



Creating New Opportunities for Community-Based HIV Prevention Services to Insured Populations

Julia Hidalgo, ScD, MSW, MPH

Community Impact Solutions (Subcontractor)

CEO, Positive Outcomes, Inc. and Research Professor, George Washington University

Beatriz Reyes

University of Washington Public Health Capacity Building Center and Cardea



Advancing Science • Reducing Risk • Improving Lives

Disclaimer

Funding for this webinar was made possible (in part) by the Centers for Disease Control and Prevention (CDC).

The views expressed in by the speakers and moderator do not necessarily reflect the official policies of the Department of Health and Human Services (DHHS), nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US Government.

Meet the Experts

Julia Hidalgo, ScD, MSW, MPH



CIS Subcontractor

Chief Executive Officer, Positive Outcomes, Inc., and Research Professor, George Washington University Milken Institute School of Public Health

Beatriz Reyes



Training Manager

University of Washington
Public Health Capacity
Building Center/ Cardea

Four-Part Training Series

- **October 28, 2014:** Delivering HIV Counseling and Testing Services to Insured Populations
- **November 6, 2014:** Medicaid Basics for HIV Prevention Programs
- **November 20, 2014:** Commercial Health Insurance Basics for HIV Prevention Programs
- **December 4, 2014:** New Opportunities for Community-Based HIV Prevention and Care Management Services to Insured Populations

