Rural Health Transformation Grant Guide — Wyoming

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AUDIENCE: State health agencies, Medicaid, rural providers, collaboratives

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary Wyoming's rural and frontier geography creates distinct access, workforce, and sustainability challenges. The CMS Rural Health Transformation (RHT) Program offers a cooperative-agreement pathway (FY26–FY30) for State-led, outcomes-focused transformation across prevention, access, workforce, innovative care, and technology, with up to $50B nationally and awards to States by 12/31/2025. Half of funds are baseline and half are workload-scored; annual awards may be spent into the following fiscal year. (files.simpler.grants.gov)

The Rural Health Transformation (RHT) Collaborative can support Wyoming with configurable capabilities spanning statewide program management, secure data platforms, tele-specialty coverage, remote monitoring, pharmacy-enabled chronic care, and analytics—delivered by a multi-sector consortium (technology enterprises, systems integrators, retail health, telehealth networks, rural provider networks, and non-profits). Offerings include 24/7 tele-hospitalist/ICU/ED support (Avel eCare), continuous remote physiologic monitoring (BioIntelliSense), qualified HIE/QHIN connectivity and patient engagement (eClinicalWorks/healow, Humetrix), cyber-hardened cloud and analytics (Microsoft), AI triage and workflow tools (Viz.ai, Pangaea Data), and retail-pharmacy extensions (CVS Health, Walgreens, Walmart).

This guide aligns Wyoming's context to RHT requirements and scoring, highlights policy options that can earn technical-factor points, and presents program designs that stay within RHT spending limits (for example, provider payment ≤15% of annual award; capital/infrastructure ≤20%; EMR replacement ≤5% where prior HITECH-certified EMR exists; and "rural tech catalyst"-type initiatives limited to the lesser of 10% or $20M, with conditions). (files.simpler.grants.gov)

The Collaborative's roles remain enabling and contingent on State direction and procurement. All implementation statements herein are explicitly conditional on State policy choices, contracting, integration, data-sharing agreements, and federal approvals.

1.1 One-Page Printable Summary (for internal distribution)

- Purpose: Map Wyoming's priorities to CMS-RHT (CMS-RHT-26-001) and identify Collaborative-supported options that can score well on Table 3 technical and rural-population/facility factors. (files.simpler.grants.gov)
- Key dates: Optional LOI due 9/30/2025; application due 11:59 p.m. ET on 11/5/2025; expected award and earliest start 12/31/2025. Submission via Grants.gov. Executive Order 12372 does not apply; check "No" on SF-424 19c. (files.simpler.grants.gov)
- Funds and distribution: ~$50B (FY26–FY30); 50% equal baseline; 50% workload based on a weighted points system; technical factors recalculated annually; rural/facility factors fixed using Q4-2025 data. Workload formula: Total Available Workload Funding × State Points ÷ Sum of All Approved States' Points. (files.simpler.grants.gov)
- Required contents: Project summary; 60-page Project Narrative; 20-page Budget Narrative; attachments (Governor letter, business assessment, duplication assessment, indirect cost rate if used). Admin cost cap ≤10% of allotted amount per period (direct + indirect). (files.simpler.grants.gov)
- Spending limits (selected): Provider payments (Use-of-Funds B) ≤15%; capital/infrastructure (J) ≤20%; EMR replacement ≤5% if HITECH-certified EMR in place as of 9/1/2025; "Rural Tech Catalyst Fund"-like initiatives ≤ the lesser of 10% or $20M with Appendix conditions. (files.simpler.grants.gov)
- Collaborative focus areas for Wyoming:
    - Stabilize access via tele-ER/ICU/hospitalist coverage, EMS consult, and retail-pharmacy chronic care extensions.
    - Frontier-appropriate remote monitoring and care navigation tools to reduce transfers and readmissions.
    - Workforce skilling, licensure-compact utilization, and AI-enabled documentation relief to address burnout.
    - State data platform and dashboards for RHT reporting and evaluation; cybersecurity uplift.

