

Sharing, Helping, Growing: Part III

CDC Performance Improvement Managers Network Call

August 23, 2012

Today's Presenters: Josh Czarda, Virginia Department of Health and Geoff Wilkinson, Massachusetts Department of Public Health

Moderators: Teresa Daub & Melody Parker, CDC/OSTLTS

Maryann (Operator): Welcome, and thank you for standing by. At this time all participants are in a listen-only mode until the interactive Q&A session. This conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the call over to Teresa Daub. Ma'am, you may begin.

Teresa Daub: Thank you, and welcome, everyone, to the August Performance Improvement Managers Network Call. I'm Teresa Daub with the Office for State, Tribal, Local and Territorial Support and I'm joined here today by colleagues from OSTLTS, including Melody Parker, who will co-moderate this call. Thank you for joining us today. This is our seventh call this year. As most of you know, the PIM Network is the forum intended to support all of you, the Performance Improvement Managers, and learning from each other as well as from partners and other experts. These calls are a way for members of the Network to get to know each other better, learn about the practices, and share information about resources and training opportunities related to our work in quality improvement and performance management. We have heard from many of you that you want to hear more about what the rest of your PIM colleagues are doing, so on today's call we have representatives from two agencies who will highlight some of their NPHII efforts. Before we introduce our speakers, Melody will review some of the technological features of today's call. Melody?

Melody Parker: Thank you, Teresa. For those of you who are not able to access the web portion of today's call, you may refer to the slides that I e-mailed to you yesterday. For those of you on the LiveMeeting site, you will see the slides on your screen right now. You can also download the slides via the icon at the top right of your screen. It looks like three itty-bitty pieces of paper. If you are on the web you will also be able to see other sites participating in today's call by looking at the Attendees link under the link at the top left.



We have two ways to take your questions and feedback today. First, you may type in your questions and comments at any time using the Q&A box, which you can find by clicking Q&A in the toolbar at the top of your screen. Second, we will open the lines for discussion after our presenters have finished. So please, please, please, please, mute your phone now either by using your phone's mute button or by pressing star six on your phone's keypad. Note that we will announce the identity of those submitting questions today via LiveMeeting. If you prefer to remain anonymous to the group in posing your question, type anon either before or after your question. Today's call will last approximately one hour. The call is being recorded and the full presentation will be archived on the OSTLTS PIM Network web page. We'll be conducting a few polls today on today's call and we will have our first poll right now. Each poll question, I'll tell you what it is, and when I announce that the poll is open you may cast your vote by selecting your response with a mouse click. So please just start clicking. Our first question will give us some idea of who is participating on the call today. Please indicate your affiliation. Are you with a state health department, a tribal health department, a local health department, a territorial health department, a national public health organization, or some other agency or organization we have not named. The poll is open, please cast your vote. Thank you for your response. I'm now closing this particular poll. The next question is going to give us an idea about how many people are on the line today. How many people are in the room with you? This poll is open, please cast your vote. Looks like most of us are flying solo today. Thank you. I'm going to close this poll now. Thank you so much for participating. We'll also want to hear your feedback about today's call, so in addition to these first two polls, there's going to be a final one at the end of the hour where you can tell us what you thought about this call today. Teresa?

Teresa Daub: Thanks, Melody. We'll get right to our presenters from the Virginia Department of Health and Massachusetts Department of Health. Let me first introduce Josh Czarda, who is Performance Improvement Manager for the Virginia Department of Health. Prior to joining the Virginia Department of Health, Mr. Czarda served as the Director of Operations for Mid-Atlantic Evercare, and before that as Assistant Director for Evaluation and Quality at the United Network for Organ Sharing. Geoff Wilkinson is Senior Policy Advisor to the Commissioner of the Massachusetts Department of Public Policy. He served as a member of the department's senior management responsible for public health infrastructure, work force, community health, research, planning and environmental health initiative. He also teaches Health Politics and Policies for the Boston University School of Public Health, and before joining state government in 2007, he directed the state affiliate of the American Public Health Association for five years and served for ten years as Executive Director of a statewide senior citizens advocacy organization. A former community organizer, Mr. Wilkinson is a graduate of the Boston University School of Social Work, where he has taught since 1994. Gentlemen, welcome to the call today, and Josh, the floor is yours now.