**ALL
WEBINARS**

2 PM EST

1 PM CST

11 AM PST

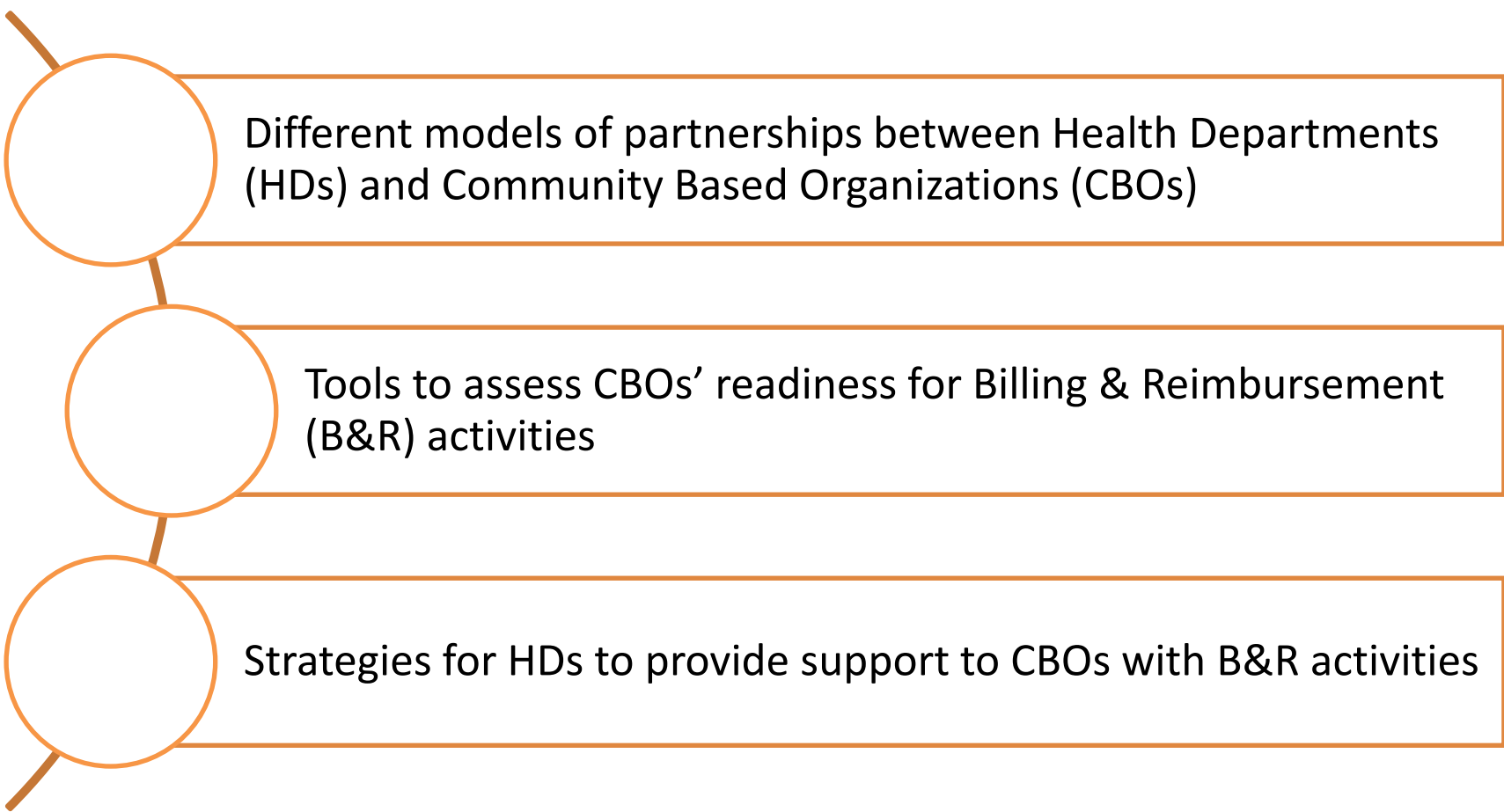
Housekeeping

- Please use the chat feature to ask any questions
- Please complete the brief, but important, evaluation of today's webinar as you exit this session
- The webinar recording and slides will be available on the CIS website 24 hours after the presentation
- Thank you

Overview of Today's Topics

- Roles that CDC grantees can play in educating insurers about HIV prevention services and ways prevention providers can fulfill insurers' contractual and legal requirements
- Ways that health departments (HDs) can support community-based organizations (CBO) billing infrastructure
- Tools to assess CBOs' readiness for billing and reimbursement activities
- Models of HDs and CBO partnerships
- Case studies to illustrate the key steps in offering high impact HIV prevention services to insured populations
- Key steps for preparing for participation in health insurance plans

Overview



Different models of partnerships between Health Departments (HDs) and Community Based Organizations (CBOs)

Tools to assess CBOs' readiness for Billing & Reimbursement (B&R) activities

Strategies for HDs to provide support to CBOs with B&R activities

National Alliance of State and Territorial AIDS Directors (NASTAD) Survey

- Of the 46 HDs that responded, 29 indicated that they directly provide HIV/AIDS or viral hepatitis services
- Of those, only 11 billed third party payers

NASTAD Survey

- Of the 46 HDs that responded, 32 reported that at least some HD-supported providers bill third party payers
- Only 11 required HD-supported providers to bill third party payers

Billing Capacity is Greatest in Venues Providing Medical Services

- 72% reported that community health centers are billing
- 63% reported that HIV/ID physicians are billing
- 53% reported that health department clinics are billing
- 34% reported that CBOs are billing

Health Departments and Community Partners

Billing capacity depends on the type of community partner

- Community health centers
- Private providers
- Emergency departments
- CBOs

Community Health Centers, Private Providers and Emergency Departments

- Have billing capacity
- May not see the value of routine screening
- May not be interested in adapting flow to provide HIV services

CBOs

- May have little to no billing capacity
 - Staff
 - Systems
- May not provide billable services
- May not have adequate volume

Partnerships between HDs and Community Partners

- Partnerships with LHDs
 - Support HIV/STD testing, partner services, other initiatives
 - Provide training to support HIV prevention activities
- Partnerships with CBOs
 - Support HIV testing (including test kits), linkage to care, EBIs, other initiatives
 - May provide support via a lead agent

Assessing Readiness for Billing and Reimbursement Activities

- Capacity assessment
- Cost comparison

Assessments

- Assessment should answer the following questions:
 - What “billable” services are provided?
 - Are those services provided by the appropriate type of providers? If not, then services are not billable.
 - Is it feasible to have a higher level clinician, such as an MD or PA provide the services?

New Opportunities for Medicaid Payment for Counseling as Part of CTS

- CMS published a final rule effective in January 2014
- **Before the rule change:** preventive services could only be provided by a physician or other licensed practitioner (OLPs) of the healing arts to be paid by Medicaid
- **After the rule change:** other practitioners, not just physicians and OLPs, can be paid to provide preventive services *recommended* by a physician or OLP
- Assigns authority to State Medicaid Programs to
 - Define practitioner qualifications
 - Ensure appropriate services are provided by qualified practitioners
 - Define the preventive services to be provided
 - Design the reimbursement methods
- *Does not define the type of personnel to be covered*

Assessments

STAFF

8. Please describe the types of clinical staff currently providing HIV/STD testing, treatment and counseling services to your clients, as well as the types of services they provide:

Dedicated on-staff clinician(s) (e.g., MD, NP, PA)

Types of services:

Visiting/traveling clinician(s) days/week

Types of services:

Nurse(s)

Types of services:

Medical assistant(s) and/or phlebotomist(s)

Types of services:

None of the above

Other, please describe:

Types of services:

Notes:

Assessments

- What systems are in place and what needs to be built in order to bill?
 - What types of patient information are collected?
How is information collected and stored?
 - Are there policies/procedures in place around fees or billing?
 - Are there any staff who have experience with billing?
 - Is there another program that is billing?

