1,503	1,588	1,706
Average # of children (ages 1-5) served/month	4,118	3,843	3,732	3,621	3,916	3,652	3,622	3,853	3,979
Average # of infants (ages 0-1) served/month	1,837	1,735	1,653	1,536	1,591	1,535	1,540	1,542	1,640
Average # of nutrition education contacts/month	2,874	2,389	2,183	2,316	2,206	2,333	2,299	2,175	2,237
Average # of referrals documented/month	2,891	2,818	2,343	2,607	2,346	2,889	2,384	2,329	2,363

Women, Infants, and Children (WIC) Program

EFFICIENCIES									
Average food cost/participant/ month	$47.91 ($425,798/ 8,888)	$47.14 ($367,282/ 7,791)	$44.41 ($354,429/ 7,289)	$48.97 ($343,088/ 6,999)	$56.57 ($377,489/ 6,673)	$50.87 ($363,442/ 7,141)	$47.07 ($322,733/ 6,857)	$54.47 ($363,983/ 6,682)	$58.67[2] ($407,764/ 6,730)
Average nutrition education cost/participant/ month[6]	$6.50 ($54,564/ 88,513)	$6.02 ($45,819/ 7,607)	$6.70 ($48,396/ 7,227)	$7.15 ($49,296/ 6,896)	$8.31 ($55,397/ 6,664)	$4.55 ($32,189/ 7,077)	$9.89 ($66,402/ 6,714)	$8.63 ($57,430/ 6,652)	$7.68 ($51,331/ 6,688)

Footnote
Number 6 denotes further explanations provided in the Story Behind the Performance.

Story Behind the Performance

- WIC participant survey was modified in SFY2023. The prior first two outcomes are no longer tracked and one new outcome has been added. Therefore, SFY2023 response is the baseline for the new metric and targets will be identified in subsequent years.
- WIC continued to receive additional funding ($49 and $44 for women, up from $11, and $25 for children, up from $9) for fresh fruits and vegetables for FFY23.
- Slight decreases in SFY21 and SFY22 in the percent of WIC infants who were ever breastfed are likely due to limited physical contact with new WIC moms as a result of COVID-19. It was challenging to support breastfeeding moms remotely.
- 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. In SFY2022 and 2023 WIC has been able to increase outreach efforts. Additionally, a media campaign was conducted in Wyoming to raise awareness of WIC and the benefits of the program through one time grant funds through the Health Disparities grant. This campaign ran through SFY2023. In SFY2023, participation levels have been increasing from 6,794 in July, 2022 to 7,484 total participation in June, 2023. Likely these increases are a result of increasing food costs and increased outreach efforts.
- Changes in the WIC data system that collects breastfeeding data occurred in 2021. The data conversion and staff training on these changes likely contributed to the lower rate in 2021 and higher rates in 2022.
- Nutrition education cost per participant per month is calculated based upon the federal fiscal year (FFY) versus state fiscal year in order to better reflect accurate cost per participant. WIC is required to spend at least one-sixth of all nutrition services administration funds on nutrition education or be subject to funding penalties. FFY23 numbers are preliminary.

Wyoming Cancer Program

SFY 2023 Program Snapshot

Program Description

Wyoming Cancer Program (WCP) provides eligible Wyoming residents with screening assistance through the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP also known as BCC) and the Wyoming Colorectal Cancer Screening Program (WCCSP). WCP reimburses for cancer screenings and diagnostic services (mammograms, Pap tests, colonoscopies, and biopsies) for eligible low-income, uninsured, and underinsured clients. The Wyoming Cancer Program (WCP) also implements evidence-based interventions across the cancer continuum through the Wyoming Comprehensive Cancer Control Program (WCCCP), and provides radon testing kits to Wyoming residents at no cost through the Wyoming Radon Program (WRP).

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$2,260,387	$2,248,929	$2,245,461
People Served	2,438	3,401	1,733+
Cost per Person	$927.52	$661.25	TBD
Non-600 Series*	52%	48%	55%

* 600 series is defined as direct service contracts and grants.
+ This number is not final, as providers have up to 12 months after providing services to submit a claim.

Program Cost Notes

- WBCCEDP activities are funded with federal, state general, and tobacco settlement funds.
- WCCSP activities are funded through state general and tobacco settlement funds.
- WCCCP activities are funded by federal and tobacco settlement funds.
- WRP activities are funded through the State Indoor Radon Grant by the Environmental Protection Agency.
- WCP receives funds for Patient Navigation Only projects through a partnership with Women's Breast Cancer Institute (WBCI), for those patients who are ineligible for our program but still need breast screenings.

Program Staffing

- 10 FTE
- 0 AWEC

Program Metrics

- WBCCEDP began in 1997. Since then, over 13,093 women have received clinical services, and 487 breast cancers, 55 cervical cancers, and 802 high-grade cervical pre-cancers have been detected.
- WCCCP began in 2004. Since then, the program has developed five 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.
- WCCSP began in 2007. Since then, 5,449 Wyoming residents have received colonoscopies; 53% had polyps removed, 42% had pre-cancerous polyps, and 99 had colon cancer.

Events that Have Shaped the Program

- WCP works under the Wyoming Cancer Control Act, Wyo. Stat. §§ 35-25 -203 through -205.
- Wyo. Stat. § 35-25-204 was amended during the 2023 Legislative Session. Program rules are currently being promulgated to reflect statutory change.
- The colorectal program has worked to extend coverage to include at-home stool-based testing options. In 2023, the program worked with Wyoming Medicaid to extend coverage for Medicaid recipients to include these at-home stool-based tests.
- In 2021, the program worked to extend coverage for underinsured individuals to assist with out-of-pocket costs remaining after primary insurance payment. In SYF 22, the program assisted 37 BCC insured enrollees (3.2% of total screened) and 24 COL insured enrollees (5.9% of total screened). In SFY 23, the program aided with 93 BCC insured enrollees (7% of total screened) and 51 COL insured enrollees (7.9% of total screened).
- WBCCEDP must comply with 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.

Program Core Purpose

The purpose of the Wyoming Cancer Program (WCP) is to provide eligible Wyoming residents with screening assistance through the Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP also known as BCC, a grantee of the NBCCEDP) and the Wyoming Colorectal Cancer Screening Program (WCCSP). The WCP reimburses for cancer screenings and diagnostic services (mammograms, Pap tests, colonoscopies and biopsies) for eligible low-income, uninsured, and underinsured clients. The Wyoming Cancer Program (WCP) also implements evidence-based interventions across the cancer continuum through the Wyoming Comprehensive Cancer Control Program (WCCCP) and provides radon testing kits to Wyoming residents at no cost through the Wyoming Radon Program (WRP).

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% of screened* by WBCCEDP[1] (# unduplicated screened/# enrolled)	80%	80%	72% (726/ 1,012)	47% (635/ 1,355)	61% (852/ 1,390)	72% (837/ 1,164)	64%+ (822/ 1,284)
% of screened* by WCCSP (# unduplicated screened/# enrolled)	39%	60%	46% (278/ 603)	50% (262/ 517)	40% (279/ 694)	43% (196/ 453)	25%+ (164/ 645)
% of completed home radon testing kits (# tested/# distributed)	65%	70%	27% (563/ 1,355)	92% (1,268/ 1,384)	66% (688/ 1,046)	62% (645/ 1,042)	49% (430/ 870)

* - Screened in this definition refers to 'clients served' by NBCCEDP definition, which includes clients screened and those diagnosed with cancer.
+ - Data is not final, as providers have up to 12 months after providing services to submit a claim.
1 - Outlines the total count of WBCCEDP clients receiving one or both types of screenings in that year.

Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-Q2**	**2022 Q3-Q4**	**2023 Q1-Q2**	**2023 Q3-Q4**
OUTPUTS									
# of outreach screening events completed	N/A	6	9	13	5+	N/A*	N/A*	N/A*	N/A*
# of people who received a cancer screening at a community event	N/A	867	568	1,796	98+	N/A*	N/A*	N/A*	N/A*
EFFICIENCIES									
% of clients whose time from breast cancer screening to diagnosis < 60 days	95.3% (80/84)	97.3% (142/146)	100% (24/24)	100% (19/19)	100% (21/21)	100% (14/14)	100% (5/5)	100% (9/9)	100% (12/12)
% of clients whose time from cervical cancer screening to diagnosis < 60 days	99.4% (12/13)	100% (36/36)	100% (15/15)	100% (13/13)	100% (21/21)	100% (7/7)	100% (6/6)	100% (11/11)	100% (10/10)
% of clients whose time from colorectal screening to diagnosis < 60 days	100% (6/6)	100% (2/2)	100% (3/3)	100% (4/4)	100% (0/0)	100% (3/3)	100% (1/1)	100% (0/0)	100% (0/0)

N/A indicates no data is available for this time period.
N/A* indicates data not available on a quarterly basis.
+ These numbers are not final as community grantees have until January of each year to submit their annual report.

Story Behind the Performance

- Outcome 1 data for SFY 2022 Performance Report contained duplicate information that has now been removed. SFY2023 reported data accounts for unduplicated individuals.
- Outcome 2 data for SFY 2020 and 2021 increased slightly due to previously denied claims being corrected and resubmitted.
- Outcome 3 data for SFY 2023 is specific to radon test kits purchased by the WCP. Data reported in prior years includes all test kits Alpha Energy distributed and tested for Wyoming addresses.

Efficiency

- The program reimburses for screening services at the Medicaid/Medicare rates, updating regularly, utilizing the Medicaid billing system and Medicaid enrollment processing. This shadowing process allows us to release the need for individual provider contracts and automates most billing, enabling staff to focus on data analysis and client relations.
- WBCCEDP has the highest CDC data rating with 0% error rate and full compliance with 12/12 core performance indicators.
- Wyoming's cancer screening rates relative to the population who enroll are overall very high: for breast cancer screening 77%BCC, 62.2% statewide; for cervical cancer screening 82% BCC, 66.8% statewide; and for colorectal cancer screening 40%WCCSP, 62% statewide. (Statewide statistics are from the 2020 BRFSS survey. Although this is not the most reliable barometer of statewide screenings, no other alternative exists to the BRFSS). The program published an interactive data map in 2022 that allows counties to assess their cancer screening rates and risk factors for members in their community.
- 100% client referrals to treatment for BCC, or counseling/case management for WCCSP clients, all under 60 days. CDC sets the standard for breast and cervical cancer screening to diagnosis at 60 days or less.

Current Actions

- Ongoing modernizations and streamlining of processes for provider billing.
- The program is currently in the process of many quality improvement projects geared toward increasing ease of access for patients and creating general efficiency from the level of enrollment to outreach events and provider relations.
- Previous metrics removed to more accurately reflect programmatic focus and alignment.

Youth and Young Adult Health Program

SFY 2023 Program Snapshot

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 adolescent motor vehicle safety, prevent adolescent suicide, and promote healthy and safe relationships among adolescents.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$550,618	$470,319	$841,757
People Served*	5,311^	1,711^	12,260
Cost per Person	$103.68	$274.88	$68.66
Non-600 Series**	34%	38%	46%

* People served are those who received direct services from the program. This count includes PREP participants, individuals receiving evidence-based RPE programming, individuals who participated in Teens in the Driver's Seat, and Sources of Strength training and programs, the number of adolescents (ages 12-24) served in pilot clinics, people receiving services funded by PHHSBG, and members of the young adult council.
^ Several pilot clinics completed the Adolescent-Centered Environment Assessment Process (ACE-AP) program and phased out in SFY 2021 as YAYAHP transitioned to new program priorities.
** 600 series is defined as direct service contracts.

Program Cost Notes

- 100% federally funded: Title V Maternal and Child Health Services Block Grant, Rape Prevention Education (RPE) Grant, Personal Responsibility Education Program (PREP) Grant, Preventive Health and Health Services Block Grant (PHHSBG), and Pediatric Mental Health Care Access Grant (PMHCA).
- The increase in program expenditures between SFY 2022 and SFY 2023 is due to a quality improvement initiative for PREP; SFY22 activities that weren't billed until SFY23; and implementation and billing of PMHCA. Activities initiated in SFY22 increased the reach of funded programs, so while the overall program cost increased, the cost per person served dropped significantly.

Program Staffing

- 1.0 FTE
- 0 AWEC
- 1.0 CDC PHAP

Program Metrics

- 82.7% of Wyoming high school students report having an adult in their community with whom they can talk about their problems. Youth-adult connectedness is an important protective factor for youth mental and physical health (Wyoming Prevention Needs Assessment, 2022).
- The Wyoming teen birth rate has decreased from 20.6 births per 1,000 in 2018 to 16.5 births per 1,000 in 2022. However, the Wyoming rate still remains higher than the U.S. rate (Wyoming and National Vital Statistics Services).
- In combined calendar years 2017-2021, the suicide rate among Wyoming residents 15 - 19 years was 29.83 per 100,000 (Wyoming Vital Statistics Services).
- The rate of hospitalization for non-fatal injury per 100,000 adolescents (10 - 19 years) was 235.0 in 2020, compared to 210.1 nationally.