Josh Czarda: Great. Thanks. I plan this to be the shortest presentation you hear all year, but I believe some of it is helpful. So, we undertook a very simplistic tip to see if we were leaving any money on the table, essentially. Next slide. So, Virginia, as you know, is a centralized system, although we do have 35 different health districts and we have about 119 different health clinics out there. And none of the



billing is centralized, so each of those individual districts are ultimately filling out their own paperwork, putting it in our WebVision system and submitting it in. And we've got one lonely person here in the office, in the central office, that kind of oversees all our operations in terms of billings. Just to see for big patterns in terms of claim denials, miscounting, that type of thing. Next slide.

So, as you can see, pretty much everybody – this is a very simplified process, but for purposes of this pip I think it's okay. So for all of our health districts and the clinics that are out there, they're all basically going through the same process. So a patient will come in, they'll get it through all the demographics, get their name, register them. We have an eligibility determination process to see if they have private insurance, if they're on Medicaid, you know, what level of income they might be to see if they can be charged a small, nominal fee. Services ultimately get rendered. That entire whatever it was is ultimately recorded in our WebVision system, which serves as good at the time as our medical record as well as our billing system. It's a self-proprietary system. It's, you know, fairly clunky, not a lot of – a diminished rate of function. But it's doing the job right now. And then a good majority of the billing can be done through auto batches. So on a monthly basis, whoever's in charge of billing can go out there, submit a batch and process a vast majority of the claims. But it doesn't capture everything. And for those things that it doesn't capture it's a fairly intensive process where you're going back looking at the encounters that were ultimately – or the services ultimately delivered and then submitting bills, you know, the old-fashioned way. And then again we've got that one person at the central office who kind of does a reconciliation, looks over all that, follows up on some of the accounts receivable, which is a long standing problem here, and then checks to see if we're having any systemic problems in terms of claims or denials and that type of thing. Next slide.

So, just looking at this briefly, we determined right off the bat two areas of potential opportunity. One is in regards to eligibility, and the other being basically how we were billing and that manual process that's occurring for anything that doesn't otherwise get batched. In regards to eligibility, there's a lot of instances where we just – we are capturing it right here in our district offices but we aren't asking the questions. And there are also cases where folks will come in, will be serviced, and then they will ultimately after the fact get approved for Medicaid. Here in Virginia, as well as I think all states, you have basically three months retroactivity, which for us is, you know, some revenue potential. Meaning so if they come into the office, we service them, and then within the next three months they get approved for Medicaid we could potentially bill Medicaid. But we had no process in place to actually look that up. Next slide.

So, what we did, starting with a data agreement through our DSS, our Department of Social Services, we started to get the batch Medicaid eligibility file and then we would take basically a batch report of all of the people that we serviced where we had zero invoices billed for something we know to be billable and then we bumped those two lists basically up against each other to see, hey, is there anybody that we just missed that we could have billed for and should have billed for. And I already covered the retroactivity. Next slide. Those results were fairly surprising for us. When we ran the first reports as the test report, we found basically a quarter million dollars in potentially billable services, meaning it



was a service we billed for to someone who was Medicaid eligible for whom we never sent an invoice for. You know, pretty good chunk of change out there and this is just for one quarter. So this is three months of data. And we looked at that, and then we ultimately sent that out to all of the districts and we said, you know, here's the patient name, here's the soc [SSN], here's the date of the service it was rendered on. Go back in your records and see if you can indeed bill. We found basically, roughly \$70,000 of absolutely unidentified potential, meaning a lot of the \$243,000 was identified through just claim lack. They just hadn't gotten around to it. So that's, you know, that's a pretty nebulous baseline, but we're going to take their word for it that they never got around to it. But there is definitely about 68,000 bucks they just didn't know about. And so for us it's been a great, you know, good revenue stream. We do this four times a year. We've got an extra quarter million coming in. And in addition to that benefit, it's greatly, greatly simplified the process for the folks who are out there billing. 'Cause now they're, you know, they're getting a pre-printed list for them, it tells them what was billable and who they should have billed for. So very, very simplistic performance improvement process. There was no lock to this. And that's about it. Happy to take questions.

