Final Evaluation Report: Southeast Central Regional Public Health Network Pilot Project

June 30, 2011

Mona P. Klose, MS, RN, CPHQ

Introduction

The Southeast Central Regional Network Pilot (SECRN) project was a collaborative between Central Valley Health District (CVHD)—the grant administrator, City-County Health District, LaMoure County Public Health Department and Wells County District Health Unit. A collaboration describes efforts of people or organizations working together to achieve a common goal that could not be done with individual efforts. (Strieter & Blalick, 2006) The collaborative formed to increase capabilities, create consistency and realize efficiencies with respect to administrative (capacity building) functions - billing, standard policies, community health assessment and public health accreditation; public health services - family planning, chronic disease management (CDM), sexual assault response team (SART) and immunizations. The functions selected for the project were chosen because participants determined they were capacity-building activities; services selected for the project were identified according to county health profile information in addition to being existing services that had potential to be expanded within the pilot area. For the purposes of this report, efficiencies are defined as steps or practices that generated new revenue and those which demonstrated time/cost savings (interchangeable) realized by identification of avoidable costs. The final evaluation report includes findings from all pilot agencies gathered utilizing personal interviews and online survey monkey which will be presented in general discussion, administrative function efficiencies, public health services, fiscal revenues, benefits and challenges, succession planning and implications for future regionalization of public health services.

General Discussion:

Funds for the regionalization project were received in July 2010, one year later than expected, with a completion date for the project of June 30, 2011. This 'fast track' time period of less than 2 years as planned for organization, relationship building, as well as implementation and training must be considered. Staff at the grant holding agency should be commended for their efforts to provide service to the 3 affiliating collaborative agencies over and above already existing duties. The affiliating agencies should also be commended for the addition to regular provision of services to implement this system. Evaluation data presented includes primarily qualitative data, as the short time period makes it extremely difficult to produce reliable quantitative data. The data presented in this report identify the following: where efficiencies were gained (+), where efficiencies were not gained (-) and where efficiencies may be gained by a change in approach (*) – please see categorization in the table on page 2, where N/A denotes not applicable.

Efficiency Type:	Function or Service:	Efficiency Gained (+)	Efficiency Not Gained (-)	Change in Approach Necessary (*)
Capacity Building	Time Information Management System (TIMS)	+ Time Savings	N/A	* Env Health IMS
Capacity Building	Single Client Chart	+ Time Savings	N/A	N/A
Capacity Building	Billing System (Ahlers)	+ Cost Savings	N/A	N/A
Capacity Building	Standardized Policies	+ Time Savings	N/A	N/A
Capacity Building	Community Health Assessment (CHA)	+ Cost Savings	N/A	N/A
Service Sharing	Family Planning	+ Cost Savings	-	* Gas Cards
Service Sharing	Chronic Disease Management	+ Time Savings	N/A	* Billable Service
Service Sharing	Sexual Assault Response Team (SART)	N/A	-	N/A
Service Sharing	Immunizations	N/A	-	N/A

Capacity (Administrative) Functions – Efficiency Detail:

- **Time Information Management System (TIMS):** TIMS is a web-based time recording system that offers report functionality. It is particularly useful for payroll and fiscal purposes in that manual tabulation is minimized and hours by cost center (program) can be tracked in summary or detail formats. TIMS also useful for completing request for reimbursement reports where personnel and fringe costs are listed. Additionally, TIMS is used to track statistics such as number served when providing immunizations, number of participants receiving health education and county served for regional programs. As a web-based system, TIMS is accessible anywhere there is internet connectivity and requires virtually no annual maintenance. By utilizing TIMS as a time recording tool, end users involved in payroll and fiscal-related activities reduce time spent by about half compared to manual processes.

When TIMS is used for statistical purposes, such as for state aid reports identifying skilled nursing services, results are instantaneous. Although tracking time by county is possible with TIMS, more detail is needed with respect to the provision of Environmental Health Services so that counties readily know the status of work in their particular area. Central Valley Health District staff implemented an Excel-based tracking method previously used by Fargo-Cass public health to record such work, however an information management system with inspection documentation capability is needed to fully maximize provision of regional environmental health services.

The online survey of administrative support personnel (N=3) provided the following data:

- **Client Charts**: Client charts were condensed into one chart with uniform forms and tabs. 100% reported utilizing 1 chart per client for services and inactive charts are separated from active charts. Utilization of one client chart resulted in minimizing time spent (at least 1 minute per client = $3,218.00) checking several different places to obtain the desired client information and expedited the process of checking in for client visits/appointments. By utilizing the Ahlers system, clients are identified by a chart number, which also enhances confidentiality and HIPAA compliance.