Assessments

INFORMATION SYSTEMS

1. What types of patient information do you collect and keep on file?

- Demographic (name, address, date of birth, etc.)
- Insurance (carrier, policy number, etc.)
- Medical (visit/service documentation, test results, health history, etc.)
- Other: _____

Notes: _____

2. What best describes your systems for collecting and storing patient information?

- Primarily paper
- Primarily electronic (e.g., practice management system or electronic medical record).

Type of EMR: _____

- Combination of paper and electronic
- Other, please describe: _____

Notes: _____

3. Please describe any efforts to learn how many of your clients are covered by insurance and/or which plans they use? *If insurance information collected for all individual clients (see #1) or from some other sample, probe deeper into how the agency analyzes/applies the info collected.*

Assessments

POLICIES & PROCEDURES – FEES & BILLING

1. Does your agency currently charge fees to clients for services?

If yes, probe about payment types accepted:

No Yes: Cash Credit card Other payment method:

Notes:

If yes, probe about patient billing/collections:

What efforts, if any, are made to follow up on patients' outstanding balances? (e.g., printed bills/receipts, notification at subsequent visits)

Notes:

2. Does your agency consider any of the following when assessing fees (and/or waiving fees) for services?

<input type="checkbox"/> Results of cost analysis (<i>Question 1</i>)	<input type="checkbox"/> Patient's income (i.e., sliding scale)
<input type="checkbox"/> HIV/STD risk factors	<input type="checkbox"/> Symptomatic v. asymptomatic
<input type="checkbox"/> HIV/STD exposure or positivity	<input type="checkbox"/> DIS (Disease Intervention referral)
<input type="checkbox"/> Other, please describe: <input type="text"/>	

Notes:

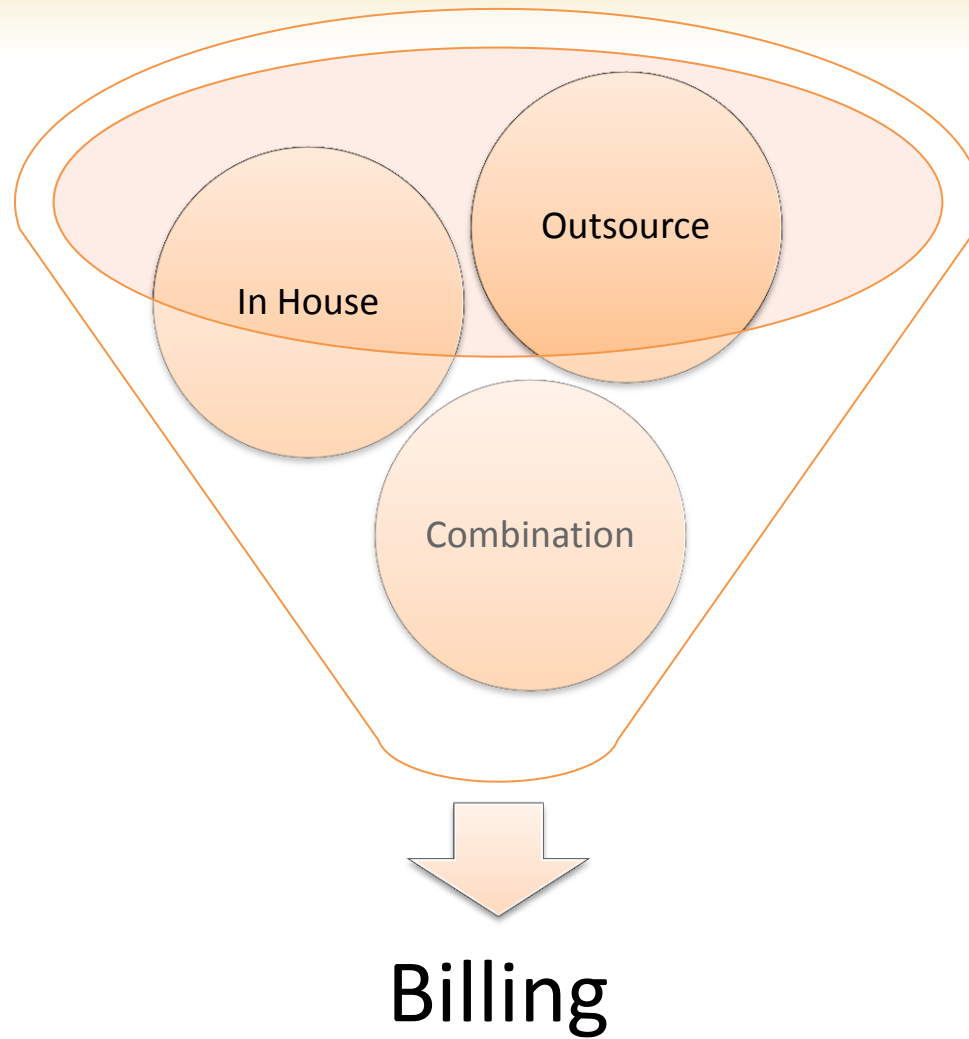
Cost Comparison

- Cost Comparison tools
 - Quickly estimate what it costs to provide a service
 - Compare to potential reimbursement rate
 - Assess if billing makes sense for your agency

Strategies for Collaboration & Support

- Strategy—Consideration of options for B & R
- Training—Learning Collaborative
- Funding—pilot projects such as initial infrastructure development or initial work with a clearinghouse
- Advocacy—Joint HD and CBO advocacy with Medicaid, MCOs and other payers

Billing Options



Fee Collection

- Fee Collection
 - Sliding Fee Scale
 - Patient Donation

Texas Revenue Generation Learning Collaborative

- Promoting and supporting capacity and systems improvement among LHDs in Texas
- Two-day meeting with seven LHDs in Austin on July 29-30, 2014
- Meeting follow-up—monthly calls with individual districts for updates and assistance
- Partnership with Texas Department of State Health Services, University of Texas at Austin, and Cardea

Idaho Revenue Generation Learning Collaborative

- Partnership with Idaho Department of Health & Welfare HIV, STD, and Hepatitis Programs
- Two-day meeting with seven local health districts—
February 3-4, 2015
 - Pre-meeting assessments (individual and group)
 - Peer-to-peer presentations and discussion
 - Action planning
- Action plan follow-up and ongoing collaboration and support

Strategies to Build Capacity for Billing & Reimbursement

- Consult with other HD programs that have successfully implemented billing and reimbursement
- Assess HD and local provider capacity for billing and reimbursement
- Require HD-supported providers that have capacity for billing to do so

Q and A



**Case Studies Illustrating Ways
to Create Opportunities for
Community-Based
HIV Prevention Services to
Insured Populations**

Key Steps for Contracting

Align with your agency's vision

Build billing infrastructure

Identify opportunities in the health insurance market

Identify services, populations, and delivery models

Compute service costs and determine payment model

Contract with insurers

Three Case Scenarios



Outreach to insured HIV+ populations



HIV and STD counseling and testing



HIV+ linkage and retention services

Case Scenario 1



Outreach to insured HIV+ populations



HIV and STD counseling and testing



HIV+ linkage and retention services

Identifying Opportunities in Texas

**TX Health and Human Services Commission (HHSC)
Uniform Medicaid Managed Care Contract requires
MCOs to**



- Provide STD/HIV services- prevention, screening, counseling, diagnosis, and treatment
- Implement procedures to ensure Members have prompt access to appropriate services for STDs/HIV
- Allow Members access to STD/HIV diagnosis services without prior authorization or referral by a primary care provider
- Provide all covered services required for a diagnosis by the Provider, as well as the STD/HIV treatment plan

Identifying Opportunities in Texas

HHSC Uniform Medicaid Managed Care Contract requires MCOs to

- Make education available to Providers and Members on the prevention, detection, and effective treatment of STDs/HIV
- Require Providers to report all confirmed cases of STDs/HIV to the regional health authority using required forms and procedures for reporting
- Require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of STDs/HIV receive risk reduction and partner elicitation/notification counseling