Teresa Daub: ... very simplistic but powerful tool, I would say. Thank you for your presentation. We will take question after Geoff presents. So Geoff, I'll turn the floor over to you now.

Geoff Wilkinson: Good afternoon, everybody. This couldn't be much different of a presentation. We're going to go from specific billing operations to talking about the public health infrastructure of a state. Go to the next slide. Since this is a group of PIMs, I want to emphasize that the initiative I'm describing is related to the top strategic priorities as defined by our Commissioner, and one of those is to strengthen the state and local public health system. Next. Next slide, please. So I'm going to describe a process to try to transform our local public health system and to create public health districts through which groups of cities and towns will share staff and services across municipal boundaries to improve the scope and quality of local health service. We've got the 13th largest population in the country but the 44th in land area. We have more local health departments than any other state in the nation. Most of you probably are in states that have county health systems. We don't have any county health systems. Aside from our emergency preparedness regions, we don't have any coherent regional structure for local health services. We don't have any direct state funding to support local health operations. Next slide. So our local public health boards, as they're called, one for every city and town, established by the legislature and invested with tremendous responsibility, are facing a lot of significant capacity gaps. Did we miss a slide there? There was – yeah.

So basically our local public health boards are managing and triaging core services—food safety, infectious disease, community sanitation—and they are working with typically inadequate resources and very disparate resources from one part of the state to another and even within regions of the state, even for cities and towns with similar populations, depending on the characteristics and priorities of the budget-making authorities in those cities or towns. They may have cities and towns with similar populations working with very different budgets. And like a lot of the country we have an aging local health work force. Unlike most of the country, there are no standards except for TB nurses for the work



force. So you can be a public health director just appointed by a town manager because he knew you, or you know, family or business relations. It's a real mixed bag in terms of the professional qualifications. Ironically we have some of the highest, best health outcomes in the nation but it's a real disparate picture in terms of the local health. And now the next slide.

So most of our local health boards do not have capacity to address emerging threats of chronic disease, health disparities, behavioral health issues. Very few get into systematic health assessments, policy development, certainly research is way off the map for most of them. Next slide. So we are like many states trying to steer local health into embracing more than the traditional role of environmental health and community sanitation, food safety inspections, septic inspections for a lot of cities and towns, that's what they define as core public health. Many would like to get into some of the policy issues in the Health Impact Pyramid I'm assuming most of us are familiar with. But this initiative is to try to drive more work towards policy-making and increase the capacity to address health disparities, chronic disease and other challenges. Next slide. The initiative is based in work that started in about 2005 involving five state-wide local health associations. Most of them are the state affiliates of the national public health associations. Along with some academic partners, this state Department of Public Health, some legislators, and we had funding at different points along the way from NACCHO and the Robert Wood Johnson Foundation.

That initiative – go ahead, next slide – defines a half a dozen core principles. And we build support for these over the course of several years. So well before we got funding from NPHII, we had developed the base for the initiative that CDC is now supporting. Kind of key points here with – everybody deserves equal protection and access to public health services. It shouldn't be based on where you live, and also that we need to respect the existing authority of our boards of health because some academically-based suggestions that we scrap the existing system and go to a more rational county-type system made sense theoretically but were political non-starters. So we really made this a voluntary initiative since the state legislature doesn't provide direct funding support for local health operations, there's precious little leverage to require cities and towns to do this. And also one size doesn't fit all. We've provided a lot of flexibility in models. We've enabled people to choose their own partners and the premise is that this should augment the existing resources, not replace them, which, as you can imagine in the economic recession, there was a real fear for local health directors that their municipal officials would use this as an excuse to gut funding that they already had. Let's move on.