Youth and Young Adult Health Program

Events that Have Shaped the Program

- In 2022, YAYAHP was assigned a CDC Public Health Associate (PHAP) to focus on the Personal Responsibility Education Program. The PHAP term ends October 2024.
- The YAYAHP maintains a collaborative relationship with the Wyoming Department of Education to support adolescent health in a student setting.
- In SFY 2021, YAYAHP initiated a new young adult health council. The council launched in July 2020 with 14 members ages 18-24. Members provide input to young adult health programs throughout the state.
- In 2020, the Maternal and Child Health (MCH) Unit completed the Title V Needs Assessment leading to the development and adoption of 2021-2025 MCH priorities. The priorities that directly relate to the YAHAP include: (1) Prevent Adolescent Suicide and (2) Promote Adolescent Motor Vehicle Safety.
- Wyoming does not participate in the Youth Risk Behavior Surveillance System (YRBSS), leaving a gap in data for youth and young adults. The YRBSS monitors health-risk behaviors that contribute to the leading causes of death and disability among youth and young adults.

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	CY 2023 Target	CY 2024 Target	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
% high school students reporting wearing a seatbelt always or most of the time[1]	77.5%[1]	77.5%[1]	N/A*	N/A*	N/A*	77.5%^	N/A
% students reporting an adult in their community with whom they can talk about their problems[1]	85%[1]	85%[1]	N/A	83%	N/A	82.7%	N/A
% 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]	80%	80%	73.2%~ (540/ 738)	71.2%~ (422/ 593)	72.6%~ (757/ 1,042)	71.8%+ (379/ 528)	70%+ (319/ 456)
Rate of births per 1,000 among 15 - 19 year old females[3] (national rate)	16.0	15.0	19.4 (16.7)	18.1 (15.4)	16.6 (13.9)	16.5 (13.5)	(-) (-)

Data Sources

[1] Prevention Needs Assessment (PNA). The PNA is offered in even-numbered years. The 2023 targets will remain at the 2022 level since the survey will not be administered again until 2024.

[2] WyPREP exit survey; denominator reflects only participants completing the exit survey and thus may not match the total number of participants.

[3] Wyoming and National Vital Statistics Service.

Footnotes

N/A* Indicates data not available due to the new metric.

N/A Indicates data not available.

^ 2022 is the first year this data was collected and serves as the baseline rate.

~ Reported on an academic calendar (September through August). The most significant COVID-19 impacts on participation are reflected in the CY 2020 reporting column.

+ Reported on the state fiscal year. YAYAHP shifted the Healthstat reporting calendar for WyPREP in 2022 to better align WyPREP data across reported program outcomes and outputs.

(-) Indicates data not yet available.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	2022 Q1-2	2022 Q3-4	2023 Q1-2	2023 Q3-4
OUTPUTS									
# of individuals participating in evidence-based programming through the Rape Prevention Education (RPE) grant	N/A	816	819	617	100	N/A**	N/A**	N/A**	N/A**

# of WyPREP implementing sites	9	9	10	6	6	N/A**	N/A**	N/A**	N/A**
# of schools implementing YAYAHP-funded evidence-based teen driver safety programming~	N/A*	N/A*	N/A*	1	0	N/A**	N/A**	N/A**	N/A**
EFFICIENCIES									
Dollars spent per individual youth receiving personal responsibility and adult preparation education through the WyPREP program	$123 $134,322 /1,090+	$129 $92,743 /720+	$217 $133,213/ 613+	$196 $103,541 /528^	$256# $117,094 /456^	N/A**	N/A**	N/A**	N/A**

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.
+ The reporting year for the number of individuals served by the WyPREP program is based on a 12-month period from April 1st through March 31st. The most significant COVID-19 impacts on participation are reflected in the SFY 2021 reporting column.
^ The reporting year for the number of individuals served by the WyPREP program aligns with the state fiscal year. YAYAHP shifted the Healthstat reporting calendar for WyPREP in 2022 to better align WyPREP data with other program outputs already reported on the state fiscal year. Participation counts in the denominator are pulled from student exit surveys, and may be an under count of total participation.
~ YAYAHP implements Teens in the Driver's Seat as the evidence-based teen driver safety program.
# The increase in cost per participant in SFY23 is partly due to expenditures stemming from a quality improvement project initiated in SFY22.

Story Behind the Performance

The priorities of the YAYAHP are to promote adolescent motor vehicle safety and prevent adolescent suicide. These priorities were determined by the Maternal and Child Health (MCH) Unit Title V Needs Assessment in 2020. The YAYAHP also works to promote healthy and safe relationships among adolescents through the WyPREP and RPE programs. The YAYAHP works in partnership across the department and with other state agencies to drive improvement on these priorities, including partnering with key stakeholders in the Healthcare Financing Division, the Wyoming Department of Education, and the Wyoming Department of Transportation.

- The Prevention Needs Assessment (PNA) survey is sponsored by the Wyoming Department of Health and distributed by participating school districts. 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 risky behaviors. It is administered in even-numbered years to 6th, 8th, 10th, and 12th graders in Wyoming. The YAYAHP measures students reporting having an adult in their community with whom they can talk about their problems, known as "connectedness," because connectedness is protective against a wide variety of health and wellness concerns. The YAYAHP added a measure of seatbelt use, which was first assessed on the 2022 PNA.
- The YAYAHP administers the Wyoming Personal Responsibility Program (WyPREP) in Wyoming. WyPREP supports the delivery of evidence-based comprehensive reproductive health and adult preparation education curricula to adolescents in middle and high schools and other youth-serving organizations. The goal of WyPREP is to prevent teen pregnancy and reduce the rate of STI/HIV. The peer pressure performance measure only includes participants that had parental consent and student assent to complete the WyPREP Exit Survey. Different reporting calendars capture COVID-19 impacts due to school closures in different reporting years - CY 2020 for WyPREP outcomes, and SFY 2021 column for efficiencies and outputs.

- The Rape Prevention Education (RPE) grant focuses on primary prevention of sexual violence with a specific emphasis on youth and young adults (12-24 years old). The Wyoming Coalition against Domestic Violence and Sexual Assault (WCADVSA), an RPE sub-recipient, works within communities to implement primary prevention activities. Federal reporting methodology changed in Fall 2019. As a result, the program began implementation of a new monthly reporting tool in February 2020. RPE funds activities on a 5-year cycle. The current cycle ends in January 2024, and a new funding cycle will begin in February 2024. The current 5-year cycle had a height of four funded local communities in SFY2020 and SFY2021, and has dropped to one funded local community in SFY2023 as communities have been phased out in anticipation of the end of the grant funding cycle.

- Teens in the Driver's Seat (TDS) is an evidence-based motor vehicle safety program focused on promoting and improving teen driver safety. YAYAHP implemented TDS for the first time during the 2021-2022 school year. YAYAHP paused implementation in the 2022-2023 school year to review challenges and develop an evaluation plan.

Community Services Program

FFY 2023 Program Snapshot

Program Description

The Community Services Program (CSP) administers the Community Services Block Grant (CSBG) through local governments, community action agencies, and community-based nonprofits that provide services directly or sub-contract with local service providers to assist low-income populations with an array of anti-poverty related health and human services. CSBG assists with items such as rent, utility bills, car repair bills, medical and insurance bills, training and school, gas cards, food cards, work clothing, etc.

Program Expenditures and People Served

	FFY 2021	FFY 2022	FFY 2023**
Total Program Cost	$3,464,238	$3,631,390	$3,687,590
People Served	8,398	8,072	NA**
Cost per Person	$412.51	$449.88	NA**
Non-600 Series*	$329,484	$368,759	$236,809
COVID-19 Response Cost	$1,622,455.00***	$1,278,427.58***	$329,085.26***

*600 series is defined as direct service contracts
**Data for FFY2023 not available until spring of 2024
***$3,397,776 was distributed to grantees to be spent across a three year period from FFY2021 to FFY2023 (Numbers corrected from prior years.)

Program Cost Notes

- 100% federal funding. Funding amounts change annually due to a federal formula and for each Wyoming county based on poverty data. Grantee award amounts are calculated using a state poverty formula, also known as an allocation chart.
- $3,687,590 for FFY2023 in CSBG dollars was received, and $4,683,350 in CARES Supplemental dollars was received (to be spent by September 2023).

Program Staffing

- 1.00 FTE
- 0 AWEC
- .25 FTE Contractor

Program Metrics

- CSBG Programs are statutorily required to collect, maintain, and report client demographic details, programmatic statistics, and fiscal data to the CSP.
- The CSP submits statutorily required annual reports to the Office of Community Services to measure year-over-year change.

Events that Have Shaped the Program

- CSBG allocations are determined for each county through a poverty formula which considers seven factors: low-income population, unemployment numbers, number of Medicaid recipients, SNAP (Supplemental Nutrition Assistance Program) recipients, Supplemental Security Income recipients, POWER recipients, and DFS applications recommended for assistance.
- Each county makes funding decisions through a Tripartite Board which consists of one-third elected officials, one-third members of the local community, and one-third representatives of low-income populations with lived experience. Tripartite Boards utilize the findings from the most recent Community Needs Assessments (required every 3 years) and annual public hearings to determine which services and programs to fund.
- Recipients of services funded by CSBG must normally meet financial eligibility of 125% of the FPL (Federal Poverty Level), or $33,125 for a family of four, however the FPL was changed to 200% in March of 2020, to account for the pandemic. This FPL has continued to date.
- $3,397,776 in CARES Supplemental dollars was distributed to grantees to be spent from FFY2021 to FFY2023.

Community Services Program

Program Core Purpose

To reduce the causes and conditions of poverty in Wyoming's communities.

OUTCOMES							
Performance Metric	**FFY 2023 Target**	**FFY 2024 Target**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
% of individuals and families that successfully achieved an outcome related to health and social/behavioral development.	90%	90%	85% (6,031/ 7,152)	80% (5,240/ 6,542)	90% (3,184/ 3,546)	92% (4,171/ 3,840)	N/A*
% of individuals and families that successfully achieved outcomes related to housing.	80%	80%	53% (2,817/ 5,338)	80% (3,260/ 4,025)	92% (3,461/ 3,753)	89% (3,718/ 4,139)	N/A*
% of individuals and families that successfully achieved an outcome related to education and cognitive development.	90%	90%	85% (1,390/ 1,640)	71% (414/ 579)	93% (348/ 375)	94% (247/ 262)	N/A*
# of community initiatives that produced outcomes in infrastructure and asset building.	2	1	0	1	1	1	N/A*
N/A* indicates finalized data not available until March 2024.							

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
% of grantees meeting the Organizational Standards at 70% or better	18% (3/17)	38% (6/16)	93% (14/15)	80% (12/15)	93% (14/15)	N/A*	N/A*	N/A*	N/A*
# of trainings and webinars the Community Services Network of Wyoming (CSNOW) & CSP provided to the network.	7	8	22	28	41	12	16	N/A*	N/A*
EFFICIENCIES									
Average cost per Community Needs Assessment (CNA)	$6,549 ($26,197/ 4 CNAs)	$6,167 ($37,000/ 6 CNAs)	$9,416 ($56,000/ 6 CNAs)	$10,000 ($70,000/ 7 CNAs)	$10,000 ($10,000/ 1 CNAs)	N/A*	N/A*	N/A*	N/A*
N/A* indicates data not available or tracked on a quarterly basis.									

Story Behind the Performance

- All metrics are reported on the Federal Fiscal Year (FFY) starting October 1st and ending September 30th. CSP data is not finalized and reported to the Office of Community Services (OCS) until March following the end of the previous FFY.

- The Community Services Block Grant (CSBG) provides services to all 23 counties in Wyoming to alleviate the causes and conditions of poverty and support the self-sufficiency of low-income populations. Ninety percent (90%) of Wyoming's CSBG funding is distributed directly to communities to meet the mission of CSBG through employment, education, training, income and asset building, housing, health and social/behavioral development, civic engagement domains, and through linkages with other social and human services.

- More specific National Performance Indicator (NPI) examples:
  Health and Social/Behavioral Development: In FFY 22, 4,171 individuals received health, social, behavioral support or services from the CSBG network. As a result, 92% (3,840) of individuals served demonstrated an improvement in their mental, social and behavioral health and well-being.
  Housing: In FFY 22, 4,139 individuals and families with low-incomes received housing support or services from the CSBG network. As a result, 88% (3,718) of individuals obtained safe and affordable housing.
  Education and Cognitive Development: In FFY 22, 262 individual youths and adults were provided support from the CSBG network for education and cognitive services. As a result, 94% (247) of individuals increased or improved their education and learning skills.