ACA Requirements: Preventive Services

DHHS US Preventive Services Task Force (USPSTF) recommends an

- “A” grade for HIV infection screening
 - Adolescents and adults ages 15 to 65 years
 - Younger adolescents and older adults who are at increased risk
 - All pregnant women, including those who present in labor who are untested and whose HIV status is unknown
- “A” grade for syphilis for all pregnant women and other persons at increased risk for infection
- “B” grade for chlamydia screening for sexually active women age 24 or younger and in older women at increased risk for infection
- “B” grade for STI counseling for sexually active adolescents and for adults at increased risk for STIs

Identifying Opportunities in Texas



Health Insurer	Medicaid MCO	ACA QHPs
Aetna	*	*
Amerigroup	*	
Assurant Health		*
Blue Cross and Blue Shield	*	*
Christus Health Plan	*	
Cigna		*
Community First Health Plan	*	*
Community Health Choice	*	*
Cook Children's Health Plan	*	
Driscoll Children's Health Plan	*	
El Paso First Plan	*	
FirstCare	*	*
HealthSpring	*	
Humana		*
IdealCare		*
Molina Healthcare of Texas	*	*
Parkland HealthFirst	*	
Scott & White Health Plan	*	*
Sendero Health Plans	*	
Seton Health Plan	*	
Supervisor HealthPlan (Ambetter)	*	*
Texas Children's Health Plan	*	
United Healthcare	*	*
Valley Baptist Health Plan		*

Decision Points for Focusing Our Marketing Efforts

- MCOs operates in our service area
- MCOs likely to have relatively large number of HIV+, STD+, or at risk individuals
- Network participation in a Medicaid MCO may also result in participation in a QHP

Our Services, Populations, and Delivery Model

Target Population

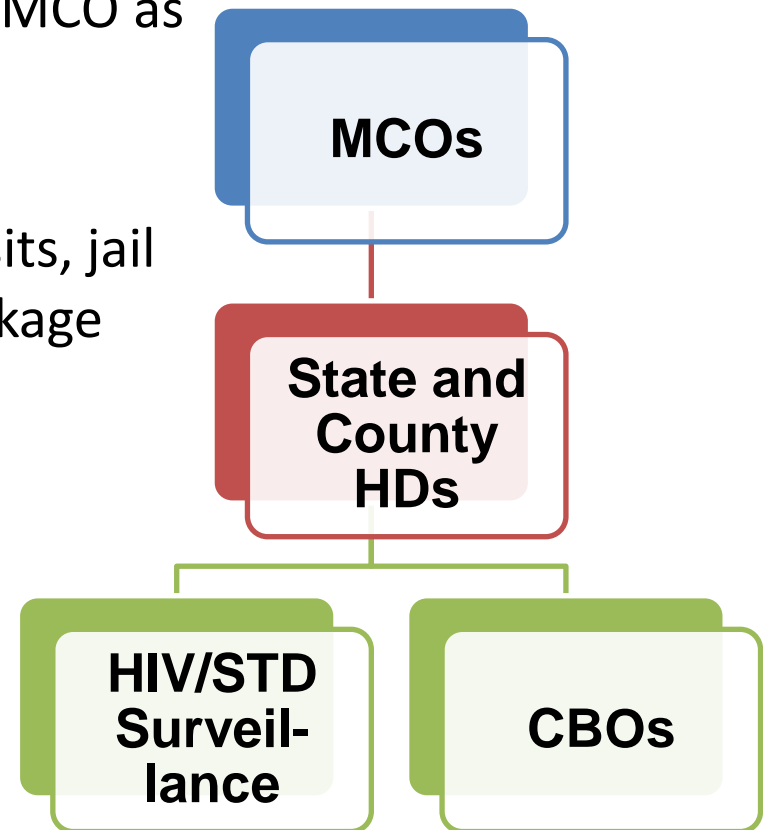
- HIV+ insured individuals identified by MCO as lost to care

MCO Contract

- HIV/STD screening, location, home visits, jail and prison in-reach, outreach, and linkage services using public health model
- Behavioral prevention
- Provider education
- Subcontract to CBOs in counties with insufficient HD resources

HD

- Partner services
- Communicable disease reporting



Marketing Strategy

- TX Medicaid and Dept of State Health Services (DSHS) HIV/STD program meet with State and local HDs and MCOs' medical directors and care management staff
 - May include Medicaid MCOs and QHPs staff
- Before meeting, TX Medicaid calculates rates of HIV/STD testing by MCOs, treatment rates, HIV/STD expenditures, results of the Medicaid HIV linkage projects, and return on investment (ROI) if MCOs fund HIV services
- Before meeting, HDs prepare epi profiles documenting rates of community viral load and STDs, services offered by HDs, and related materials
 - MCO care cascade
- DSHS and HD staff identify key marketing messages for inclusion in meeting presentations