2. Eligibility and RFP Fit 2.1 Summary of RFP

- Applicant: Only the 50 U.S. States; Governor-designated lead agency; one official application per State; no cost-sharing; awards via cooperative agreement. (files.simpler.grants.gov)
- Timeline: LOI 9/30/2025; application due 11/5/2025; awards by 12/31/2025; five budget periods (FY26–FY30); spend into the following fiscal year permitted. (files.simpler.grants.gov)
- Distribution: 50% baseline (equal split), 50% workload; workload factors include data-driven metrics, initiative-based scoring, and State policy actions with conditional points. (files.simpler.grants.gov)
- Scoring Weights (Table 3): Rural facility/population factors 50% (A1–A7), Technical factors 50% (B1–F3) with specified percentages. (files.simpler.grants.gov)
- Conditional points and recovery: Technical score credit can be granted for committed policy changes; if not finalized

by 12/31/2027 (by 12/31/2028 for factors B.2 and B.4), CMS recovers payments tied to those points. (files.simpler.grants.gov)

- Funding policies: Selected prohibitions under 2 CFR and HHS GPS; telecom/video-surveillance restrictions (2 CFR 200.216); selected program-specific limitations and caps; SF-424 Item 19c "No." (files.simpler.grants.gov)

2.2 Requirement-to-Capability Map (evidence examples)

- Use ≥3 categories of funds (A–K). Collaborative can align prevention (A), provider payments (B, within cap), consumer tech (C), training (D), workforce (E), IT/cybersecurity (F), right-sizing services (G), behavioral health (H), innovative care/value (I), capital/infra (J), partnerships (K). (files.simpler.grants.gov)
- State policy factors (Table 3 B–F). Collaborative advisory members (Accenture/KPMG/PwC/AVIA) support policy analytics, legislative options, and implementation planning; rural HVN formation and governance via Cibolo Health; retail-pharmacy models via CVS/Walgreens/Walmart.
- Data and reporting. Microsoft secure cloud and analytics; Humetrix population analytics; eClinicalWorks/QHIN PRISMA; dashboards for KPI tracking.
- Tele-specialty and remote care. Avel eCare (virtual hospitalist/ICU/ED/behavioral crisis support); Teladoc (nationwide virtual services); BioIntelliSense continuous monitoring; Viz.ai acute detection and triage.

Table: CMS-RHT requirement → Collaborative capability → Evidence

- Application completeness and formats → Program management templates; grant writing TA → Collaborative deck; advisors' program management role.
- Interoperability and TEFCA alignment → eClinicalWorks PRISMA/QHIN; Microsoft cloud and security controls → Collaborative summary.
- Workforce skilling and burnout mitigation → Ambient documentation tools; tele-mentoring; pharmacist workforce pipelines → Collaborative workforce section.
- Behavioral health and SUD support → Tele-behavioral access; 988 crisis, virtual teams; consumer opioid-risk alerts → Collaborative behavioral health section.
- Right-sizing service lines and EMS → GrowthOS analytics; tele-specialty clinics; EMS consults → Collaborative service-mix and EMS sections.

3. Wyoming Context Snapshot

- Rural and frontier profile
    - Share of residents living in rural areas: 37.4% (ACS 1-year, 2023). Wyoming ranks among the most rural states. (americashealthrankings.org)
    - Frontier/remoteness: USDA ERS identifies Wyoming among states with the highest shares of Frontier and Remote (FAR) areas; FAR methodology ties remoteness to travel time to larger urban areas. This increases travel burden for high-order services and supports remote-care strategies. (2010 FAR codes; product updated 5/8/2025.) (ers.usda.gov)
- Rural facility mix (outside Census UA≥50,000; HRSA data)
    - 19 Critical Access Hospitals (CAHs), 0 Rural Emergency Hospitals, 28 Rural Health Clinics, 17 FQHCs, 6 short-term/PPS hospitals (as of July 2025). (ruralhealthinfo.org)
    - Collaborative fit:
        - Tele-ICU/ED/Pharmacy coverage for CAHs and PPS (Avel eCare).
        - Remote monitoring for chronic disease and post-discharge (BioIntelliSense).
        - QHIN/HIE integration and patient engagement (eClinicalWorks/healow; Humetrix).
        - Pharmacy-embedded chronic care and tele-services in retail locations.
- Workforce and HPSA indicators
    - HRSA's HPSA dashboard shows primary care, dental, and mental health HPSA designations across rural Wyoming (data tool as of 10/12/2025), indicating persistent access constraints and recruitment/retention needs in frontier counties. (data.hrsa.gov)
    - Collaborative workforce supports include tele-mentoring for rural clinicians, ambient documentation relief, pharmacist pipeline partnerships, and community health worker skilling.
- Medicaid program context (selected, 2023–2025)