So with support from CDC and the NPHII program, under Component 2, Massachusetts was one of the 14 states that received so-called Component 2 funding, and we had two elements to our Component 2. One was this district incentive grant program that I'm describing. The other was a set of three stabilized public health data systems, which I'm not going to discuss this afternoon unless you ask about it specifically. Our funding was pretty generous for this in the originally approved budget but with the other Component 2 grantees we took a cut of about 50% in year two and most of that cut came out of this regionalization initiative, or, as it's now being called, cross-jurisdictional sharing. So we're supplementing the CDC funding with a source that we have control over here. It's actually not state-



legislated funds but money from a determination of need program that hospitals contribute into, and again, I could add some more specific questions about that. We also have participated in an initiative that our governor and lieutenant governor have championed to promote regionalization or shared services across a whole array of municipal services. Since public health was kind of ahead of the curve on this, when the legislature approved the funding to promote general regionalization of municipal services, a different state agency that controlled that program worked closely with us, and as a result we've got another district formed with a different source of state support. So the CDC funding through NPHII has leveraged some considerable additional support for public health. Next slide.

The goals of this problem are to improve the scope and quality of our local public health services and promote policy change to improve population health as I mentioned earlier with that reference to the Health Impact Pyramid, and try to optimize results with the very limited resources that local health has. We saw this CDC grant as an historic opportunity, and you'll see a map later in my brief presentation here where you can see the geographic impact of even the districts that we've been able to salvage with the funding cuts. So we really want to encourage shared services across cities and towns to make best use of available resources. Next slide.

Let's talk about the program design a little bit. We had two phases. In the first phase we had a competitive RFR process and we invited groups of cities and towns that wanted to explore the possibility of creating districts to apply for planning grants. We got 18 groups of cities and towns that applied. We chose 11 of them. Together they comprised 113 cities and towns and almost two million residents. And with grants that ranged up to \$30,000 they worked over the best part of a year coming up with proposals for implementation grants, which we agreed to provide over a four-year period. That's Phase 2 and we're in Phase 2 now. Nine of those 11 grantees applied for implementation grants, and we were able to afford to fund five of them. We would have liked to have funded all of them, and we've executed contracts early this year and so they are up and running. Together they comprise nearly 50 cities and towns and just shy of a million residents in the state. They are each getting grants over a four-year period. So they all got \$100,000 in year one, which is NPHII year two. They're all getting another \$100,000 in year two of the implementation grant period, or NPHII year three. And then there will be a two-year step-down after which time they're expected to be financially self-sustaining. We're providing a lot of technical assistance through separate contracts that the Department manages. And I'll talk a little bit more about that in a minute. But that's off-budget for them so they are able to use this money flexibly. Most of them are hiring staff and/or contracting for specific services, like nursing and inspectional services. We also have professional evaluation for the overall project and for each of the five grantees. So they all have their own logic models, their own performance goals and their plans, which they're being evaluated against. Next slide.

So you can see with the colored areas here the areas that we were able to fund with the planning grantees. And as I say, all of those – all but two of those groups sought funding to do implementation. Next slide. Here you can see where we actually funded the five districts. So there's some significant territory that wants to do this, and with some available additional funding we will keep the momentum



rolling trying to connect more of our cities and towns in shared service arrangements. Next slide. Each of the districts had to meet certain qualifications to be defined as such, and we were flexible in terms of defining boundaries, recognizing that the state's population is divided very differently. We have large rural areas. You probably don't think of Massachusetts that way but in fact a lot of the state is technically rural, especially out in the western part but also in south central and southeastern Mass. So we allowed districts to cover a large population or a large land area or a certain number of cities and towns to provide flexibility and to provide models of different approaches to doing this. We require everyone to have their own governance structure and these are typically augmenting the existing boards of health so they can enter into these agreements without losing local autonomy, which was a big issue for them. But they do have to establish governance over whatever it is that they're sharing, and some of these are very comprehensive service-sharing models. They also have to establish work force qualifications for their directors, nurses and environmental health inspectors hired with grant funds. We're requiring that the boards of health get training under this program, because one of the things we've found is that elected or appointed boards of health typically lack qualifications and experience. Next slide.