- The Sheridan Goose Creek Transit system, part of the Sheridan HUB, started in 2021 and was expanded and rebranded from a senior center transport system to a permanent bus route for the entire community in 2022. It grew to include 8 new buses, 32 stops, and pick-ups every 30 minutes. In 2023, they were successful in building 4 permanent bus shelters at the most utilized stops. Sheridan County reported they were able to leverage CSBG dollars to get more funding for the transportation system and are continuing to investigate ways to make the program sustainable.

- In 2015, the federal Office of Community Services (OCS) developed CSBG Organizational Standards for Community Action Agencies to provide a foundation of organizational capacity for all CSBG eligible entities across the nation. Wyoming eligible entities are required to provide and upload documentation for review by the CSP into the state-wide database, CAP60. In FFY 23, the state of Wyoming reached a 79% average for organization standards compliance, as compared to 70% the year before. Starting in FFY 24, the State minimum requirement of 70% will be increased to improve the overall expectation of organizational compliance and to work to achieve OCS's preferred goal of 100%.

- Eligible entities are required to have a CSBG Community Needs Assessment (CNA) completed every three years. CNAs may be supported through the use of CSBG funds. These CNAs are used by the Tripartite Boards to determine community needs and which services to provide to meet those needs. In 2023, the CSP received OCS's approval to suspend the 3-year CNA requirement for eligible entities, to align the scheduled with Critical Access Hospitals' Community Health Needs Assessments (CHNA), and to form regional CNA/CHNA cohorts with the intention of improving collaboration, efficiency and effectiveness in the process.

- The CSP tasked the Community Services Network of Wyoming to increase training and technical assistance provided to the eligible entities. This has resulted in an almost 70% increase in training provided and improved communication, organizational standards and program monitoring results.

Healthcare Preparedness Program

SFY 2023 Program Snapshot

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

	2021	2022	2023
Total Program Cost*	$943,008	$1,031,448	$989,036
People Served	576,851	578,803	581,381
Cost per Person	$1.63	$1.78	$1.70
Non-600 Series**	37.8%	36.1%	30.6%
COVID-19 Response Cost	$871,671	$181,004	$69,343

*Traditional, non-COVID-19-related program costs. These are considered typical costs. The cost per person served is calculated based on this total.
**600 series is defined as direct service contracts.

Program Cost Notes

- 100% federal funding
- Cooperative agreement with the U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response (ASPR).
- 10% match requirement primarily from healthcare coalitions.
- The program received two COVID-related administrative supplements totaling $1,129,359. No additional match was required.

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- HPP supports five healthcare coalitions (HCC) which, in turn, assist over 200 healthcare facilities throughout Wyoming.
- All five healthcare coalitions met all contract deliverables during SFY2022.
- HPP oversees the Hospital Available Beds for Emergencies and Disasters and the Wyoming Activation of Volunteer in Emergencies programs.
- The Administration for Strategic Preparedness & Response 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 the Program

- Federal funding for this program became available after the events of September 11, 2001.
- 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.
- In March 2020, a Public Health Emergency and a Presidential Emergency Declaration were issued due to the COVID-19 pandemic. The HPP provided assistance in the response by activating its emergency caches and provided technical assistance to the healthcare community. The HCCs held weekly calls with hospital members. In addition, HPP assisted Wyoming hospitals with scarce resources, expanding hospital capacity, medical equipment and resources such as ventilators, cardiac monitors, and staffing support. On May 15, 2023, the Public Health Emergency was lifted.

Healthcare Preparedness Program

Program Core Purpose

The Healthcare Preparedness Program (HPP) enhances the capacities and capabilities of healthcare entities and communities in the management of public health and medical emergencies by exercising and improving all-hazards preparedness plans, improving surge capacity, and enhancing healthcare system readiness.[1]

OUTCOMES							
Performance Metric*	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% of essential member agencies participating in a healthcare coalition (HCC)[1]	75%	75%	75%	75%	91%	82%	86%
% of other potential member agencies participating in a HCC[2]	30%	30%	22%	24%	28%	42%	34%
% EMS and nursing home member agencies with a disaster plan or emergency operations plan.[3]	N/A	30%	N/A	N/A	N/A	N/A	84%
% of acute care hospitals reporting bed availability daily	100%	100%	35%	81%	100%	100%	100%

*Outcome data show percentages only in order to provide more consistent results.

Footnote
Numbers 1 - 3 denote further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Recipient-Level Direct Cost[4]	$89,880	$90,237	$86,891	$93,848	$99,657	$48,870	$44,978	$50,646	$49,011
Hospital reported gloves on hand[5,6]	N/A	-	5,550,465	5,139,441	4,282,445	5,883,036	5,139,441	4,079,819	4,282,445
Hospital reported gowns on hand[5,6]	N/A	139,056	617,522	429,596	341,940	474,192	429,596	368,064	341,940
Hospital reported facemasks on hand[5,6]	N/A	360,418	902,540	883,161	708,516	1,211,531	883,161	758,744	708,516
Hospital reported N95 respirators on hand[5,6]	N/A	N/A	348,020	388,664	361,603	420,043	388,664	370,344	361,603

Healthcare Preparedness Program

EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
Recipient-Level Direct Cost Ratio[4]	11.6%	9.8%	9.3%	9.3%	10.1%	14.0%	6.8%	13.7%	7.9%
Increase (decrease) in amount of hospital reported gloves from previous reporting period	N/A	N/A	-	(7.41%)	(16.7%)	6.0%	(12.6%)	(20.6%)	(16.7%)
Increase (decrease) in amount of hospital reported facemasks from previous reporting period	N/A	-	150.4%	(2.15%)	(19.8%)	34.2%	(27.1%)	(14.1%)	(19.8%)

N/A indicates data not available due to the creation of a new metric
- indicates data not available
Footnote
Numbers 4 - 6 denote further explanations provided in the Story Behind the Performance.

Story Behind the Performance

- Essential member agencies of a Healthcare Coalition are defined as Hospitals, Emergency Medical Services agencies, Emergency Management agencies, and Local Health Departments.
- 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.
- In November 2016, CMS published rules requiring nursing homes to develop emergency operations plans. The HPP program and the EMSC program are collaborating to increase the number of EMS agencies having emergency operations plans. This metric was added to determine if nursing homes or EMS agencies needed assistance in developing emergency operations plans.
- Recipient-Level Direct Cost (RLDC) is defined by the Administration for Strategic Preparedness & Response (ASPR) as personnel, fringe benefits, and travel. The maximum amount allowed for RLDC is 18% of the award. Recipient-Level Direct Cost ratio is the percentage of administrative costs divided by the total expenses. RLDC ratio must be no more than 15% of the award at the end of the grant period (SFY24).
- The program began collecting data on hospital personal protective equipment (PPE), except gloves, on February 20, 2020. Hospitals began reporting glove inventory on July 17, 2020. The numbers reported are the amount of each PPE item as reported by the hospitals as of June 30th and December 31st.
- On March 13, 2020, the day of the Presidential Declaration of Emergency, hospitals reported 33,631 gowns, 41,806 masks, and 21,782 N95 respirators. To highlight the effectiveness of the program, HPP was able to assist the hospitals to increase their "on-hand" supplies to the current levels.

Healthcare Workforce Recruitment, Retention, and Development Program

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

	2021	2022	2023
Total Program Cost	$313,319	$214,857	$235,232
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	29%	39%	42%

*600 series is defined as direct service contracts.

Program Cost Notes

- SFY23: 33% State General Funds (SGF) and 67% Federal Funds (FF)
- Significant reduction in expenditures and increase to non-direct service costs between SFY20 and SFY23 due to loss of remaining $244,000 per biennium in SGF for Wyoming Provider Recruitment Grant Program (PRGP) awards, $68,000 per year in SGF and $68,000 in FF for the Wyoming State Loan Repayment Program (WY-SLRP), and the 0.35 AWEC position as result of SFY2021 budget reductions.

Program Staffing

- 1 FTE
- 0 AWEC
- 0 Other

Program Metrics

- The Wyoming Healthcare Professional Loan Repayment Program (WHPLRP) provided awards to physicians, dentists, and other health professionals and was last funded in SFY15-16. A total of 286 awards were issued from 2006 and 2016.
- 28 WY-SLRP awards were issued between SFY15 and SFY20 to healthcare professionals practicing in designated Health Professional Shortage Areas. No awards were issued in SFY21 or SFY22 due to elimination of WY-SLRP funding as part of statewide budget reductions. WDH recently was awarded WY-SLRP funds for SFY23-SFY25 which do not require state matching funds. Matching funds will be required again beginning in SFY26. Five new awards were issued in late SFY23 and program payment expenditures for SFY23 and SFY24 awards will be reflected under SFY24.
- Between 2008 and 2019, the PRGP provided 41 awards to recruiting entities between 2008 and 2019 resulting in the successful recruitment of 19 healthcare providers statewide. Program funding was eliminated as part of statewide budget reductions in SFY21.

Events that Have Shaped the Program

- Wyo. Stat. § 9-2-118,119 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, increased the maximum allied healthcare professional WHPLRP award and expanded PRGP eligibility to non-physicians.

- As a result of agency-wide budget reductions for SFY17-18, funding for WHPLRP (100% tobacco settlement funds) was eliminated resulting in the loss of approximately 40 total awards; funding for PRGP ($400,000 SGF) was reduced to$244,000 for SFY17-18 and 19-20, and the remaining $244,000 was eliminated in SFY21 as part of additional statewide budget reductions. This results in the loss of approximately six PRGP awards/recruited providers per biennium.

- 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.

- The SORH 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. Funding is 50% federal and 50% state matching funds. Funding and budget authority for WY-SLRP was eliminated during SFY21 statewide budget reductions resulting in the loss of approximately 10 awards between SFY21-22. New federal funding was awarded for SFY23-25 which does not currently require matching funds; however, matching funds will be required again for SFY26.

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 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
# of physicians needed to eliminate primary care health professional shortage areas (HPSAs)[1]	≤ 24	≤ 24	24	24	26	24	24
# psychiatrists needed to eliminate mental health HPSAs[1]	≤ 25	≤ 25	25	25	21	28	28
# dentists needed to eliminate dental HPSAs[1]	≤ 5	≤ 5	5	5	8	8	8
# of obligated healthcare professionals in HPSAs (all disciplines)[2]	5	5	21	18	12	8	6

Footnote
Numbers 1 - 2 denote further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Loan Repayment Program (LRP) Amount awarded (# awards)[3]	$136,000 (5)	$112,000 (6)	0	0	$185,208 (5)	0	0	0	$185,208 (5)
Provider Recruitment Grant Program (PRGP) Amount awarded (# awards)[3]	$244,000 (6)	0	0	0	0	0	0	0	0
# of candidates placed[6]	13	9	8	16	13	2	14	7	6
# of new J-1 Visa Waivers[7]	6	5	4	4	4	1	3	2	2

Healthcare Workforce Recruitment, Retention, and Development Program

EFFICIENCIES									
% LRP Applicants Awarded (#awards/ #applications)[3]	56% (5/9)	46% (6/13)	-	-	26% (5/19)	N/A	N/A	N/A	N/A
LRP obligation completion rate by cohort[4]	100% (12/12)	75% (3/4)	80% (4/5)	100% (6/6)	-	N/A	N/A	N/A	N/A
PRGP recruitment rate by cohort[5]	33% (2/6)	-	-	-	-	N/A	N/A	N/A	N/A
Average cost per placement[6]	$6,407 ($83,287 /13)	$7,556 ($68,000 /9)	$8,000 ($64,000 /8)	$5,250 ($84,000 /16)	$7,692 ($100,000 /13)	$4,000 ($8,000 /2)	$5,429 ($76,000 /14)	$7,143 ($50,000 /7)	$8,333 ($50,000 /6)

N/A indicates data not available on a quarterly basis or for specific quarters indicated
- indicates data not available
Footnote
Numbers 3 - 7 denote further explanations provided in the Story Behind the Performance.

Story Behind the Performance

- 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.

- Obligated health professionals (OHPs) are those with an active service obligation during the corresponding fiscal year. For SFY2023 there are 6 OHPs practicing in HPSAs statewide (5 loan repayment recipients and 1 J-1 Visa Waiver physician), down from 8 for SFY2022. This decrease is a direct result of the elimination of funding for the Wyoming State Loan Repayment Program (WY-SLRP) during the 2021 legislative session.