- **Ahlers Billing System**:
  - 100% reported NOT utilizing the appointment scheduler.
    ** One respondent reported inadequate time to learn and use the system, no comments from the others.

  - 66.6% reported 100% of client demographic and insurance information is entered into the system, 33.3% reported 50% of their client demographics and 25% of their client insurance information is entered into the system.
    **Respondents reported this information is entered at the time of the encounter. Note one health department reported the volume of 3300 charts to update.

  - 33.3% reported services are entered into Ahlers at the time of the client encounter, 66.6% reported entering at a different time.

  - 100% reported nurses are NOT filling out the billing/charge sheet at the time of the client encounter

  - 33.3% reported front desk and billing staff enter the billing/charge sheet information completed by the nurse at the time of the client encounter, 66.6% reported no.
    Respondents reported nurses have difficulty remembering to fill out forms or are not filling them out timely, charge/billing slips are not being used at all, and slips are fill out when nurse returns from the field. **These findings indicate process issues among staff at the health departments which need to be corrected in order for full efficiency potential to be met.

- 66.6% reported entering client payments at the time of receipt and printing receipt for client from Ahlers, 33.3% do not.
  **Respondent reported entered at the time billing sheet is entered, and hand written receipts continue to be used. One respondent would like itemized receipts for their clients, however this is not possible with the Ahlers system.

- 100% reported utilizing Zirmed (claims clearinghouse) to process insurance claims – cost savings identified by using Ahlers and converting to Zirmed is approximately $12,208.00 (time spent reduced from 98.5 minutes to 6 minutes, or 16 times less).

- 66.6% are entering insurance payments into Ahlers at the time they are received, running monthly reconciliation reports for clients and insurance and using worksheets from CVHD for monthly reconciliation, 33.3% are not
  **one agency has not fully implemented---just beginning lack of time to commit and learning curve identified as problematic

- 33.3% reported using the procedure code report to identify service statistics, 66.6% are not.
- 33.3% reported using Ahlers reports to complete AAR chart audits, 66.6% are not
  ** The respondent utilizing Ahlers noted time savings from approximately 60 minutes to 5-10 minutes in the process, and hoping to also use it for program evaluations and to figure actual cost of services. Respondents not using the system to the fullest note lack of knowledge.

- 100% reported no longer using manual processes for statistical purposes; however they are not using Ahlers for mailings.
- 66.6% reported implementing the sliding fee scale and providing education to clients regarding it, 33.3% have not.

This data collected indicates a positive response for implementation of the Ahlers system with efficiencies gained. Additional time to fully learn and utilize the potential of the system is needed. Processes within agencies need to continue to be modified and reinforced to assist in the full use of the system. Overall, the implementation of the Ahlers billing system has reduced staff time resulting in cost savings. Additionally, the Ahlers system has provided a mechanism for participating health departments to track outstanding balances, payments, generate service-related statistics, and more accurately identify revenue.

Cost Savings, Revenue and Return on Investment:

The SECRN was successful in cost savings and efficiencies in several areas. The largest cost savings (70 %) was on the implementation of the Ahlers system as a network for the collaborative agencies. Proceeding in this manner saved roughly $15,000 in software costs versus implementing each agency as its own entity.

	Cost Per User	# of users	Reg cost	Rate per addl user	Network cost	Total savings
City-County	2400	3	**7200**	733.33	**2,200**	**5,000**
Wells	2400	2	**4800**	733.33	**1,467**	**3,333**
LaMoure	2400	2	**4800**	733.33	**1,467**	**3,333**
CVHD	2400	2	**4800**	733.33	**1,466**	**3,334**
			$21,600		**$6,600**	**$15,000**

Implementing the Ahlers billing system has made to it possible for these sites to function more like a business and in one particular case resulted in establishing a revenue stream of at least $10,000 per year. The billing system also provides the means to convey the value of public health services to clients. The pilot group partners are currently working on calculating an estimated Return on Investment (ROI) with respect to implementation of the Ahlers billing system.