There are various services and activities that they are all required to perform. There are different timelines for these, but all of them are required to address their core legally-mandated responsibilities for food safety, surveillance and follow-up on some 90 reportable diseases that we have in Massachusetts and basic community sanitation. You think well, isn't everybody doing that anyway? And the answer, unfortunately, is no. And so to bring up these communities to compliance with those state responsibilities will mark a dramatic achievement in some areas of the state. They are all required to do formal community health assessments. We are integrating information about preparation for accreditation as part of this. We're not requiring preparation for accreditation but we are requiring health assessments so that they can start on that road and get some introduction into formal health planning. They all have to join the Mass Virtual Epidemiological Network, which is an electronic infectious disease surveillance and control system that we have established. And they all have to do some kind of policy campaign on tobacco and/or obesity over the period of the grant. We had some very specific requirements about them involving local municipal officials, not just public health, to try to get buy-in from beyond public health to sustain this work over time. And they're all collaborating with private provider networks, academic partners, or others, to strengthen the overall public health system through these districts. Next, please.

I mentioned that we're providing technical assistance. So we have a team of lawyers that are available to them and that has probably been the most used of the technical assistance services, and they have explored how to set up inter-municipal agreements, formal agreements among the cities and towns. They've gotten into liability issues, collective bargaining issues especially in a district that literally bringing all of the employees from the member communities under the employment of the lead city in that district, and a host of other legal issues. We've provided some financial planning assistance. They're all getting professional evaluations, as I mentioned. They're getting professional assistance with their community health assessments, and there's a learning collaborative that we have established that



meets periodically in person or by phone so that they can share information together and we can maintain communication with them as a group. We also developed an online tool kit to start the planning process, and it is available. If you're interested I'll provide the web link through our CDC partners and you can – I think Melody will be available to pass that out if you want it. But it's very specific and very user-friendly and it includes a number of tools that help jurisdictions look at opportunities, look at potential benefits, or look at their personnel and their financial arrangements, compare what they're doing against partner communities and think about in a logical way the steps to develop shared service arrangements. Now, this is not just something that's relevant in Massachusetts, and so even in states with county systems there's a lot of experimentation and interest in cross-jurisdictional sharing. And I think the tool kit may be useful to those of you who may be engaged in some of that work. Can we have that next slide?

So before NPHII funding, we had less than 10% of the population covered in health districts. The areas you see way up in northeastern Mass and a little bit south of that near the Boston area in red had just started some shared service arrangement through their own private initiatives. The green areas on this map are longer-standing districts. So we had a little experience which was actually useful in helping to sell the idea of the efficiencies of cross-jurisdictional sharing. But if we go to the next slide, you can see the rather dramatic impact geographically of the districts that we've formed. And if you think about those planning grantees that you saw earlier and imagine that huge swath of communities in southeastern Mass, for instance, and others, there's a potential for really historic transformation of our local public health infrastructure. So we are enormously grateful to NPHII and CDC for supporting this, and we think it's very promising although, you know, it's still really getting underway and a lot of work ahead of us. That's it for me, and I look forward to the discussion that follows.

Teresa Daub: Geoff, thank you, and Josh, thank you as well for both of your presentations. You did a great job and we have plenty of time remaining for questions. So why don't we go ahead and open the lines now, Maryann, and we'll take questions live. We will also continue to take questions via the LiveMeeting site if you all prefer. The one question that came in through the LiveMeeting site was will we send the tool kit link from Jeff via e-mail, and we will certainly do that. Are there any questions on the line today? Any additional comments from our presenters?