- 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 has not been funded since SFY2017, PRGP's funding was reduced significantly for SFY2017, and the remaining funds were eliminated during the 2021 legislative session.

  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, mental health clinicians, dentists and registered dental hygienists, registered nurses, and pharmacists 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. No awards were issued during SFY2021 or SFY2022 as the program's matching funds were eliminated during the 2021 legislative session. New federal funding without a match requirement was received for SFY2023 and 5 awards were issued during SFY23. Any funding received in SFY2026 will again require matching funds.

- Between 2006 and 2023, 319 loan repayment awards were issued through both WHPLRP and WY-SLRP. As of the 4th quarter of SFY2023, 287 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 2020 indicates a retention rate of 85% for NHSC Loan Repayment participants between 2012 and 2019. 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 was updated and new data was gathered. During SFY2020, an assessment of licensure files and the National Provider Identifier (NPI) registry was conducted to determine how many WHPLRP participants were still licensed and practicing in Wyoming. The assessment determined that 220 (77%) of the 286 WHPLRP participants are still licensed and 66% are still practicing in Wyoming.

- Between 2008 and 2019, 41 Provider Recruitment (PRGP) awards were issued to recruiting entities. The awardees had one year to recruit a provider from out of state that met all program requirements. Nineteen (46%) have been successful. 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. PRGP was last funded in SFY2019.

- 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 ($10,000/physician, $5,000/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.

- Coordination of the Conrad 30 J-1 Visa Waiver Program is a requirement under the federal Primary Care Offices (PCO) Cooperative Agreement from HRSA. 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. No state funds are used to administer the Conrad 30 J-1 Visa Waiver Program.

Medicare Rural Hospital Flexibility Program

SFY 2023 Program Snapshot

Program Description

The Community Medical Access and Capacity Program provides education and infrastructure support for critical access hospitals, small rural hospitals, rural health clinics, rural emergency medical services (EMS), and community health centers.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$740,509	$556,086	$543,237
People Served*	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series**	17.57%	23%	26%
COVID-19 Response Cost	$0	$1,307,017	N/A

*This program is responsible for serving critical access hospitals (CAHs) and other small rural health care providers. It does not provide direct services to clients.
**600 series is defined as direct service contracts.

Program Cost Notes

- SFY 2023 expenditures reflect 100% federal funds and 0% state general funds.
- Medicare Rural Hospital Flexibility (Flex) Program, 9/1/2022-8/31/2023, 100% Federal Funding (FF) ($543,237).
- Small Rural Hospital Improvement Grant Program (SHIP), 6/1/2022-5/31/2023, 100% FF ($154,629).
- American Rescue Plan Small Rural Hospital Improvement Grant Program (ARPSHIP), 1/1/2021-12/31/2022, 100% FF ($4,392,392). Six (6) hospitals were granted a No Cost Extension until 12-31-23 to complete projects delayed by supply chain issues.

Program Staffing

- 1 FTE
- 0 AWEC
- 1 Contractor

Program Metrics

- The Flex Program provides critical access hospitals (CAH) support for quality, operational, and financial improvement, population health, and rural Emergency Medical Services (EMS). The Flex Program designated hospitals for CAH status in Wyoming and may provide technical assistance for 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 ARPSHIP Grant is federally funded to support small rural hospitals of 49 beds or less with activities related to ensuring safety, responding to the coronavirus, and maintaining hospital operations during the coronavirus pandemic.

Medicare Rural Hospital Flexibility Program

Events that Have Shaped the Program

- Wyo. Stat. § 9-2-117 created the Office of Rural Health in 1993, which is charged with oversight of several federal programs and to address rural health improvement.
- Wyo. Stat. § 9-2-127 created the Primary Care Support Act (2011).
- Critical access hospitals (CAHs) and the Flex Program were established by the Balanced Budget Act (BBA) of 1997.
- Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) received one time federal funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act for eligible SHIP hospitals to prevent, prepare for, and respond to the COVID-19 public health emergency and one-time funding from the American Rescue Plan (ARP) for eligible SHIP hospitals to assist with COVID-19 testing and mitigation.

Medicare Rural Hospital Flexibility Program

Program Core Purpose

The Medicare Rural Hospital Flexibility (Flex) Program provides federal funds to critical access hospitals (CAHs) for improvement in quality of care, operations, finances, population health, and rural emergency medical services (EMS). Small, rural hospitals receive federal funds from the Small Rural Hospital Improvement Grant Program (SHIP) to support technical assistance in achieving the aim of the Flex Program.

OUTCOMES

Performance Metric	FFY 22 Target	FFY 23 Target	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022
% of CAHs meeting minimum requirements in the Medicare Beneficiary Quality Improvement Program (MBQIP)	100% (16/16)	100% (16/16)	100% (16/16)	100% (16/16)	100% (16/16)	100% (16/16)	100% (16/16)
% of CAHs improving in Emergency Department Transfer Communication measures (EDTC) [1]	100% (16/16)	100% (16/16)	57% (9/16)	63% (10/16)	63% (10/16)	53% (9/16)	25% (4/16)
% of CAHs improving in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) [2]	100% (16/16)	100% (16/16)	69% (11/16)	69% (11/16)	44% (7/16)	27% (4/15)	42% (5/12)
% of CAHs improving Patient Safety [3]	100% (16/16)	100% (16/16)	69% (11/16)	81% (13/16	94% (15/16)	60% (10/16)	50% (6/12)
% of CAHs providing financial and operational data to Quality Health indicators (QHi)	100% (16/16)	100% (16/16)	81% (13/16)	75% (12/16)	81% (13/16)	50% (8/16)	44% (7/16)
# of small rural hospitals participating in SHIP	18/18	18/18	15	15	18	16/18	18/18

1 Four (4) is the number of hospitals who showed improvement in FFY2022. This does not take into account the hospitals that stayed at 100% or those that had a small dip.
2 There were 12 hospitals that had initiatives in place to improve HCAHPS. Five had data that indicated improvement. Other CAHs may be improving but no data is available yet. There is always a lag in the availability of the data.
3 This measure includes Antibiotic Stewardship, healthcare provider vaccinations and decreasing falls within a CAH. Flex had an initiative to help CAHs decrease the number of falls within the CAH. Twelve (12) CAHs participated with 6 showing improvement.

OUTPUTS AND EFFICIENCIES

Performance Metric	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022
OUTPUTS					
# of Quality Improvement (QI) Roundtables (# of people present)	14 (225)	10 (136)	6 (126)	5 (73)	7 (170)
# of CAHS with staff receiving a scholarship for training, education, and professional development	11/16	6/16*	15/16	11/16	9/16
Wyoming Quality Improvement Matters (WYQIM) website # of visitors - Flex is moving information from WYQIM to the Wyoming Department of Health (WDH) website. The Office of Rural Health/Flex pages on the WDH website had 1,766 visits.	1,144	1,505	2,905	1,810	230/1,766

Medicare Rural Hospital Flexibility Program

# of operational and financial improvement (FI) activities (# of people present)	21	12	8 (190)	5 (60)	22(315)
# of quality and financials activities with the COVID-19 focus	0	5	7	2	0
EFFICIENCIES					
The average cost per CAH participating in QualityImprovement Initiatives	$10,154	$14,914	$9,735	$3,446.08	$4,900
The average cost per CAH participating in FI and Operational Improvement (OI) Initiatives	$15,789	$11,902	$13,663	$7,142.00	$9,062.50
Cost per CAH to participate in QHi	$993	$1,241	$1,184	$1,117.81	$1,173.88

Story Behind the Performance

The Federal Fiscal Year for Flex is from September 1 - August 31. Federal Fiscal Year for SHIP is from June 1 - May 31.

The Flex Program provides federal funds to critical access hospitals (CAHs) to improve quality of care, operations, finances, population health, and rural emergency medical services (EMS). In addition, the Flex Program may assist with CAH designation and innovative healthcare models. CAHs are defined as a hospital with twenty-five (25) or fewer acute care beds and are located more than thirty-five (35) miles from another hospital.

Wyoming CAHs voluntarily report financial and quality data using the benchmarking system, Quality Health indicators (QHi). The program was specifically developed for small rural hospitals and rural health clinics to provide selected quality and financial measures with similar hospitals and clinics. This data also helps the Flex Program in decision making for financial and quality improvement projects.

The Flex Program Grant focus is on six (6) areas: Quality Improvement, Operational and Financial Improvements, Population Health Improvement, Rural EMS Improvement, Innovative Model Development (an optional area), and CAH Designation.

Program Area 1: Quality Improvement. The Medicare Beneficiary Quality Improvement Program (MBQIP) is utilized to measure Quality Improvement. The MBQIP core measures are patient safety, patient engagement, care transitions, inpatient and outpatient measures. All hospitals are reporting their measures.

Program Area 2: Operational and Financial Improvements. The Flex Program is required to report on this area. Flex convened two (2) cohorts to facilitate operational and financial improvement. The first cohort pertained to swing bed education and expansion. The second cohort was based on workforce recruitment and retention.

Program Area 3: Population Health Improvement. Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities. This area is optional but Wyoming is reporting on activities conducted.

Program Area 4: Rural EMS Improvement. Improve the organization capacity and quality of rural EMS. This area is optional for the Flex Program to report on and Wyoming chose to work on it and is now providing scholarships to EMS agencies.

Program Area 5: Innovative Model Development. This is an optional area for the Flex Program to report on. The Flex Program does not participate.

Program Area 6: CAH Designation. The Flex Program is required to report on this area if there is a hospital that wants a CAH designation. Two facilities reached out for information and one, Memorial Hospital of Sweetwater County, is pursuing CAH designation.

Medicare Rural Hospital Flexibility Program

Small, rural hospitals (49 beds or less), receive federal funds from the Small Rural Hospital Improvement Grant Program (SHIP) to support technical assistance in improving healthcare quality.

1) Small rural hospitals (49 beds or less), are eligible to request SHIP funds to assist with the cost of implementing data system requirements established under the Medicare Program, including improvements in healthcare value and quality.
2) 18 hospitals in Wyoming participate in the SHIP Program.
3) All funds are passed directly to the hospitals once reimbursement receipts are submitted.

Emergency Medical Services

SFY 2023 Program Snapshot

Program Description

The Office of Emergency Medical Services (OEMS) operates under a statutory requirement to develop a comprehensive EMS and trauma system. The OEMS EMS Program oversees various activities, including licensing of EMS providers, oversight of the EMS educational system, assuring compliance, conducting investigations, collecting data, and the provision of technical and other assistance to EMS providers and agencies throughout Wyoming.

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY2023
Total Program Cost	$477,369	$487,376	$437,503
People Served	576,851	576,851	581,381
Cost per Person	$0.83	$0.84	$0.75
Non-600 Series*	99.4%	96.9%	100%

*600 series is defined as direct service contracts

Program Cost Notes

- 90% General Funds
- 10% Federal Funds
- Budget reductions in FY2021 included a reduction of one staff member
- The EMS program is partnering with the Office of Training, Performance, and Equity to administer $2.4 million in Community EMS grants

Program Staffing

- 5 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Ensures minimal entry requirements for medical privileges for providers to care for the sick and/or injured at five different certification levels.
- 87% of Wyoming's population resides in a community with a full-time staffed ambulance service.
- 36% of Wyoming EMS agencies are operated by fully compensated staff, 11% are operated by partially compensated staff, and 40% are strictly volunteer.
- SFY 2021 recorded 84,991 requests for service statewide.
- SFY 2022 recorded 88,424 requests for service statewide.

Events that Have Shaped the Program

- The Wyoming Emergency Medical Services Act of 1977 authorized the Department of Health to regulate and license EMS professionals in the state of Wyoming. *See* Wyo. Stat. § 33-36-101 et. seq.
- Wyoming's rural and frontier setting causes a significant reliance on Critical Access Hospitals. This reliance requires patients to be transported frequently to higher levels of care, which creates a heavy reliance on a well-functioning and dependable EMS system.
- The EMS Program provides a statewide electronic medical records system for the patient's continuum of care and public health monitoring, resulting in savings of approximately 2.1 million dollars a biennium in pass-through costs to patient care.
- Budget reductions initiated in 2020 were fully implemented in 2022 and have resulted in a reduction of services provided by the EMS program.