- **Standardized Policies**: Over the twelve-month period policies and procedures utilized by all agencies were evaluated in an effort to develop a standard set that could be agreed upon and posted on Central Valley Health District's website. After careful evaluation, it was determined that because each health department had subtle variations due to medical director and services that standard policies and procedures would not be possible (except for environmental health where standardization was accomplished). Central Valley Health District staff posted the agency's policies and procedures on www.centralvalleyhealth.org (facilitating current and future updates). As a result, LaMoure County Public Health Department was able to become up-to-date on policies and procedures, which saved staff time and personnel expense. Individual websites were also created by Central Valley Health District staff for each health department where agency-specific policies are accessible. Staff at each health department was trained to facilitate in-house website updating, which saves consultant costs for web updates.

- **Community Health Assessment**: Community Health Assessment is the process of formally assessing and documenting the health status of a community. Community Health Assessments provide the ability to leverage community resources so they can do the most for you. A community health assessment document was completed for the SECRN and data was delineated by health department (county-level data distributed in summary form). Key data sources included the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS). The document was formatted in a way that will facilitate statistical updating in subsequent years when the CHA needs to be completed. From here, health departments can convene community partners to review the data, identify priorities and work toward creating a community health improvement plan (CHIP). Completion of a CHA is now a requirement of not-for-profit hospitals and for half of the health departments having a CHA document has strengthened the relationship between the health department and local hospital. CHA's and CHIP's are key aspects of sustainability due to the comprehensive (non-programmatic silo) approaches required for each component.

- **Public Health Accreditation:** Strong administrative policies and a Community Health Assessment are two key components in preparing for public health accreditation. SECRN health departments have engaged in both activities and Central Valley Health District staff has shared recommendations from the beta test site process completed in 2010.

Public Health Services – Efficiency Detail:

The members of the collaborative project all provide services to their constituents as identified by needs and federal programs in their jurisdiction. The four main services targeted for this project included chronic disease management, immunizations, family planning and sexual assault response team (SART).

Due to the fact that no formal comprehensive assessment of the regional communities were conducted prior to the establishment of the pilot group through the Joint Powers Agreement the services area was not able to meet full potential. The following depicts the progress:

- **Chronic Disease Management (CDM)**: City-County Health District and Central Valley Health District are completing the third year of a Health Resources and Services Administration (HRSA) – funded chronic disease management program (Tri-County Chronic Disease Management Program). This program is the only public health CDM program in North Dakota and CDM is an Evidence-Based Practice. Copies of all CDM program materials including protocols, educational materials (such as My Personal Health Journal) were shared. Training in the form of videos and concepts were provided. SECRN staff indicated the CDM training was beneficial and would like to expand the CDM program to each respective area. Currently, the HRSA funding cannot support additional counties. SECRN collaborative agencies are exploring partnering for the next application cycle of the HRSA grant as well as pursuing discussions to facilitate billing for CDM services.

- **SART**: Much information was gained with this collaboration. Services for SART are available in other regions for 2 of the 3 participating health units. Lamoure County has a resource in the Kedish house in Ellendale (neighboring Dickey County), and Wells County has services out of Devils Lake. Even with these other existing services, there are gaps that must be addressed. One agency is interested in services from Central Valley Health District and details are being investigated.

- **Family Planning**: The need has been assessed and is present, however SECRN participants determined it would not be cost effective for Central Valley Family Planning staff to travel and provide services in the outlying areas (substantiated by a survey to gage interest in outlying communities if services were offered onsite). Hours for CVHD Family Planning have been modified to include evening hours, which has proven to be successful. Five evening clinics were scheduled over a six-month time period and clients from the SECRN areas received services during two of the five evening clinics. Providing transportation assistance (gas cards) may be a way to increase provision of services to clients in outlying areas.

- **Immunizations:** No new activities have transpired in this area due to the collaborative project. All involved agencies had worked together in the past with sharing of vaccines if needed and assisted in clinics as needed. A comparison of vaccine serum was completed by Central Valley Health District staff and it was determined that there is consistency in vaccine serum costs among the SECRN health departments, so group purchasing is not warranted.

- **Environmental Health:** This area has expanded services in a wider area than the SECRN collaborative agencies (Wells, Foster, Barnes, Dickey, LaMoure, Logan, McIntosh, Stutsman). It is also self sustaining as each health department contributes a portion of funds to augment state aid dollars from the general fund allocation.

Expanding or sharing services is not feasible without further fiscal support. Efficiencies realized are not enough to sustain any increases. Current funds minimally cover cost of living and maintaining existing services where they are currently provided. The collaborative agencies continue to plan 'cooperative' events such as immunization clinics to share staff and assist. Discussions on 'sharing' an FTE for a designated service, such as school nursing, chronic disease management nurse etc., is occurring, however is not recommended as fragmentation could occur---problems arise on non scheduled days for the FTE in that area. Also, it is known that communities respond more positively with local personal providing services. Nutrition services may be an option for sharing an FTE due to the nature of the type of service provided.