    - 12-month postpartum coverage SPA approved 9/14/2023 (effective 7/1/2023). (medicaid.gov)
    - SPAs in 2025 addressing services for certain justice-involved youth; four-walls exception for IHS/Tribal clinics; quality reporting assurances; inpatient hospital reimbursement updates; Miller Trust admin-fee deduction. (medicaid.gov)
    - Fit to RHT: These updates position Wyoming to integrate RHT initiatives with SPA-backed delivery/reimbursement frameworks and to target reporting and quality improvement. (medicaid.gov)
- Broadband/telehealth and frontier access
    - High FAR prevalence underscores digital-access challenges; RHT eligible uses include tech modernization, cybersecurity uplift, and remote-care expansion, aligned to HHS cybersecurity performance goals. (ers.usda.gov)

Table: Wyoming metrics and matching Collaborative capability

- Rural share (37.4%, 2023, ACS) → Remote monitoring + tele-specialty to reduce travel burden; pharmacy care points. (americashealthrankings.org)
- FAR prominence (ERS) → Prioritize remote-first models and digital navigation; EMS tele-consult. (ers.usda.gov)
- CAH/RHC/FQHC inventory (RHIhub, 7/2025) → Tele-ICU/ED, RPM, value-linked analytics, pharmacy extensions. (ruralhealthinfo.org)
- Postpartum 12-month SPA (2023) → Maternal remote monitoring + tele-behavioral integration pathways. (medicaid.gov)

4. Strategy Aligned to RFP

- Rural transformation model for Wyoming (illustrative)
    - Access stabilization: State-supported tele-hospitalist/ICU/ED coverage for CAHs; EMS tele-consult; 24/7 virtual behavioral crisis support for law enforcement and EDs.
    - Chronic disease prevention/management: Community screening (AHA with kiosk partners), pharmacy-enabled hypertension/diabetes support, home RPM for high-risk cohorts, and virtual specialty follow-up.
    - Frontier navigation and tech: Consumer-facing triage and care-guidance apps; TEFCA/QHIN record retrieval; Azure-based analytics and threat-protected infrastructure.
    - Sustainability and governance: Member-owned High Value Networks (HVNs) to steward funds, coordinate purchases, and track outcomes.
- Alignment to Table 3 scoring dimensions
    - B-F technical factors:
        - B.1/B.2 clinical infrastructure and health/lifestyle—RPM, tele-chronic pathways, and community screenings.
        - C.1/C.2 partnerships and EMS—HVN formation; tele-EMS support.
        - D.1/D.2/D.3 workforce, licensure compacts, scope—skilling and pharmacy-enabled models (subject to State policy).
        - E.1/E.2 payment incentives and duals—analytics for value-linked incentives; duals integration analytics.
        - E.3 STLDI—policy analysis support (if pursued) per Appendix methodology. (files.simpler.grants.gov)
        - F.1–F.3 remote care/data/consumer tech—telehealth, Azure data stack, patient apps.
- Equity strategy for rural and Tribal communities
    - Combine IHS/Tribal four-walls flexibility (SPA 2025) with virtual specialty access, multilingual triage, and community screening routed to FQHCs/Tribal clinics. (medicaid.gov)
- Data use and privacy
    - HIPAA/FHIR-conformant cloud with role-based access, audit trails, consent tools, and TEFCA connectivity; adherence to HHS Cybersecurity Performance Goals.

5. Program Design Options (Wyoming-tuned; subject to policy, procurement, contracting) Option A: Rural Access

Stabilization Network (CAH-anchored)

- Target population: Residents served by CAHs and EMS in frontier counties.
- Problem: Night/weekend specialty coverage gaps, avoidable transfers.
- Collaborative components: 24/7 tele-hospitalist/ICU/ED; tele-pharmacy; Viz.ai stroke/other algorithms; EMS tele-consult; data dashboards.
- Payment logic: ≤15% for direct provider payments tied to gap-filling services; remainder for tech, training, and data. (files.simpler.grants.gov)
- Enabling policy: Clarify telehealth modalities and cross-facility credentialing; evaluate licensure compact utilization; EMS protocols.
- Pros/risks: Rapid access lift; dependency on broadband and credentialing; mitigations via cyber/broadband grants and unified privileging.