EMS Sustainability Trust Accounts				
	SFY 2020	**SFY 2021**	**SFY 2022**	**SFY 2023**
Fund 579 EMS Trust	$500,000	$500,000	$500,000	$500,000
Interest Income	$21,290	$19,228	$11,065	$20,848
Fund 571 EMS Income Account	$187,184	$160,474	$114,702	$105,767

In 2023, two needs assessments were conducted and funded by the EMS Sustainability Trust Account. The purpose of the needs assessments is to determine possible solutions (master plan) for sustaining EMS in a local community or service area and to assist a community in implementing a master plan after a needs assessment has been conducted. The EMS Sustainability Trust Account was established through Enrolled Act No. 94 of the 2009 General Session of the Wyoming Legislature. The act created Wyo. Stat. § 33-36-115 within the "Wyoming Emergency Medical Services Act of 1977" and provided authority and funding to the Department of Health, Public Health Division, OEMS to oversee the needs assessments.

Emergency Medical Services

Program Core Purpose

The Emergency Medical Services (EMS) program works to enhance Wyoming's EMS system through programmatic and regulatory activities, including data collection, rule development and 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 2024 Target**	**SFY 2025 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% Chute Times <10 Minutes Emergency (911) with delay exception Chute Time = En Route minus PSAP	94.0%	95.0%	95.0%	93.8%	93.8%	94.5%	94.6%
% Operational Time <10 Minutes (Ground transport) Unit En Route minus Unit Notified	98.0%	98.0%	98.3%	98.2%	98.2%	98.4%	97.8%
% of Records validity score is > 90 points (All records, services, and responses)	98.0%	98.0%	99.8%	99.8%	99.7%	99.6%	99.1%
% of responses < 8:59 minutes* (Arrive Scene minus PSAP)	60.0%	60.0%	55.0%	51.0%	50.0%	52.2%	51.0%
% of responses < 30:00 minutes* (Arrive Scene minus PSAP)	97.0%	97.0%	97.1%	97.2%	98.0%	97.5%	94.7%
*The fraction of percentages were removed for continuity across all performance metrics							

OUTPUTS AND EFFICIENCIES									
Performance Metric	**2019**	**2020**	**2021**	**2022**	**2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
Total Requests for Services in WATRS	81,280	80,120	84,991	88,424	89,301	46,734	41,690	45,561	43,740
Estimated Technical Assistance Hours	N/A	N/A	N/A	N/A	1,900	961	1769	920	980
Number of New Providers Trained	692	569	651	593	376	382	211	121	255
Number of New Licenses Issued	753	599	629	597	380	362	235	145	235

Number of Initial Classes Offered	75	68	74	68	36	41	27	10	26
Number of Investigation	17	18	15	9	7	4	3	19	6
EFFICIENCIES									
Cost per WATRS record submitted	$0.81	$0.84	$0.89	$0.85	$0.90	$0.86	$0.86	$0.66	$0.61
Student course completion rate	80%	88%	88%	75%	93%	84%	93%	84%	89%

Story Behind the Performance

The Office of Emergency Medical Services (OEMS) is charged with regulating and licensing EMS professionals. *See* Wyo. Stat. § 33-36-101 et. seq. Additionally, OEMS is authorized to develop a comprehensive trauma and Emergency Medical Services System. *See* Wyo. Stat. § 35-1-801 et. seq. 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 EMS program 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. The previous "Cost per successful student" metric was removed due to funding reductions and to more accurately reflect the current work of the EMS program.

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. WATRS is compliant with the National EMS Information System (NEMSIS) requirements, is accessible by receiving facilities, and interfaces with the Trauma Patient Registry. The previous metric of "Services reporting in WATRS" was removed because the metric was used to track the progression of EMS agencies during the transition period to web-based patient reporting. All Wyoming EMS agencies have transitioned to reporting in WATRS for several years at this point.

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.

- "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. This interval is included in the overall response time, EMS agencies should strive to meet 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 Wyoming regulations 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.
- "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.

- "Operation Time" is the time interval between when the dispatcher notified the ambulance agency of a request for service to the time the ambulance is en route. This metric is used to identify call processing time deficiencies within the dispatch system.

In general, the EMS system continues to struggle with the workforce shift toward the paid EMS staffing model of relying on EMS volunteers. This change has added stress on agencies that often cannot afford to pay staff in the State's small frontier areas.

In FY20, the OEMS changed its processes for education management due to the realignment of personnel and a reduction in funding. This change caused a disruption in the way that courses are conducted in the state, which affected our data collection efforts. Also, in FY 2020, the OEMS lost the compliance position due to the budget reduction.

Public Health Preparedness and Response

SFY 2023 Program Snapshot

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

	2021	2022	2023
Total Program Cost	$4,880,280	$4,301,641	$4,336,767
People Served	576,851	578,803	581,381
Cost per Person	$8.46	$7.43	$7.46
Non-600 Series*	50%	50%	41%
COVID Response Cost	$2,656,712	$214,856	$452,014
Workforce Development	$0	$1,140,942	$679,750

* 600 series is defined as direct service contracts

Program Cost Notes

- Federal funding cooperative agreement with the Centers for Disease Control and Prevention (CDC) for July 1, 2022 - June 30, 2023 for SFY 2023 $5,210,000
  - 10% match requirement met by county, tribal, and state in-kind match contributions
- Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123) (Coronavirus Supplemental) COVID-19 Crisis Response Cooperative Agreement Funding March 16, 2020 - March 15, 2023 $4,567,500 - no match required
- American Rescue Plan Act of 2021 (P.L. 117-2) Workforce Development Cooperative Agreement July 1, 2021- June 30, 2024 $4,384,938 - no match required
- General Funds - $54,628 100 series for WPHL staff

Program Staffing

- 11 FTE (plus 3 funded positions in the Wyoming Public Health Lab)
- 4 AWEC (3 funded with temporary Workforce Development funding)
- 2 Other -
  - 1 CDC Career Epidemiology Field Officer (CEFO)
  - 1 CDC Preparedness Field Assignee (PFA)

Program Metrics

- PHPR maintains contracts that support 19 county public health nursing offices, four (4) independent county health departments, and two (2) tribal health departments with preparedness contract deliverables designed to improve their ability to prevent, respond to, and recover from public health emergencies.
- In SFY23, 23 of 25 local and tribal jurisdictions met all contract deliverables, with an average of 91% deliverables completed.
- PHPR funds and manages a 24/7/365 emergency notification and disease reporting hotline for the Wyoming Department of Health (WDH) with on-call epidemiologists, laboratorians, and public health professionals. In SFY23, there were 101 YTD calls to the emergency notification and disease reporting hotline, compared to 152 calls in SFY22.

Public Health Preparedness and Response

- The CDC's ability to reach WDH through a 24/7/365 phone line is a CDC metric. In SFY20, SFY21, SFY22, and SYF23, the two annual test calls were waived by CDC due to the COVID-19 pandemic response.
- There are five separate CDC requirements that states must meet annually in order to avoid having their preparedness funding penalized by 10% to 20%. PHPR consistently meets the requirements.

Events that Have Shaped the Program

- Significant events: terrorism events of 9/11; anthrax attacks in October 2001; natural disasters (flooding and fires); preparation for disease outbreaks such as the Mpox, Ebola, and Zika viruses; preparation and participation in the Vigilant Guard 2023 exercise; pandemics (the COVID-19 pandemic response, H1N1 influenza pandemic); and the opioid epidemic response.

- For SFY 2023, federal funding remained at a consistent base amount of $5,000,000, with $210,000 for Cities Readiness Initiative (CRI). CDC's CRI is a federally funded program that enhances preparedness in the nation's largest population centers, where nearly 60% of the nation's population resides. CRI jurisdictions in Wyoming are Laramie and Natrona Counties.

- PHPR received the Crisis Response Cooperative Agreement funding for the COVID-19 pandemic response in the amount of $4,567,500. The long term COVID-19 response has challenged this unit due to the substantial involvement in COVID-19 response activities. In SFY23, PHPR had 20 positions and 5 of 20 (25%) were newly hired in SFY23, and 9 positions were vacant (40%), thus 65% of PHPR positions were either newly filled or vacant. PHPR also has 27 Public Health Response Coordinator (PHRC) positions and 3 of 27 (11%) were newly hired and 5 of 27 (19%) PHRCs were hired in SFY23.

- The Wyoming Department of Health received the Crisis Response Cooperative Agreement from the American Rescue Plan Act of 2021 Workforce Development Cooperative Agreement July 1, 2021- June 30, 2024 in the amount of $4,384,938. CDC requires that at least 25% of the jurisdictional award will support school-based health programs, including nurses or other personnel. The Wyoming Department of Education provided 2,763 behavioral health and substance abuse services appointments to 118 students over 18 months. Of the remaining 75% of the Cooperative Agreement (or less, depending on the amount invested in schools), CDC expects that at least 40% will support local hiring through local health departments or community-based organizations, which provided at least one (1) full time equivalent public health response coordinator for each county and tribal nation.

- Emergency Support Functions (ESFs) are organized groups of activities organized to provide support for disasters and emergencies. ESF #8, Public Health and Medical Services, provides the mechanism for coordinated assistance to augment state, tribal, and local resources in response to potential or actual disasters or emergencies. This includes scenarios like pandemic flu outbreaks and bioterrorism attacks. Examples of support provided by ESF#8 include assessment of public health and medical needs (including behavioral health), reach back to federal resources, public health surveillance, and distribution and dispensing of Strategic National Stockpile and other medical countermeasure assets, including Personal Protective Equipment (PPE), testing, and therapeutics. PHPR is designated by WDH to be the ESF #8 lead for the state. This designation ensures efficient coordination of public health and medical services during times of crisis.

Public Health Preparedness and Response

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 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Time, in minutes, for Immediate After Hours Assembly of WDH Response Coordination Team in person or virtually [1]	<60*	<60*	8 Virtual	5 Virtual/ 30 In Person	N/A	15 Virtual	12 Virtual/ 20 In person
Wyoming (state) status for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency [2]	Established	Established	Established	Established	N/A	Advanced	N/A
Average county status for demonstrated capability to receive, stage, store, distribute, and dispense material during public health emergency [2]	Established	Established	Intermediate (23 counties)	Intermediate (23 counties)	N/A	Established (23 counties)	N/A
State, county, and tribal public health responders completing respirator fit testing [3]	95%	95%	95% (250/263)	N/A	N/A	85% (219/258)	89% (230/258)

*CDC and Healthy People 2030 target
N/A Indicates data not available.

Footnote
Numbers 1 - 3 denote further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
% of WDH Response Coordination Team trained for role requirements for WDH response management [4]	82% (23/28)	66% (21/31)	78% (25/32)	74% (11/15)	92% (12/13)	74% (11/15)	74% (11/15)	92% (11/12)	92% (12/13)
# of COVID-19 pharmaceutical	N/A	N/A	96,233	13,056	50,369	7,740	5,316	41,946	18,423

countermeasures coordinated and distributed [5]									
# of critical Personal Protective Equipment items distributed [6]	N/A	N/A	4,515,894	888,705	494,705	482,774	405,931	198,365	296,340
# of courses of antibiotics compared to estimated number of key personnel identified [7]	5,644/ 5,060	6,966/ 5,060	5,966/ 5,060	4,687/ 5,060	4,687/ 5,060	4,687/ 5,060	4,687/ 5,060	4,687/ 5,060	4,687/ 5,060
EFFICIENCIES									
Cost per Wyoming Alert and Response Network message recipient [8]	$1.28 ($12,995/ 10,116)	$1.08 ($12,995/ 12,034)	$1.78 ($12,995/ 7,300)	$1.50 ($12,995/ 8,638)	$0.84 ($14,350/ 17,122)	$1.50 ($12,995/ 8,638)	$1.50 ($12,995/ 8,638)	$0.84 ($14,350/ 17,122)	$0.84 ($14,350/ 17,122)

N/A Indicates data not available.

Footnote
Numbers 4 - 8 denote further explanations provided in the Story Behind the Performance.