Benefits/Challenges:

The participants in the SECRN grant project reported many benefits as well as challenges. General consensus overwhelmingly emphasizes the benefits gained.

- **Benefits:**

    - SECRN enabled agencies to improve business processes—billing and Ahlers Protocols
    - Uniform client charting and documentation
    - Nursing policy and procedure framework
    - Website for sharing and support
    - Improved tracking of expenses
    - Higher security for client information improving HIPAA compliance
    - Decrease time and increase efficiency for annual reports with more accurate data
    - Credible relationship building to aid in future collaborative projects
    - Improved standards of care—specifically Chronic Disease Management
    - Increased the professional level of staff as well as processes utilized
    - Availability of expertise and training
    - Trust between and among participating agencies
    - Established roadmap for the future (CHA/CHIP) to enhance sustainability

- **Challenges:**

    - Continue to learn and fully utilize Ahlers to the fullest potential
    - Time to manage and maintain website
    - Lack of adequate realized savings to move forward in increasing and/or sharing services
    - Consideration of "Regional Accreditation" for participating agencies
    - More specific tracking for Environmental Health needed over and above what TIMS offers

Succession Planning:

It is clear that although initial thoughts of hesitation existed with some employees, throughout the entire evaluation process participants fully supported the activities of the grant and worked hard to accomplish goals within the short one year time period. 100% of participants possess a desire to continue to work cooperatively and look into opportunities to do so as evidenced by the following statements reported in the survey:

- Be creative and continue to work with agencies who desire to partner or develop new areas if more conducive
- Partnering is the only way to ensure needed services at lower costs
- Build on established relationships where common trust of members is present
- Possibly utilize geographic regions or Emergency Preparedness regions as a model
- Reported areas of interest for future expansion of sharing services: Chronic Disease Management, Family Planning, Immunizations, and possibly tobacco. (note: due to short implementation time period, these areas were not able to be fully developed by the SECRN)
- Exploration of a 'shared' nutritionist for the region is necessary. Population need due to increasing obesity is the key driver. Potential funding may also be available to assist in supporting this FTE through various grant opportunities
- Funding needs to be considered in all cooperative activities, fiscal support is an incentive, details are needed to evaluate options that will benefit all. Any opportunity to save healthcare dollars and administrative costs is a way to provide improved and expanded services to the public.

Current cooperative endeavors being overseen by Central Valley Health District include:

- $2500 grant promoting of school based immunization: Barnes, LaMoure, Logan, Stutsman
- Applied for CDC study school flu clinics: Barnes, LaMoure, Logan Stutsman
- Plans to work together to apply for the HRSA Chronic Disease

Implications for future regionalization of public health services

The 'greatest good for the greatest number' is a well known phrase in the community and public health arena. This overarching concept must be kept in mind at all times when planning for the future of services. Core functions of public health services include assessment, policy development and assurance.

The Minnesota Department of Health http://www.health.state.mn.us/divs/cfh/ela/index.html has provided a well documented model to follow. The areas of essential public health responsibility identified include:

1. Assure an adequate local public health infrastructure.
2. Promote healthy communities and healthy behavior.
3. Prevent the spread of infectious disease.
4. Protect against environmental health hazards.
5. Prepare for and respond to disasters and assist communities in recovery.
6. Assure the quality and accessibility of health services.

Keeping these important areas of responsibility in mind, it is also imperative that planning must be done in a methodological fair manner. The Quality Improvement Department of Public Health in the county of Los Angles http://publichealth.lacounty.gov/qi/index.htm has documented useful method for priority-setting. The priority setting provides accountability at three levels:

- Focus resources on health issues that are of greatest importance to the community
- Must apply those resources to support interventions and strategies effective and acceptable to the community
- Must dedicate resources to evaluate work performed in order to demonstrate performance done well or improve if needed.

Conclusion

SECRN accomplished a huge task in a short one year time period and has demonstrated the ability to effectively share what works in public health. The short time-frame also inhibited participants in experiencing the full potential particularly with respect to the provision of services. Participants were engaged and worked together in a positive manner and desire to continue with this model. Continued fiscal support from local, state and federal entities with a focus on community health assessment and community health improvement planning is essential to most effectively and efficiently conduct public health programs and provide public health services.

Respectfully Submitted,

Mona P. Klose, RN, MS, CPHQ