Laverne Snow Teresa?

Teresa Daub: Yes?

Laverne Snow: This is Laverne Snow in Utah. I sent a question – I typed in a question about sending the tool kit that was discussed by the PIM ListServ?

Melody Parker: Yes, Laverne. This is Melody. I will be sending that out in the follow-up e-mail to the PIM Network list.

Laverne Snow: Thank you. That's great.



Melody Parker: You're welcome.

Teresa Daub: Are there any other questions on the line? Harald?

Harald Pietz: This is for Geoff. Both very good presentations. It's great to be seeing what's happening there. Geoff, I know it's early on that, but are you seeing any – with the consolidation in the jurisdictional services – any kind of measurement that you can report out on around a return on investment or in cost avoidance?

Geoff Wilkinson: We haven't measured that yet, so I think the simple answer is no. It's easier to talk about improved services that we're seeing. What the first performance benchmark that we established was for cities and towns to join MAVEN, this electronically-based infectious disease surveillance and control system. We have the state Health Department in our laboratory. Our epidemiologists in our lab linked with mandated reporters in the provider community, private labs and local health departments. And a number of communities were not on that, so they are facing a deadline on the end of this month and compliance is excellent on that. So that's a very significant achievement. But we don't have ROI data in yet. We won't see that for some time probably.

Harald Pietz: But it would be something you're tracking towards on that?

Geoff Wilkinson: Yep.

Harald Pietz: On the MAVEN with these things, is there a potential – I'm just thinking, you know, you might not have it now but in looking out for future stories and then we would have the increase in not only the ability to report through MAVEN but an efficiency in terms of an increase in rapidity for reporting or eliminating any lags in reporting from the systems.

Geoff Wilkinson: Yes. We will be able – we will be able to look at that and we'll be able to document an increase, not just – as an example, we did a survey several years ago where we found 18% of communities in western Mass were failing to follow up on any of their reported disease events. Pretty appalling. So we will be able to track that in a lot of detail.

Harald Pietz: That would be great.

Teresa Daub: Geoff, we have another question for you from Debra Tews in Michigan. And the question is: is there a Board of Health for each of the separate 351 jurisdictions?

Geoff Wilkinson: The answer is yes. The legislature created an authorized state board of health for every city and town. Appointed or elected, it depends on the jurisdiction. But each of them have a uniform set of responsibilities defined by the legislature under state law, and then in regulation we publish a guide and a summary with web links, it an electronically-based document that we periodically update. So we make that available to all boards of health, and it's a significant document. They have a lot of specific responsibility and authority in food control, community sanitation, infectious disease, follow-up on everything from tanning salons to labor camps, child camps, all sorts of stuff. And it's the



same set of responsibilities regardless of whether it's Boston with, you know, one of the nation's preeminent health departments, or communities in rural parts of the state that don't have their own staff.

Teresa Daub: So Jeff, thank you for that explanation. There's a follow-up question from Debra. What were the challenges to get these 351 boards on board with the shared services model?

Geoff Wilkinson: Well, I should hasten to say that they are not all on board. And as you saw from the maps this is a rather ad hoc and incentive-driven voluntary approach. So we – lacking the adequate funding to provide compelling enough incentive, we do not expect to have every city and town within some kind of a district. Our hope eventually would be that the legislature would support this effort through some directed support to local health and that if, as in the neighboring state of Connecticut, we had some incentive in the local aid for public health formula we might have a better chance of a more comprehensive approach. However, so saying, with those qualifications, that regionalization working group that I mentioned in the presentation where I showed you the different partners that started back in 2005 to build support for this, went through a very intensive and years-long process of stakeholder engagement and consensus-building around those principles and around the contours of an approach that we were able to then put before CDC, and that involved meetings, lots of meetings, evening meetings with boards of health around the state. And at one point in the process it culminated in a state-wide conference where Boston University School of Public Health loaned us marketing technologies so that every one of the over 200 people that attended – about 250 people attended and they all had their little switches in their hands so that they could dial in their personal responses sitting in the meeting. So we had that level of support for building and demonstrating consensus.