Story Behind the Performance

- The numbers in this metric reflect the total amount of time it took for pre-identified staff to report for duty in response to a public health emergency. The staff were covering activated public health agency response coordination roles or equivalent lead roles. They were required to report for immediate duty with no advance notice.
- The state, Cities Readiness Initiative (CRI) jurisdictions (Laramie and Natrona counties), counties, and tribal nations were evaluated utilizing the Public Health Emergency Preparedness PHEP Operational Readiness Review (ORR). The PHEP program helps build and strengthen public health systems readiness to respond to and recover from public health emergencies. The Centers for Disease Control and Prevention (CDC) ORR is a rigorous, evidence-based assessment used to evaluate PHEP program planning and operational functions. During the COVID-19 response, CDC paused collection of this data in favor of providing resources to the response. During the upcoming 5 year project period, the ORR will be retired, and these metrics will be replaced. The self assessment for SFY21 indicated the state status was advanced, however due to the COVID-19 response, this self assessment was not validated by CDC, thus the metric was updated to reflect N/A.
- 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 the Responder Health and Safety program effectiveness. Proxy measures can be used to estimate the effectiveness of these programs in promoting and maintaining the health and safety of responders.
- The Response Coordination Team (RCT) is a small, experienced, and response-ready public health emergency management team staffed by members of the Public Health and Preparedness Response (PHPR) unit. During the reporting period, RCT membership dropped from 15 to 12 in Q1 and Q2 due to a number of factors, including the restructuring of RCT, updates to role identification, and staffing challenges. In Q3 and Q4 RCT membership increased to 13.
- Pharmaceutical countermeasures are medical products used to prevent, treat, or diagnose diseases. These products include monoclonal antibodies, antivirals, and COVID-19 tests. The distribution of these products is measured in units, which may be multiple courses of treatment for multiple patients. For example, a unit of monoclonal antibodies may be a single infusion that is given to a single patient.
- Critical personal protective equipment (PPE) is important to protect the health of residents and responders from getting sick. PPE includes face masks, gloves, face shields, gowns, and N95 respirators. PPE was shipped to hospitals, long term care facilities, emergency management, law enforcement, fire departments, emergency medical services, schools, public health, businesses, and day care facilities.
- Maintaining a cache of antibiotics to treat key personnel during an anthrax exposure is a prudent preparedness measure. This ensures essential personnel have access to antibiotics promptly if an anthrax exposure occurs. The number of courses of antibiotics in the cache should align with or exceed the estimated number of key personnel to guarantee that everyone who needs treatment can receive it without delay in the event of an anthrax incident. PHPR was unable to procure additional antibiotics during SFY 23 due to staffing levels and ongoing COVID-19 response activities.
- The cost per Wyoming Alert and Response Network (WARN) message recipient is calculated by dividing the annual cost of the WARN contract by the total number of registered recipients. This calculation helps evaluate the efficiency and cost-effectiveness of the system in reaching its intended audience.

Trauma Program

Program Description

The Wyoming Trauma Program (WTP) 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

	2021	2022	2023
Total Program Cost	$212,589	$216,910	$194,996
People Served	576,851	581,381	581,381
Cost per Person	$0.37	$0.37	$0.34
Non-600 Series*	100%	100%	100%

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

Program Cost Notes

- 89% General Funds
- 11% Federal Funds (Wyoming Trauma Registry $22,800)

Program Staffing

- 2 FTE
- 0 AWEC
- 0 Other

Program Metrics

- All 29 of Wyoming's acute care facilities and clinics are mandated to participate in the Trauma System. One new Critical Access Hospital opened in 2023 and will be designated as a Trauma Receiving Facility once one year of data is obtained. Specific emergency and medical standards are evaluated and reviewed every three years for continued compliance to ensure quality patient care in each facility.
- WTP provides the mandatory Trauma Patient Registry for all acute care facilities.
- WTP provides support to Trauma Regions through quarterly virtual statewide trauma meetings, designation preparatory guidance, and designation site reviews.
- WTP provides technical registry and programmatic support as needed to facilities.

Events that Have Shaped the Program

- This is a mandated state program per Wyo. Stat. § 35-1-801 et seq.
- Unintentional injury is the #1 cause of death for Wyoming residents ages 1-44 years (CDC WISQARS). This remained consistent from 2018-2021, which is the most current data.
- Traumatic injury results in more years of potential life lost than any other disease, including cancer, suicide, and heart disease (CDC WISQARS).
- Acute care facilities are experiencing low rates of workforce retention for Trauma Coordinators (TC). In 2020, 33% of Wyoming TCs had been in their role for one year or less. This number decreased to 20% in 2023.
- The Wyoming Trauma Registry is updated regularly and the data is used to verify trauma facilities are meeting the reporting requirements of facility designations by the State of Wyoming and the American College of Surgeons (ACS) verifications.
- Two Regional Trauma Centers opted to undergo both State designation and ACS verification for Level II and III Trauma Center verification. These visits were done concurrently at no additional expense to the program.

Program Core Purpose

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

OUTCOMES							
Performance Metric	**SFY 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
% and # of facilities actively contributing to the Trauma Patient Registry	96%	96%	100% 27/27	88% 24/27	92% 25/27	96% 27/28	96%** 26/28
% of facilities with full designation status (2-3 year status) running total	75%	96%	78% 21/27	81% 22/27	92.6% 25/27	100% 28/28	28/28**
% of rural facilities with full designation status (2-3 year status) running total	77%	96%	80% 20/25	88% 22/25	92% 23/25	100% 26/26	100% 26/26
Median dwell time of patients who require an interfacility transfer for definitive care* (minutes)	120	120	182 n=978	171 n=1055	182 n=1052	189 n=840	206 n=1014

* Metrics revised to more accurately reflect programmatic activities.
** 2023 reflects the addition of North Platte Valley Medical Center. WTP has not had the opportunity to designate yet.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of facility site reviews conducted	9	4	9	7	4	0	7	0	4
# of Regional Trauma Councils meeting quarterly	4	2	3	5	10	5	0	5	5
# of formal educational opportunities sponsored to improve facility compliance	2	2	4	2	3	2	0	2	1
% and # of facilities sending representation to at least one sponsored educational opportunity per year	89% 24/27	78% 21/27	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# of trauma records in Trauma Registry by WY acute care facilities	4827	5264	5318	4367	4895	2186	2181	2401	2494

EFFICIENCIES									
Cost per trauma registry record	$4.33 ($22,800 /5,264)	$4.33 ($22,800 /5,264)	$4.29 ($22,800 /5318)	$5.22 ($22,800 /4367)	$4.34 ($21,250 /4895)	$5.21 ($11,400 /2186)	$5.22 ($11,400 /2181)	$4.43 ($10,625 /2401)	$4.26 ($10,625 /2494)

NA indicates data not relevant on a quarterly basis.
(-) indicates missing data
Data from the previous year was adjusted due to a data entry error.

Story Behind the Performance

- A landmark study demonstrated 20% lower in-hospital mortality and 25% lower 1-year mortality among seriously injured adults treated in Level I trauma centers compared with non-trauma hospitals (Newgard Fischer et al 2021).
- Studies have shown that regionalized trauma systems are associated with reductions in mortality (Newgard Fischer et al 2021).
- 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).
- The Wyoming Trauma Patient Registry is a data collection system of traumatically injured patients who receive hospital care. This data is primarily designed to ensure quality trauma care and outcomes for patients within trauma facilities and throughout the trauma systems. The Wyoming Trauma Registry includes only traumatic injuries based on set criteria to be entered into the data set. This is not an all-inclusive source of all injuries that are sustained in the state. Wyoming acute care facilities are required to submit this data.
- Rural Facility: A Wyoming hospital or acute care facility not designated as a Regional Trauma Center. An acute care facility for this program is defined as a hospital or clinic that receives emergency patients.
- Patient Emergency Department (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 120 minutes. 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 2 hours or less. Examples of variables that cause a high dwell time for transferred patients may be internal system barriers, challenges in finding available definitive facilities to admit patients, waiting for emergency transport, and weather. Increasing dwell times are an issue hospitals are experiencing nationally. Available bed space and staffing continue to be a major issue for receiving facilities which impedes smaller hospitals' ability to transfer patients to higher levels of care and contributes to higher patient dwell times.
- 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 seriously injured patients. This structure allows local systems to develop solutions to local problems through case studies, data evaluation, and the performance improvement process.

Communicable Disease Prevention

Program Description

The Communicable Disease Prevention Program supports the prevention, control, and investigation of communicable diseases in Wyoming. The program provides education, testing, treatment, and targeted interventions to individuals, community organizations, and healthcare providers related to chlamydia, gonorrhea, syphilis, hepatitis B and C, HIV, and tuberculosis (TB).

Program Expenditures and People Served

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost	$1,441,851	$1,445,929	$1,670,232
People Served	N/A	N/A	N/A
Cost per Person	N/A	N/A	N/A
Non-600 Series*	61%	73.7%	60.0%

*600 series is defined as direct service contracts.

Program Cost Notes

- Y5 HIV Integrated Grant – CDC
- Y5 STD Prevention Grant – CDC
- Y3 STD Prevention Supplemental Grant - CDC
- Y3 Hepatitis Integrated Grant – CDC
- Y5 TB Prevention & Control Grant – CDC

Program Staffing

- 7.25 FTE
- 2 AWEC
- 0 Other

Program Metrics

- Reduce disease transmission by providing prevention education and materials, as well accessible testing and treatment.
- Provide targeted best practice and evidence-based education by collaborating with both internal and external programs such as Immunization, Behavioral Health, Public Health Nursing, Medicaid, Healthcare Licensing and Surveys, Department of Corrections, Maternal Child Health, federally qualified health centers, Wyoming Health Council, University of Wyoming Student Health Services, Wind River Family and Community Healthcare, Indian Health Services, substance abuse services, LGBTQ+ organizations, colleges, cultural organizations, services for those who are homeless, and crisis pregnancy centers.
- Increase the number of individuals who receive prevention education and materials, as well as testing and treatment in accordance with current best practices.
- Deliver and evaluate the community health education campaigns: KnoWyo and W(h)Y PrEP Matters.

Events that Have Shaped the Program

- 2020: COVID-19 pandemic
- 2020: CDC revised gonorrhea treatment recommendations
- 2021: Continued COVID-19 pandemic
- 2021: Healthy People 2030 - Objectives include HIV, STD, immunization, and infectious disease
- 2021: STD Prevention Disease Intervention Specialists Workforce (DISWF) Capacity Supplemental Grant

Communicable Disease Prevention

- 2021: CDC revised STD treatment recommendations
- 2022: Added comprehensive at-home testing; chlamydia, and gonorrhea rates decreased compared to CY 2021
- 2022: Updated CDU Screening Recommendations
- 2023: Chlamydia and gonorrhea rates decreased compared to CY 2022. First congenital syphilis cases in many years; 38% increase in safety-net HIV testing and 30% increase in overall safety-net testing compared to SFY 2022. DISWF Y4 & Y5 rescinded.

Communicable Disease Prevention

Program Core Purpose
To prevent, control, and investigate communicable diseases in Wyoming.

OUTCOMES							
Performance Metric	**CY 2023 Target**	**CY 2024 Target**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
Chlamydia infection rate [10*]	350.0	350.0	380.8 (552.8)	335.7[4] (481.3)	359.0[4] (495.5)	308.4[4,5] (N/A)	(-)
Gonorrhea infection rate [3*]	72.0	70.0	77.9 (187.8)	67.2[4] (206.5)	90.4[4] (214.0)	53.3[4,5] (N/A)	(-)
Syphilis infection rate[10*]	7.5	7.5	6.9 (40)	5.4[4] (12.7)	7.4[4] (16.2)	11.4[4,5] (N/A)	(-)
# of congenital syphilis infection cases [10]	0	0	0	0[4]	0[4]	0[4]	2[†]
Number of newly diagnosed HIV cases [10] (rate per 100,000)	<15	<15	14 (2.4)	14[4] (2.4)	7[4] (1.2)	13[4] (2.2)	19[†]
Newly diagnosed hepatitis C infections [6,9]	60.0	60.0	59.3	53.0[4]	54.6[4]	41.5[4]	(-)
% 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" [1,2]	90%	90%	85%	84%[4]	87%[4]	98%[4]	(-)
Active TB infection rate[*]	<1	<1	0.0 (2.7)	0.0[4] (2.2)	0.5[4] (2.4)	0.2[4] (2.6)	(-)

[*]Rate per 100,000 compared to (National Rate) [†]Provisional data as of 11/17/23 (-) Data not yet available
Footnote
Numbers 1 - 10 denote further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**	**2021 Q3-4**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**
OUTPUTS									
# condoms distributed[7,9]	237,051	161,133[4]	369,178[4]	444,433[4]	(-)	220,885[4]	219,472[4]	225,424[4]	282,266
# of condom dispenser sites[7,8,9]	445	>200[4]	247[4]	311[4]	(-)	247[4]	294[4]	311[4]	321

EFFICIENCIES									
# and average cost of redeemed safety-net testing vouchers[9,11]	5,272 $27.16	3,975[4] $26.96	4,101[4] $28.44	4,753[4] $33.21	(-)	1,958[4] $30.01	2,257[4] $31.37	2,496[4] $34.87	2,975 $30.49

(-) Indicates data not available

Footnote
Numbers 7 - 11 denote further explanations provided in the Story Behind the Performance.