Marketing Strategy

- Brief presentations made at the meeting by Medicaid, DSHS, and HDs to MCO staff
- Follow-up regional meetings to discuss contracting and services to be provided via Medicaid and QHP contracting
- On-going quarterly meetings with MCO staff to identify ongoing areas of collaboration and address challenges
- TX Medicaid provides annual HIV and STD quality reports to MCOs to document improvement in their performance
- Continue to promote state-level communication between TX Medicaid and DSHS HIV/STD staff to keep up the momentum

Example of an Hourly Unit Cost Estimate and For HIV Outreach Services by HDs

Personnel Class	Annual Salary	Hourly Rate	Hourly Loaded Rate	IDC (25%)	Total Hourly Rate
Supervisor	\$75,000	\$37	\$46	\$12	\$58
Epidemiologist 2	\$65,000	\$32	\$40	\$10	\$50
Disease Investigation Specialist (DIS)	\$45,000	\$22	\$28	\$7	\$35

The loaded hourly cost includes accident, dental, life, vision, and medical insurance of 26%

Assumptions Used In Negotiating Contracts For HIV Outreach Services by HDs

Client Inputs: 500 Clients Assigned By Insurer

Labor Inputs: 20% of 500 Clients Located Require Linkage by DIS and Rest are Incarcerated, Moved, or Deceased

Hours Per Client Located and Linked	Hours	Unit Cost
Supervisor	1/4 Hour	\$15
Epidemiologist 1	1 Hour	\$50
DIS 3	4 Hours	\$140
Total Cost Per 500 Clients Located	\$32,500	
Total Cost Per 500 Clients Linked	\$15,500	
Total Cost	\$48,000	



Payment Model

- Sub-capitated monthly payment model
- HDs paid fixed amount per Medicaid or QHP member assigned for location and linkage
- Invoice is used to request monthly payment, no service-level claims
- No financial risk is borne by the HD
- Down-side
 - HD staffing must be not be nimble to meet demand
 - The number of referrals per month may vary throughout the year

Case Scenario 2



Outreach to insured HIV+ populations



HIV and STD counseling and testing



HIV+ linkage and retention services

Identifying Opportunities in DC

DC Health Care Finance Medicaid Managed Care Organization Model Contract



- Adult wellness services, furnished in accordance with the scheduling and content recommendations of the USPSTF and consisting of
 - Routine screening for STDs, HIV/AIDS screening, testing, and counseling
 - Services related to the screening, testing, diagnosis, counseling and treatment of HIV/AIDS are medically necessary
 - Contractor shall participate in the DC HD's initiatives regarding HIV/AIDS
 - Contractor shall provide an organized health education program including but not limited to the importance and availability of testing for HIV/AIDS and the services available for treatment of HIV/AIDS

Identifying Opportunities in DC



Health Insurer	Medicaid MCO	ACA QPHs
Aetna		*
AmeriHealth DC	*	
CareFirst BlueCross BlueShield		*
Health Services for Children With Special Needs	*	
Kaiser Permanente		*
MedStar Family Choice	*	
Trusted Health Plan	*	
United HealthCare		*

Medicaid disabled beneficiaries do not have to enroll in an MCO, DC covers undocumented residents in the Alliance

Decision Points for Focusing Our Marketing Efforts

- Plan likely to have relatively large number of HIV+, STD+, or at risk individuals
- Network participation in a Medicaid MCO will not result in participation in a QHP
- Must market separately to QHPs

Making the Case to DC Medicaid for HIV Preventive Services: Return on Investment

Example from the CMS Innovation Center-funded Prevention at Home Project in Washington DC for Medicaid Beneficiaries

ROI	Year 1	Year 2	Year 3	Net
Prevention Model				
Target Clients	4,000	7,804	11,423	23,227
Net Savings	-\$204,116	\$241,616	\$947,923	\$985,423
Savings PMPM	-\$51	\$31	\$83	\$42
Care Model for HIV+ Clients				
Target Clients	3,284	3,284	3,284	9,852
Net Savings	\$14.2 M	\$13.0 M	\$133.0 M	\$40.3 M
Savings PMPM	\$4,334	\$3,972	\$3,966	\$4,091
Total Net Savings	\$14.0 M	\$13.3 M	\$14.0 M	\$41.3 M