So – but it was – yeah, it was a long, tough process. And there were a lot of people who did not want this because they thought that they didn't need it or that they would lose authority or that their municipal officials would use this as an excuse to take away their current funding or that somehow their Boards of Health would disappear and they would lose local control. Lots of fears and concerns, some of them I think well-founded given the experience that some cities and towns had in the depths of recession where a local health department bore disproportionate shares of cuts as municipal authorities strive to balance budgets and figure out what to cut: schools, police, fire, public works. Public health often took the brunt of that. And so they were afraid that regionalization or shared services would be a way to, you know, kind of further cut them. So that consensus about this general approach was hard won over a long time. And it's – I think the discussion goes on. It's still controversial in some quarters, but support for the concept has really grown a lot and you can see with the map of who applied for – well, actually who got planning maps. You didn't even see the map of who applied for planning grants. There was very strong interest in it.

Teresa Daub: Geoff, thank you for sharing with us since learning from that experience. Certainly having 351 boards gives us all a lot to think about. Your point that it didn't just start with NPHII, it started in 2005, is very well taken, so thank you. Let me remind everyone that our lines are open at this point, so please use your phone's mute button to mute the line or star six to mute your line. Josh, we're going to



move to a question for you now. And this question comes from David Walton, and David is interested to know what position in the public health department, what part of your improvement teams of the project you just asked about today.

Josh Czarda: Oh, pretty small. So – well, pretty small to begin with. So it was myself and then we've got one other person who kind of oversees the billing here at the central office. Kind of a spinoff from some of the work we've been doing at Plan First, which is a Medicaid family planning program. So we had started to just check on the billing patterns of that and then we realized we had some opportunities to, you know, just match these simple reports up. So we expanded it out a little. We had our IT folks develop the algorithm for us to bump these two databases up. And then of course we had basically volunteers from our 35 districts to actually go through the billing and then kind of validate our result. So, pretty small, very simple, took less than a month to complete and has a pretty good result.

Teresa Daub: Thank you, Josh. That less than a month to complete answered another question we had here in the room. Let's go back to the lines and see if there are any additional questions or clarifications needed. Okay, hearing none I'll move back to questions on LiveMeeting, and Geoff, this is another question for you. Will you talk a little bit more about how PHAB's accreditation standards are being used, or not, and identifying and developing the capacities and activities of the district?

Geoff Wilkinson: Well, PHAB of course was based in the – 10 of the 12 PHAB domains are based on that wheel of the ten essential services of public health. That also forms the basis for this initiative, and that predates the NPHII initiative. But we proceeded on the same basis and that was part of the public education we did starting back in the mid-90s – I mean the mid-2000s – as we talked about what public health systems should be able to do. We have, with our five grantees, talked with them about PHAB and told them that they will be getting information about the PHAB accreditation process. We've talked about that already in one of the learning collaboratives. But frankly, we're not doing much about accreditation now because these districts are still in the process of negotiating the formal so-called inter-municipal agreements, which is the legal mechanism that they're using to formalize, legally formalize the districts and create their governing structures. So, that's the focus of their efforts now, along with hiring their coordinators with grant funds, getting on board with MAVEN, and addressing some of the other more immediate performance requirements that they face. So we'll be providing more education about PHAB and the accreditation process and standards as we go forward with the project.

Teresa Daub: Excellent, Geoff. Thank you for your response.

Geoff Wilkinson: I should add, though, one of the districts is formally committed and has in its logic model the intent to become accredited. And so we will be working with them through the learning collaborative in that process that I described of education and encouraging other districts to do the same. But you have to think, you know, and as you think about this just remember that some of these districts are composed of cities and towns that literally don't have any public health staff, have not had



public health nursing services, have had sporadic inspectional services. And so the idea of meeting the PHAB standards is very hard to -conceptually, very challenging to them.