Story Behind the Performance

- Healthy People (HP) 2030 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.
- This metric is for patients with laboratory confirmed gonorrhea, syphilis, HIV, hepatitis B, or 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 or identified partners in Wyoming. Partner services include: ensuring appropriate treatment has been provided and recommending additional testing (if indicated), identifying 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. A decrease in this number is reflective of individuals not responding to staff attempts to locate. Staff use phone calls, letters, and other relevant methods to locate/contact individuals.
- Gonorrhea infections have decreased in Wyoming and increased in 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 effective treatment.
- Potential impacts of the COVID-19 pandemic on access to communicable disease testing should be considered when interpreting 2020-2022 rates.
- The preliminary national Sexually Transmitted Infection (STI) incidence rates for 2022 are unavailable.
- Approximately 99% of the newly diagnosed hepatitis C cases in Wyoming were identified as chronic infections during 2022. Approximately 3.5 million persons in the U.S. have chronic hepatitis C infection. (http://www.cdc.gov/Hepatitis/hcv/cfaq.htm#cFAQ22). According to studies, the prevalence of hepatitis C among the 2.2 million people in U.S. jails and prisons ranges from ten percent to more than one-third. (https://www.hiv.gov/blog/hepatitis-c-in-corrections-a-new-resource-for-incarcerated-people/). Hepatitis C is underdiagnosed and not reportable in all states so a national rate is not available. However, CDC estimates 2.4 million people have chronic hepatitis C infection (https://www.cdc.gov/Hepatitis/hcv/cfaq.htm#A5).
- According to the CDC, condom distribution programs are structural interventions that have been shown to increase condom use, condom acquisition, and condom carrying, and promote delayed sexual initiation or abstinence among youth, provide cost-effective and cost-saving outcomes on future medical costs, and help reduce HIV, STIs,and unintended pregnancy risk among a wide range of at-risk groups.

- Condom dispenser numbers were previously reported as the cumulative number of dispensers provided by the program over time. The Unit completed a condom dispenser update at the beginning of November 2023 to evaluate the number of dispensers currently in service. The Unit estimates there were 338 dispensers in service when the survey was completed. Q1-Q2 of 2023 thirty-three were ordered and placed in service. There are currently 179 dispenser locations that wish to be listed on the KnoWyo free condom locator webpage.
- In an effort to provide a better representation of the work done in CDU the description of this metric has been updated to more accurately reflect programmatic activities.
- In an effort to provide a better representation of the work done in CDU this metric has been added to more accurately reflect programmatic activities.
- The slight increase in cost is related to our staff providing technical assistance to KnoWyo safety-net testing sites to improve the frequency of HIV testing based on risk and improve the redemption of HIV testing vouchers.

Communicable Disease Treatment

SFY 2023 Program Snapshot

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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost*	$1,505,404	$1,529,454	$1,254,241
People Served**	697	693	600
Cost per Person	$2,160	$2,207	$2,090
Non-600 Series***	24%****	13.6%	7%
COVID-19 Response Cost	$86,530	$74,481	$114*****

*Traditional, non-COVID-19-related program costs. These are considered typical costs. The cost per person served is calculated based on this total.
**The number of people served fluctuates based on disease burden and access to health insurance across Wyoming.
***600 series is defined as direct service contracts.
**** The significant increase in non-600 series realized in 2021 is due to an increase of 900 series payments.
*****COVID-19 Response Costs were spent down and time bound in 2023.

Program Cost Notes

- Ryan White Part B/AIDS Drug Assistance Program Grant—Health Resources and Services Administration (HRSA)
- Ryan White Part C Grant—HRSA
- Housing Opportunities for Persons with AIDS Grant (HOPWA), HUD
- TB Prevention & Control Grant—CDC
- Substance Abuse Block Grant Dollars—SAMHSA
- Preventative Health and Human Services—CDC
- General Fund HIV Medical/Medications
- COVID-19: GFY20 - Ryan White Part B Grant—HRSA - total award $50,000 exp 3/31/2022
- COVID-19: GFY20 - Ryan White Part C Grant—HRSA - total award $59,250 exp 3/31/2022
- COVID-19: GFY20 - HOPWA, HUD - total award $63,889 exp 3/31/2023

Program Staffing

- 3.25 FTE
- 0 AWEC
- 0 Other

Program Metrics

- Number of individuals receiving Standards of Care medical services through HIV, Sexually Transmitted Infections (STIs), 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 STIs.
- Purchasing of insurance for enrolled individuals living with HIV.
- COVID-19 funding was awarded directly to the CDTP from HRSA and HUD based on the grants the program already receives. The funding was not part of the State of Wyoming CARES Act funding.

Communicable Disease Treatment

Events that Have Shaped the Program

- Publication of Healthy People 2030 Objectives including HIV, STIs, Immunization, and Infectious Disease.
- 2011/2012: Implementation of Communicable Disease Treatment Program 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 and HRSA.
- 2018: Program moved to an open formulary, thereby removing barriers for patient access to medications.
- COVID-19 funding was allocated to support services for clients and case management sites to better serve those living with HIV in Wyoming during the year of 2023.
- 2022: 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 and HRSA (this is done every 5 years).
- As of September 30, 2023, SAMHSA no longer includes a TB component in the Substance Abuse Block Grant. As of October 1, 2023, the program's awards for the Public Health & Health Services grant has increased to cover what was previously covered by the SAMHSA Substance Abuse Block Grant.

Communicable Disease Treatment

Program Core Purpose

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

OUTCOMES							
Performance Metric	**CY 2023 Target**	**CY 2024 Target**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
% of gonorrhea cases receiving the CDC-recommended therapy medication[1,3]	90%	90%	87% 370/425	81% 317/389	67% 348/519	86% 266/310	(-)
% and # of Latent TB (LTBI) clients starting treatment in TB Program completing LTBI treatment[2,3,9]	80%	90%	89% 42/47	54% 19/35	77% 36/47	92% 44/48	(-)
% of newly identified HIV positive clients linked into primary care within 3 months of diagnosis[4,9,3]	100%	100%	100% 13/13	100% 14/14	100% 7/7	100% 13/13	(-)
% of clients enrolled in Communicable Disease Treatment Program (CDTP) with suppressed HIV Viral load[5]	90%	95%	83% 190/229	89% 133/150	76% 171/225	57% 127/221	(-)
% of new HIV infections considered a late diagnosis[6]	20%	25%	15% 2/13	14% 2/14	29% 2/7	8% 1/13	(-)

(-) Indicates data not yet available.

Footnote
Numbers 1 - 9 denote further explanations provided in the Story Behind the Performance.

OUTPUTS AND EFFICIENCIES									
Performance Metric	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of HIV clients enrolled in care with a documented CD4/Viral Load[4,7]	205	133	209	181	(-)	116	65	61	(-)
Average # of HIV clients enrolled in CDTP	232	208	246	227	(-)	232	221	221	(-)

Communicable Disease Treatment

# of individuals in the TB Program enrolled for LTBI/active TB disease treatment	56	35	50	42	(-)	19	23	29	(-)
EFFICIENCIES									
Average cost of HIV client enrolled in CDTP[8]	$3,317	$4,988	$6,021	$2,804	(-)	$3,192	$1,876	$1,818	(-)

(-) Indicates data not yet available

Footnote
Numbers 4 - 8 denote further explanations provided in the Story Behind the Performance.

Story Behind the Performance

- Healthy People 2030 goals and objectives, CDC goals and objectives, and the HIV/AIDS Bureau Standards of Care are the benchmarks for the Communicable Disease Treatment Program (CDTP).
- The CDTP provides payment for medical services for approximately 221 clients currently living with HIV/AIDS in Wyoming.
- Statutory requirements are in Wyo. Stat. § 35-4-101 – 113.
- CDC recommends using ceftriaxone 500mg - 1,000mg to treat gonorrhea. Alternative regimens are available when ceftriaxone cannot be used to treat gonorrhea. Antimicrobial resistance in gonorrhea is of increasing concern and successful treatment is important to cure the infection and prevent further transmission. CDC updated their recommendations for gonorrhea treatment in December, 2020.
- 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.
- Potential impacts of the COVID-19 pandemic should be considered when interpreting 2020 to 2022 rates. There have been challenges in obtaining updates on clients from facilities heavily involved in the COVID-19 response.
- According to recent CDC data, 82% of people receiving a diagnosis of HIV nationally were linked to care within 1 month of diagnosis. 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.
- 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 the number of patients enrolled in the CDTP.
- A patient is considered to have a late diagnosis of HIV when diagnosed as Stage 3 (AIDS) at the time of the initial HIV diagnosis or when they progress from HIV to Stage 3 (AIDS) within one year of the initial diagnosis. People who take HIV treatment as prescribed may never move into Stage 3 (AIDS). This measure will always be one year behind, given the one year needed to determine if a case is a late diagnosis.
- Quarterly numbers are based on the total quarter number of clients enrolled in the CDTP. 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.

- Based on all services funded by the CDTP, excluding medications. The program typically 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 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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost*	$678,838	$519,167	$711,104
People Served	576,851	581,348	581,381
Cost per Person	$1.18	$0.89	$1.22
Non-600 Series**	100%	100%	100%
COVID-19 Response Cost***	$14,415,237	$47,837,424	$13,421,624

*Traditional, non-COVID-19-related program costs. These are considered typical costs. The cost per person served is calculated based on this total.

**600 series is defined as direct service contracts.

***The amount shown includes expenditures for the Wyoming Public Health Laboratory (WPHL) and Epidemiology response. Totals may change over time due to billing and payment cycles and grant-approved reallocations.

Program Cost Notes

- FY23 federal funding through the CDC Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement is $589,506
- FY23 State funding is $121,608
- One-time COVID-19 Federal Response Funding through the ELC for Epidemiology and Laboratory response total is $118,152,229.

Program Staffing

- 5 FTE (4 federally funded, 1 state general funded)
- 0 AWEC
- 0 Other
- 8 Temporary epidemiologist positions for ongoing COVID-19 needs

Program Metrics

- Wyoming pediatric influenza mortality incidence was lower than the national incidence during the 2022-2023 influenza season.
- Wyoming incidence of Pertussis, Measles, and Mumps was lower than the national incidence in 2022.
- Wyoming incidence of Salmonellosis, Shigellosis, and *E. coli* was above the national incidence in 2022.

Events that Have Shaped the Program

- The Program operates under Wyo. Stats. §§ 35-1-223, 35-1-240, and 35-7-123.
- COVID-19 dramatically increased the number of cases and cluster/outbreak investigations in 2020, 2021, and 2022. The steep decrease in 2023 cases is likely due to both a decrease in incidence and utilization of home tests which are not reportable.
- Federal COVID-19 funding was spent on COVID-19 testing at WPHL, no-cost testing access to laboratories and point-of-care tests for nursing homes, schools, jails, and prisons, upgrades to electronic systems, contact tracing, county funding for COVID-19 response activities, and additional temporary epidemiology and laboratory staff.

Infectious Disease Epidemiology

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 2023 Target**	**SFY 2024 Target**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
Average # of days to complete case investigations*	3	3	1.8 (CY 2019)	3.5 (CY2020)	3.0 (CY2021)	4.1 (CY2022)	4.0** (CY2023)
# of enteric disease outbreaks detected and investigated by the program and # of other outbreaks investigated*	>5 (>8/1M population)	>5 (>8/1M population)	5 enteric 12 other	9 enteric 7 other	4 enteric 4 other	6 enteric 2 other	7 enteric 5 other**
Wyoming pediatric (<18yo) influenza mortality incidence (# per 100,000 population) (national rate)	At or below U.S. incidence	At or below U.S. incidence	0.0 (0.08)	0.0 (0.25)	0.0 (0.0013)	0.0 (0.0013)	0.0 (0.55)
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	5.2 (5.2)	1.90 (1.83)	0.0 (0.48)	0.34 (0.85)	(-)
Wyoming incidence (# per 100,000 population) of *Salmonella*, *Shigella*, and *E. coli* (enteric diseases) (national rate)*	At or below U.S. incidence	At or below U.S. incidence	21.73 (17.35)	24.78 (14.11)	24.53 (15.82)	32.85 (22.64)	(-)

* Data for this metric are for a calendar year and do not include COVID-19 investigations
**Data thru November 1, 2023
(-) Indicates data collected by calendar year and not yet available

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2021 Q1-2**	**2021 Q3-4**	**2022 Q1-2**	**2022 Q3-4**
OUTPUTS									
# of initial case reports detected by Program through surveillance*	11,500	5,621	4,246	4,913	875**	N/A	N/A	N/A	N/A
# of cases of COVID-19 detected by Program through surveillance	-	39,251	53,546	49,952	5,612**	N/A	N/A	N/A	N/A

EFFICIENCIES									
Cost per case investigated*	$68	$120	$160	$105	#	N/A	N/A	N/A	N/A

* Non-COVID-19 cases
** Data through November 14, 2023
# Data not yet available
- Data not available for this new disease
N/A Data not calculated on a quarterly basis

Story Behind the Performance

- COVID-19 dramatically increased the number of cases and cluster/outbreak investigations in 2020, 2021, and 2022. The steep decrease in 2023 cases is likely due to both a decrease in incidence and increased utilization of home tests which are not reportable.
- The program continues to be a leader in the United States in prion disease investigations. Although no cases of human prion disease have been linked to Chronic Wasting Disease to date, the program conducts risk analysis for all reported cases of Creutzfeldt-Jakob Disease and participates in a national risk assessment with the Centers for Disease Control and Prevention.
- The state incidence of enteric diseases is above the national incidence. Contact with farm and ranch animals continues to be a common risk factor for enteric diseases in Wyoming.
- The large number of initial case reports in FFY 2019 was due to a particularly severe influenza season with large case counts and fatality reports.