Option B: Frontier Chronic Care at Home

- Target: High-risk CHF/COPD/diabetes and postpartum patients (leveraging 12-month coverage). (medicaid.gov)
- Components: BioIntelliSense RPM, pharmacy care management, virtual specialty clinics; AI risk stratification; FQHC integration.
- Payment logic: Device/services via categories A/C/D/F; limited gap-filling direct payments under B (≤15%). (files.simpler.grants.gov)
- Pros/risks: Reduced readmissions/transfers; requires patient engagement and device logistics; mitigated by digital navigators.

Option C: Maternal–Behavioral Integration for Remote Areas

- Target: Pregnant/postpartum individuals and those with co-occurring behavioral health needs.
- Components: Virtual perinatal consults, behavioral telehealth, community screening, remote BP/weight/glucose; crisis line integration.
- Fit: Aligns to RHT H (behavioral health) and A (prevention); leverages WY postpartum SPA. (medicaid.gov)

Option D: EMS Modernization and Community Paramedicine

- Target: Rural EMS agencies and high-utilization patients.
- Components: Tele-EMS support; ePCR data to State platform; community paramedicine protocols; workforce skilling.
- Pros/risks: Faster field guidance and safer non-transport; needs protocols, liability, and training plans.

6. Governance and Collaborative Roles

- Operating model (illustrative)
    - State lead agency (Governor-designated) sets strategy, selects initiatives, and owns RHT reporting; CMS provides substantial involvement under the cooperative agreement. (files.simpler.grants.gov)
    - HVN(s) convened by rural providers with Cibolo Health as neutral enabler; SI partners support PMO, procurement readiness, and benefits realization modeling.

RACI (selected)

- Strategy and selection: State (R), CMS (C), Collaborative (A for advisory), Providers (C).
- PMO and reporting: State (A/R), SI partners (R), Microsoft analytics (C).
- Tele-specialty operations: Providers/HVNs (A/R), Avel eCare (R), State (C).
- RPM/home programs: Providers/HVNs (A/R), BioIntelliSense (R), Retail partners (C).
- Community screening: AHA plus kiosk partners (A/R), local providers (R).
- Data/cyber: State (A), Microsoft (R), HIE/QHIN vendors (C).

7. Payment and Funding

- RHT-compatible paths
    - Value-linked provider incentives (within E.1), duals integration analytics (E.2), and administration ≤10% (direct + indirect). (files.simpler.grants.gov)
    - Caps to monitor: B ≤15%; J ≤20%; EMR replacement ≤5%; rural tech catalyst-type initiatives ≤ lesser of 10% or $20M. (files.simpler.grants.gov)

    - Prohibitions: Funding cannot finance any non-Federal share via IGT/CPE/other; 2 CFR 200.216 telecom/video surveillance restrictions; specified sex-trait modification procedures at 45 CFR 156.400. (files.simpler.grants.gov)

Illustrative funding table (ROM; subject to award sizing and procurement)

- State program management and analytics platform (F): 10–12% of award; State + Microsoft + SI deliverables (dashboards, SORH linkages).
- Tele-specialty coverage (G/I): 20–30%; Avel eCare and provider subawards.
- RPM/home monitoring (A/F): 10–20%; BioIntelliSense devices/services, provider staffing.
- Pharmacy-enabled chronic care (A/C/E): 8–12%; retail partners + FQHCs.
- Capital/renovations (J): ≤20% combined; minor retrofits and equipment (no new construction). (files.simpler.grants.gov)
- Direct provider payments (B): ≤15% combined; narrowly targeted to non-reimbursable gaps. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Core measures and cadence
    - Access: ED transfer rates, time-to-specialist consult, EMS response and tele-assist utilization.
    - Quality/outcomes: 30-day readmissions, ambulatory-care-sensitive admissions, hypertension/diabetes control, maternal remote-BP control.
    - Financial: Net transfer avoidance, avoidable days, cost per episode proxy.
    - Workforce: Vacancy and turnover, documentation time saved, tele-mentoring participation.
    - Technology and cyber: Patch cadence, MFA adoption, incident rates.
- Data sources and integration
    - Claims (Medicaid/Medicare), EHR feeds (QHIN/TEFCA), EMS ePCR, HIE, and consumer tools; Azure data lakehouse; privacy controls and consent management; evaluation-ready datasets for CMS.