Our Services, Populations, and Delivery Model

Target Population

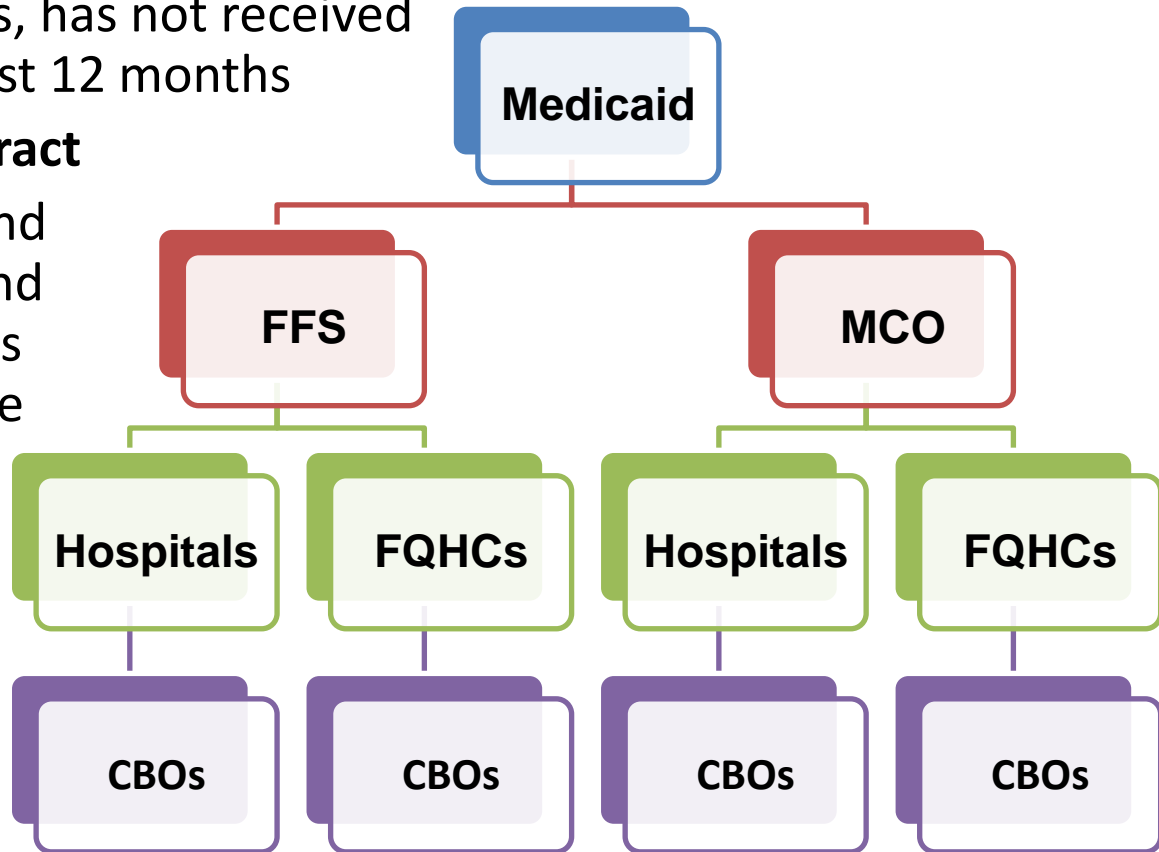
- Medicaid beneficiaries served by hospital outpatients and EDs and FQHCs
 - Unknown HIV status, has not received an HIV test in the last 12 months

Healthcare Provider Contract

- HIV counseling, rapid and confirmatory testing, and linkage services by CBOs embedded in healthcare settings, including homeless mobile units

Delivery Model

- CBO staff embedded in healthcare setting
- Routine testing offered



Marketing Strategy

- DC HIV/STD program staff, key HIV providers, CBOs, and MCOs present new model of HIV screening to DC Medicaid for buy-in
 - Medicaid FFS and MCO HIV testing rate data presented to identify the extent to which healthcare providers must expand their routine HIV testing efforts to meet federal and contractual benchmarks
- Similar meeting with hospital and FQHC leadership to obtain their buy-in
- In meetings, CBOs demonstrate their capacity to provide culturally and linguistically competent HIV counseling services, offer metrics demonstrating their expertise, and demonstrate their capacity to provide cost-effective HIV testing and counseling