Public Health Laboratory

SFY 2023 Program Snapshot

Program Description

The Wyoming Public Health Laboratory (WPHL) performs laboratory testing and services in support of public health, safety, and emergency response. 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

	SFY 2021	SFY 2022	SFY 2023
Total Program Cost*	$3,703,829	$3,264,245	$3,684,950
People Served	576,851	581,348	581,381
Cost per Person	$6.42	$5.61	$6.34
Non-600 Series**	97%	95%	87.6%
COVID-19 Response Cost***	$14,415,237	$47,837,424	$13,421,624

*Traditional, non-COVID-related program costs. The cost per person served is calculated based on this total.
**600 series is defined as direct service contracts.
***The amount shown includes expenditures for the Wyoming Public Health Laboratory and Epidemiology response. Totals may change over time due to billing and payment cycles and grant-approved reallocations..

Program Cost Notes

- In FY23 total expenditures were broken down as follows:
  - General funds - 59% of total expenditures
  - Revenue - 18% of total expenditures
  - Federal grants - 24% of total expenditures
- 600 series is increased due to samples referenced to NMS for testing. This is expected to decrease in Q3-Q4 2024.
- Payroll - 50% of total expenditures
- One-time COVID-19 Federal Response Funding for Epidemiology and Laboratory response total is $118,152,229.

Program Staffing

- 28 FTE (18 state funded, 8 federal funded, 2 revenue funded)
- 1 AWEC
- 9 Temporary COVID-19 Response Expanded Workforce Employees

Program Metrics

- Provide rapid, accurate and reliable laboratory testing.
  - Monitor time from specimen receipt to result reporting as an indicator of turnaround time.
- Increase the number of Microbiology and Chemistry clients receiving real-time laboratory results.
- Develop and deliver relevant training for WPHL clients including Law Enforcement, the Wyoming Department of Family Services (DFS), Department of Corrections (DOC), and sentinel laboratorians; monitor the number of trainings and the number of attendees.
- Report number of test menu changes as a reflection of adaptation to technology and customer needs.
- COVID-19 related metrics:
  - Monitor number of specimen collection kits distributed
  - Monitor number of samples tested
  - Monitor number of rejected samples

Events That Have Shaped the Program

- SFY2023 has largely been shaped by the COVID-19 pandemic and a return to standard testing capacity. SARS-COV-2 testing began in March, 2020, as the pandemic spread across the nation. Through SFY2023, WPHL has responded by maintaining high throughput testing capabilities. For SFY2023, turnaround time for 95% of SARS-CoV-2 testing remained at <24 hours.
- Federal COVID-19 funding was spent on COVID-19 testing at WPHL, contracts with other COVID-19 testing vendors, upgrades to electronic systems, contact tracing, county funding for COVID-19 response activities, and additional temporary epidemiology and laboratory staff.
- SFY2023 required teamwork across agency partners to address problems including specimen storage, waste management, and aging and inadequate infrastructure. The WPHL partnered with the Preparedness and Response Unit and Homeland Security to ensure specimens and critical reagents were stored correctly after multiple infrastructure failures at the WPHL. The WPHL partnered with the Wyoming Division of Criminal Investigation to dispose of waste when waste management systems failed. The WPHL partnered with the Governor's Council for Impaired Driving, the Wyoming Department of Transportation, and the Division of Criminal Investigation to validate new intoximeters for 57 sites throughout Wyoming. Finally, the WPHL has worked collaboratively with the Department of Administration & Information to replace failing infrastructure including chiller (HVAC) systems.
- Response to emerging diseases, new designer drugs, and technological advancements have required implementation of new instrumentation and advanced technologies to accurately and rapidly detect pathogens or drugs. The Microbiology Program has expanded and enhanced its whole genome sequencing capabilities by staying current with methodologies and cross training staff to complete this work. The WPHL has remained one of the highest throughput sequencing laboratories in the nation per capita. The Chemical Testing Program has been actively working to add additional testing capacity and new methodologies to detect drugs of abuse. Multiple funding requests have been submitted by the Chemical Testing Program to state, national organizations, and federal agencies to support these new advances.
- The WPHL operates the microbiology program under Wyo. Stat. §§ 35-1-240, 35-4-133, 35-4-221, 35-4-501, and 35-7-123 and the chemical testing program under Wyo. Stat. §§ 31-6-105 and 31-5-233.

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	**FFY 2023 Target**	**FFY 2024 Target**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
# of non-WPHL employees trained[1]	200	150	113	350	131	134	150
# of changes to the testing menu[2]	≥ 4	≥ 4	6	9	5	2	2
Average time (in days) from specimen receipt to result reporting in Microbiology and Preparedness (TB culture and whole genome sequencing excluded) [3]	1.3	1.3	1.18	0.56	0.92	0.76	0.90
# of SARS-Cov-2 Sequences (# of Variants)	8,000	3,000	N/A	92 (8)	10,171 (15)	28,261 (>20)	4,365 (>20)
% and # of Microbiology clients receiving real-time laboratory results	100%	100%	75.2% 828/ 1,095	82.9% 1,059/ 1,278	90.9% 1,283/ 1,412	97% 1,128/ 1,168	98.3% 1,123/ 1,143
# of EC/IR.II Breath Instruments Repaired	4	≤4	N/A	N/A	N/A	6	3

OUTPUTS AND EFFICIENCIES									
Performance Metric	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**2022 Q1-2**	**2022 Q3-4**	**2023 Q1-2**	**2023 Q3-4**
OUTPUTS									
# of Microbiology and Preparedness tests performed	54,827	64,699	420,495	260,911	58,499	175,007	85,904	35,258	23,241
# of trainings provided[1]	18	32	12	8	11	2	6	5	6
# of SARS-Cov-2 collection kits distributed	N/A	67,377	459,762	230,217	32,164	142,246	87,971	24,499	7,665
# of SARS-Cov-2 tests completed (multiplex tests)[4]	N/A	23,681	152,719 (382,785)	88,743 (218,661)	6,241 (18,325)	61,019 (153,605)	27,724 (65,056)	5,073 (14,641)	1,168 (3,684)
# of Chemistry samples tested (# confirmed)[5]	9,284 (3,996)	6,157 (2,193)	4,526 (3,353)	5,111 (3,178)	5,313 (2,361)	2,575 (2.040)	2,536 (1,138)	2,802 (1,209)	2,511 (1,152)
# of Litigation Support Packages provided	90	45	114	170	138	88	82	61	77

# of times court testimony provided	24	14	20	18	16	7	11	9	7
# of Breath Alcohol Tests performed[6]	6,048	6,048	6,775	5,652	4,148	3,195	2,457	2,261	1,887
EFFICIENCIES									
Cost per test[7]	$52.36 $3,880,970 74,115	$69.94 $3,876,309 55,416	$67.04 $3,510,627 52,364	$47.16 $2,649,918 56,191	$70.86 $3,684,950.24 51,996	$51.10 $1,492,687 29,212	$42.89 $1,157,231 26,979	$68.77 1,849,321.67 26,889	$73.11 $1,835,628.57 25,107
% of expenses from revenues[7]	16.6% $643,875 $3,880,970	11.1% $430,984 $3,876,309	8.7% $306,759 $3,510,627	14.0% $369,971 $2,649,918	17.6% $648,982.12 $3,684,950.24	12.5% $187,224 $1,492,68	15.8% $182,747 $1,157,231	23.2% $429,162.94 $1,849,321.67	11.9% $219,819.18 $1,835,628.57
% of expenses from Federal Grant (no match)[7]	27.7% $1,075,731 $3,880,970	34.2% $1,328,328 $3,876,309	24.1% $846,175 $3,510,627	20.9% $553,477 $2,649,918	23.5% $866,002.92 $3,684,950.24	27.2% $406,699 $1,492,687	12.7% $146,785 $1,157,231	17.5% $324,663.01 $1,849,321.67	29.5% $541,339.91 $1,835,628.57

Story Behind the Performance

- The Preparedness Laboratory program conducts training for sentinel laboratorians in rule out/refer for select agents, biosafety, and risk assessment. The Chemical Testing Program conducts training for county coroners, law enforcement agencies, Department of Family Services, and Department of Corrections officers involved in drug and alcohol testing. In FFY2018, the Microbiology Program was named as Bioinformatics Training Lead (BTL) laboratory for bioinformatics and whole genome sequencing. As the BTL, the Microbiology Program was responsible for laboratory and analytical training for up to 11 jurisdictions in the mountain region. Due to COVID-19, the number of trainings provided was limited to small in-person or online trainings. Due to consolidation efforts by CDC, the BTL was transferred to Utah in 2022. Additionally, due to staff turnover, limited staff are able to complete training for all three laboratories. These limitations caused the number of trainings offered to be significantly reduced.

- In order to meet the needs of WPHL submitters, keep up with changes in technology, meet grant requirements, and address changing public health needs, tests are often added or removed from the testing menu. While the addition of new tests in some years is a reflection of program success, removal of tests may also be a reflection of program success. For FFY2020, WPHL changed this metric. Prior to FFY2020, the metric assessed was the number of new tests validated (all new tests must undergo a validation prior to implementation). For FFY2020, it is more prudent to list all testing menu changes, including test additions and removals, to better reflect the full scope of dynamics the program does to meet the needs of our local, state, and federal partners. For FFY2023, test menu changes included discontinuance of Fecal Occult Blood testing and addition of new Whole Genome Sequencing (WGS) testing.

- 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 are excluded from this calculation because of the wide range of acceptable times (e.g., negative urine tests require 3 days, whereas confirmation requires 10 days for all confirmations except 6-acetylmorphine (20 days).

Regardless, TATs are closely monitored in the Chemistry program. For FFY2023, TAT is less than 1 day, signifying rapid turn around for diagnostic assays. Additionally, due to severe infrastructure problems at the PHL, testing was unable to be completed for 12 business days in all testing areas, and up to 42 business days in certain program areas, resulting in acutely increased TATs for specific assays.

- These numbers represent the total number of SARS-CoV-2 tests completed by the microbiology program. The total number of tests completed for SARS-CoV-2 alone is presented as the top number and the number in parenthesis represents the number of SARS-CoV-2 tests completed using all SARS-CoV-2 methods including the CDC multiplex assay that determines if a sample is positive or negative for SARS-CoV-2, Influenza A, and Influenza B. For FY2023, the majority of SARS-CoV-2 tests were completed using the multiplex assay.

- These numbers account for the total number of samples tested by the Chemistry program. All samples are initially screened for the presence of drugs or alcohol. If the screening results are positive, then the sample must be tested to confirm the presence of alcohol or a particular type of drug. The total number of samples submitted to the PHL is represented as the top number and the total number of confirmation tests are presented in parentheses.

- Under Wyo. Stat. § 31-6-105 (a), the Chemical Testing Program promulgates rules for the testing of alcohol within breath, urine and blood for impairment while driving. As such, the program certifies and retains data from all Intoximeter EC-IR.II instruments that conduct evidential breath alcohol testing. These test numbers represent all breath subject tests conducted by law enforcement for evidential, training, or instrument accuracy purposes. Test collection from each instrument site is downloaded manually. Total number of breath alcohol tests collected during FY2023 is incomplete, additional data will be available December 31, 2023.

- These numbers only account for State general funds, revenue, and federal funds allotted to WPHL on a recurring annual basis, and does not include the monies spent from the CARES Act, the Preparedness COVID-19 CoAg grant, or other COVID-19 specific federal funding (e.g. ELC Enhanced Detection or PHL Intoximeter). For FFY2020 and FFY2021, cost per test was higher and percent of expenses from revenue are lower due to significantly reduced numbers of non-COVID-19 samples submitted. For FFY2023, sample submission to NMS caused revenue expenses to temporarily increase. It is expected that the incorporation of new test methods in early 2024 will reduce revenue expenses.

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.

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

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

Division of Health Care Financing (Medicaid)

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

Appendix A: Program Budget Strings

Public Health Division