9. Implementation Plan (12–24 months; indicative) Gantt-style table (quarters from award)

- Q1 (Jan–Mar 2026): PMO stand-up; governance charter; baseline data ingest; cyber baseline; procurement launches. Owners: State PMO (A), SI partners (R).
- Q2: Tele-ER/ICU/Pharmacy go-live in first CAHs; RPM pilot cohorts; screening events; dashboard v1. Owners: Providers/HVN (A/R), Avel, BioIntelliSense, AHA (R).
- Q3: Expand RPM to maternal/behavioral cohorts; EMS tele-consult; pharmacy chronic care pathways; dashboard v2. Owners: Providers (A/R); retail partners (R).
- Q4–Q6: Scale statewide; refine payment incentives; submit required annual report; technical score refresh inputs. Owners: State PMO (A), SI partners (R). (files.simpler.grants.gov)

10. Risk Register (selected)

- Broadband/cyber limitations in frontier areas → Mitigation: prioritize offline-tolerant tools, invest in cyber uplift and device MDM; Owners: State CIO/PMO, Microsoft.
- Staffing/turnover at rural sites → Mitigation: tele-mentoring, ambient documentation, pharmacy extensions; Owners: Providers/HVN; Collaborative workforce partners.
- Procurement delays → Mitigation: SI advisory on contracting pathways and templates; Owners: State PMO, SI.
- Policy actions miss 2027/2028 deadlines → Mitigation: legislative calendar tracking, early drafting support; Owners: State Legislative Liaison, SI; Consequence: point loss/recovery. (files.simpler.grants.gov)
- Data-sharing barriers → Mitigation: QHIN participation, BAAs/DUAs playbook; Owners: State PMO, HIE vendors.
- Cap over-runs (B/J/EMR/catalyst) → Mitigation: budget guardrails and cap tracking in dashboards; Owners: State CFO/PMO. (files.simpler.grants.gov)
- Compliance with 2 CFR/HHS GPS/telecom bans → Mitigation: procurement checklists, vendor attestations; Owners: Grants Office. (files.simpler.grants.gov)
- Sustainability post-FY31 → Mitigation: payer-aligned incentives and service-line right-sizing; Owners: HVN, payers, SI.
- Community acceptance → Mitigation: non-profit partners' outreach and cultural tailoring; Owners: AHA/NACHC/local

orgs.

- Measurement burden → Mitigation: automate data flows; Owners: PMO, Microsoft/Humetrix.

11. Draft RFP Response Language (paste-ready; adapt to final decisions) 11.1 Project Narrative excerpt: Goals and Strategies "Wyoming proposes to improve rural access, quality, and outcomes by deploying a statewide, cyber-hardened data and tele-specialty backbone; expanding frontier-appropriate remote monitoring and navigation; and forming rural provider High Value Networks to coordinate investments and sustain gains. These strategies address RHT strategic goals and are aligned to the Use-of-Funds categories A, C, D, F, G, H, I, J, and K. We will operate within program spending caps and 2 CFR/HHS GPS requirements." (files.simpler.grants.gov)

11.2 Policy commitments (technical factors) "Wyoming will evaluate and, where appropriate, advance policy changes tied to Table 3 technical factors (e.g., EMS and rural partnerships; workforce recruitment tools; licensure compacts; pharmacist scope pilots; Medicaid value-linked incentives; duals alignment; consumer tech enablement). Conditional points are requested per NOFO, with final enactment by 12/31/2027 (by 12/31/2028 for B.2 and B.4)." (files.simpler.grants.gov)

11.3 Use of funds and caps "Direct provider payments will not exceed 15% of any annual award and will be targeted to non-reimbursable coverage gaps; capital/renovations (Category J) will not exceed 20% and will be limited to right-sizing minor alterations and equipment; replacement EMR spend will not exceed 5% where a prior HITECH-certified EMR exists; and any rural innovation-catalyst initiative will not exceed the lesser of 10% or $20M and will meet Appendix conditions." (files.simpler.grants.gov)