Teresa Daub: Thank you for elaborating on that. Let me again go to the phone lines and see if there are any further questions or comments.

Harald Pietz: This is Harald. I have another question for Josh. Josh, when you were pulling together the work that you were doing, did that stem from your year one work when you compiled or looked at all the different systems and put them into one kind of performance management system?

Josh Czarda: In part, but it was a little unrelated in the sense that this really came from our Plan First efforts. The Plan First Medicaid family planning program classically low on enrollment. Started off with about 6,000 people. We've bumped it up to about 30,000 people now as of, I think, last week. As part of that project we started to look at the revenue gained by the districts from being able to bill Medicaid for basically family planning. And in doing that we realized we had opportunities to kind of do it across the board for all the folks we were servicing since we were getting the Medicaid eligibility filed. So yeah, it's an offshoot and ...

Harald Pietz: So I was just curious in, you know, the process that goes into that and many different activities that are going on there. When you were looking at your first quarter savings and then projecting out and looking at your annual saving, is this something that is predicted to be able to go on for as long as, you know, the well is there to be tapped?

Josh Czarda: I think so. And I think it's, you know, revenue, we've – I would love to actually go back and look at just past years to see how much money we left on the table altogether. Which we could. But yeah, I think this will be, you know, an enhanced revenue stream going forward. Our levels of patients that we service with these type of services has stayed fairly consistent if not increased over the last five years, so there's no reason to think that, you know, this revenue stream would dip any. We'll just become more efficient at billing, and save some time for our billings in the process.

Jill Lewis: This is Jill Lewis with Alaska, and this is something that we have employed in our state, primarily with the actual Medicaid program but in other billing areas as well. And in addition to the retroactive eligibility of that is very important to look at, you also should remember that there's retroactive claiming for eight quarters, the current quarter plus seven prior quarters that you can go back and re-examine and then submit an amended claim for. So just about two years. And where we found our greatest savings, Alaska has a lot of Indian Health Service claiming in the Medicaid program, which is 100% federal. There is no state match for those claims. And we found that there were a lot of folks who were not initially identified as being IHS eligible but were later identified, and by doing the retroactivity analysis on a regular basis we have continued to find revenue years into this. Those are all ways that you could build on what you've already started.

Josh Czarda: That's a good point.



Teresa Daub: Thank you, Jill. Thank you. Are there other questions and/or comments or stories? We have the line for eight more minutes, so this time and space is yours to talk with one another if you have any other questions or comments from the lines.

Carol Heier: This is Carol Heier from Alabama. I wondered if you had any problems in getting access to the Medicaid eligibility file and if you did, how did you overcome those?

Josh Czarda: No real problems. We pretty much got our Commissioner together with the Commissioner of DSS in the room and I explained the reasons and rolled it by the lawyers and – that’s probably the lengthiest part of the process. But it really wasn’t problematic. These were folks we were servicing anyway. And I would think in most states that eligibility file can or should be pretty easily integrated with the state health department.

Carol Heier: Thank you.

Teresa Daub: Anything else from the group? Very good, then. We will go ahead and close out today’s call. Geoff and Josh, I want to thank you for your presentations and everyone else for your questions. We do have one last poll on the call, so please respond. How would you rate this webinar overall? If you have any additional feedback on this call, including topics for future calls, please e-mail us at pimnetwork@cdc.gov. We would love to hear from you. We hope you will mark your calendars and plan to join us on September 27th for the next call. The topic will be Engaging Leadership and Gaining Buy-In. This is a special request repeat of the popular session from the May 2012 NPHII Grantee Meeting. So don’t forget in the meantime that you can view and download all calls and materials from the PIM Network web conference call series on the OSTLTS PIM Network website, and if you have any questions or concerns, please let us know at pimnetwork@cdc.gov or call us directly. So thank you all for participating and we will say goodbye now.