11.4 Reporting and evaluation "Wyoming will submit required performance and financial reports, cooperate with CMS/third-party evaluation, and provide annually refreshed technical-score evidence. State dashboards will monitor cap compliance and progress toward KPIs." (files.simpler.grants.gov)

12. Assumptions and Open Questions

- HPSA counts: This guide references HRSA's dashboard (10/12/2025) but does not reproduce counts. Prior to submission, export Wyoming-specific HPSA counts (primary, dental, mental health) from HRSA and update Section 3. (data.hrsa.gov)
- Medicaid managed care status: Wyoming historically operates predominantly fee-for-service; confirm current managed-care penetration and any care-management carve-outs to finalize payment design language.
- Broadband metrics: Insert 2024–2025 FCC/State Office of Broadband unserved premises statistics when available.
- CCBHC inventory: Per NOFO, attach CCBHC list as of 9/1/2025 with sites and addresses; confirm with SAMHSA/State behavioral health.

13. Implementation Checklist (condensed)

- Governance: Name State lead agency; attach Governor letter; designate AOR; confirm SF-424 19c "No." (files.simpler.grants.gov)
- Narrative completeness: Rural needs; goals and KPIs; initiatives with outcomes/baselines/targets; timeline; stakeholder engagement; evaluation plan; sustainability. (files.simpler.grants.gov)
- Budget compliance: Admin ≤10%; category caps; indirect cost documentation (if used); map lines to initiatives. (files.simpler.grants.gov)
- Risk controls: 2 CFR/HHS GPS alignment; 2 CFR 200.216; prohibited uses (e.g., specified sex-trait procedures). (files.simpler.grants.gov)

14. High-Level Gantt Table (illustrative; quarters from award)

- Q1: PMO; data platform ingest; cyber baseline; procurement milestones (tele-ER/ICU, RPM, analytics).
- Q2: First-wave go-lives (3–5 CAHs tele-ER/ICU; 300 RPM enrollees; screening events); dashboard v1.
- Q3: Scale to 10+ CAHs; expand RPM cohorts (maternal/behavioral); EMS tele-consult; pharmacy disease management.
- Q4–Q6: Statewide scale; value-linked incentives; annual report; technical-score refresh.

15. References

1. Rural Health Transformation Program NOFO (CMS-RHT-26-001), Centers for Medicare & Medicaid Services, files.simpler.grants.gov/opportunities/.../cms-rht-26-001_final.pdf (accessed 2025-10-14). (files.simpler.grants.gov)
2. RHT Program Overview, CMS, cms.gov/priorities/rural-health-transformation-rht-program/overview (accessed 2025-10-14). (cms.gov)

3. CMS Press Release: CMS Launches Landmark $50 Billion RHT Program (9/15/2025), CMS Newsroom (accessed 2025-10-14). (cms.gov)
4. Current CMS Funding Opportunities listing (CMS-RHT-26-001), CMS (accessed 2025-10-14). (cms.gov)
5. RHIhub State Guide: Wyoming, Rural Health Information Hub (last updated 2025-09-11), ruralhealthinfo.org/states/wyoming (accessed 2025-10-14). (ruralhealthinfo.org)
6. American Health Rankings: Rural Population — Wyoming (ACS 2023), americashealthrankings.org (accessed 2025-10-14). (americashealthrankings.org)
7. USDA ERS, Frontier and Remote (FAR) Area Codes — Documentation and Overview (updated 2025-05-08), ers.usda.gov (accessed 2025-10-14). (ers.usda.gov)
8. HRSA Data Warehouse: Health Workforce Shortage Areas Dashboard (data as of 2025-10-12), data.hrsa.gov (accessed 2025-10-14). (data.hrsa.gov)
9. Medicaid SPA WY-23-0005 (Postpartum 12-month coverage), medicaid.gov (approval 2023-09-14; accessed 2025-10-14). (medicaid.gov)
10. Selected 2024–2025 Wyoming SPAs (WY-24-0008; WY-25-0001; WY-25-0002; WY-25-0004; WY-25-0005; WY-24-0001), medicaid.gov (accessed 2025-10-14). (medicaid.gov)
11. Internal: Rural Health Transformation Collaborative. R1. 10-11-25.pdf, RHT Collaborative members' capabilities compendium (provided by client; accessed 2025-10-14).

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