Example of an Hourly Unit Cost Estimate and Cost Scenarios For CBO HIV Counseling and Testing Services

Personnel Class	Gross Pay	Annual Salary	Hourly Rate	Hourly Loaded Rate	Plus 5% Fee	Plus 10% Fee	Plus 15% Fee
Supervisor	\$1,771	\$42,500	\$20	\$30	\$32	\$33	\$35
HIV Outreach Tester 1	\$979	\$23,500	\$11	\$15	\$16	\$17	\$17

The loaded hourly cost includes accident, dental, life, vision, and medical insurance

Why assign fees when computing your costs?
 CBOs can cover their indirect costs and health insurance readiness costs through this strategy

Assumptions Used In Negotiating A Contract For CBO HIV Counseling and Testing Services

Fee Assumptions to Cover Indirect Costs: 15%

Client Inputs: 500 Clients Screened, 1 Hour Per Client For Pre and Post Test Counseling, Rapid Testing, and Documentation

Screening Inputs	Unit Cost Per Hour (Including 15% Fee)
Supervisor	\$35
HIV Outreach Tester 1	\$17
Total Screening Cost Per Client	\$52
Cost Per Unit for OraQuick Test Kit	\$35
Total Screening Cost for Total Clients	\$43,420



Payment Model

- Subcontracts between healthcare provider and CBOs
- Healthcare clinicians serve as “ordering clinician”
- CBOs submit FFS or MCO claims for HIV test kits
- Payment rate per unit of HIV counseling negotiated between healthcare provider and CBOs
- CBOs submit claims to request monthly payment
- No financial risk is borne by the CBO
- Down-side
 - Healthcare staff may resist integrating CBO staff into patient flow
 - Number of referrals per month may vary throughout the year
 - CBOs’ may be unable to negotiate low prices for HIV test kits
 - CBOs must have billing infrastructure

Case Scenario 3



Outreach to insured HIV+ populations



HIV and STD counseling and testing



HIV+ linkage and retention services

Identifying Opportunities in Michigan

Michigan Medicaid Managed Care Model Contract

- Covered services provided to enrollees under the Contract include preventive services required under the ACA
- To facilitate coordination and collaboration, the Contractor is encouraged to enter into agreements or contracts with local HDs
 - Such agreements or contracts should provide details regarding confidentiality, service coordination, and instances when local HDs will provide direct care services for the Contractor's enrollees
 - Agreements should also discuss, where appropriate, reimbursement arrangements between the Contractor and the local HDs



Identifying Opportunities in Michigan



Health Plans	Medicaid MCOs	ACA QHPs
Alliance Health and Life Insurance		*
Blue Cross Blue Shield of MI	*	*
Consumers Mutual Insurance of MI		*
CoventryCares of MI	*	
Grand Valley Health Plan		*
Harbor Health Plan	*	*
Health Alliance Plan		*
HealthPlus Partners	*	
Humana		*
McLaren Health Plan	*	*
Meridian Health Plan of MI	*	*
Midwest Health Plan	*	
Molina Healthcare of MI	*	*
Physicians Health Plan	*	*
Priority Health	*	*
Time Insurance Company		*
Total Health Care USA	*	*
United HealthCare	*	*
Upper Peninsula Health Plan	*	

Decision Points for Focusing Our Marketing Efforts

- MCOs operating in our service area
- Plan likely to have relatively large number of HIV+, STD+, or at risk individuals in urban areas where HIV expert care is available
- Network participation in a Medicaid MCO may also result in participation in a QHP
- Extensive geographic network coverage by insurers in MI rural counties, with limited HIV expertise in many counties

ACA Requirements: Essential Community Providers (ECPs)

ECP Category	ECP Provider Type
Federally Qualified Health Centers (FQHCs)	FQHCs and other community health centers, and healthcare facilities operated by Indian tribes and other Indian organizations
Ryan White Provider	Ryan White HIV/AIDS Program-funded providers
Family Planning Provider	Title X family planning clinics and look alike family planning clinics
Indian Health Provider	Indian Health Service (IHS) providers, Indian tribes organizations, and urban organizations
Hospital	Disproportionate share hospitals (DSH) and eligible hospitals, children's hospitals, sole community hospitals, and other similar facilities
Other ECP Providers	STD clinics, TB clinics, and other entities serving predominantly low-income, medically underserved individuals

Our Services, Populations, and Delivery Model

Target Population

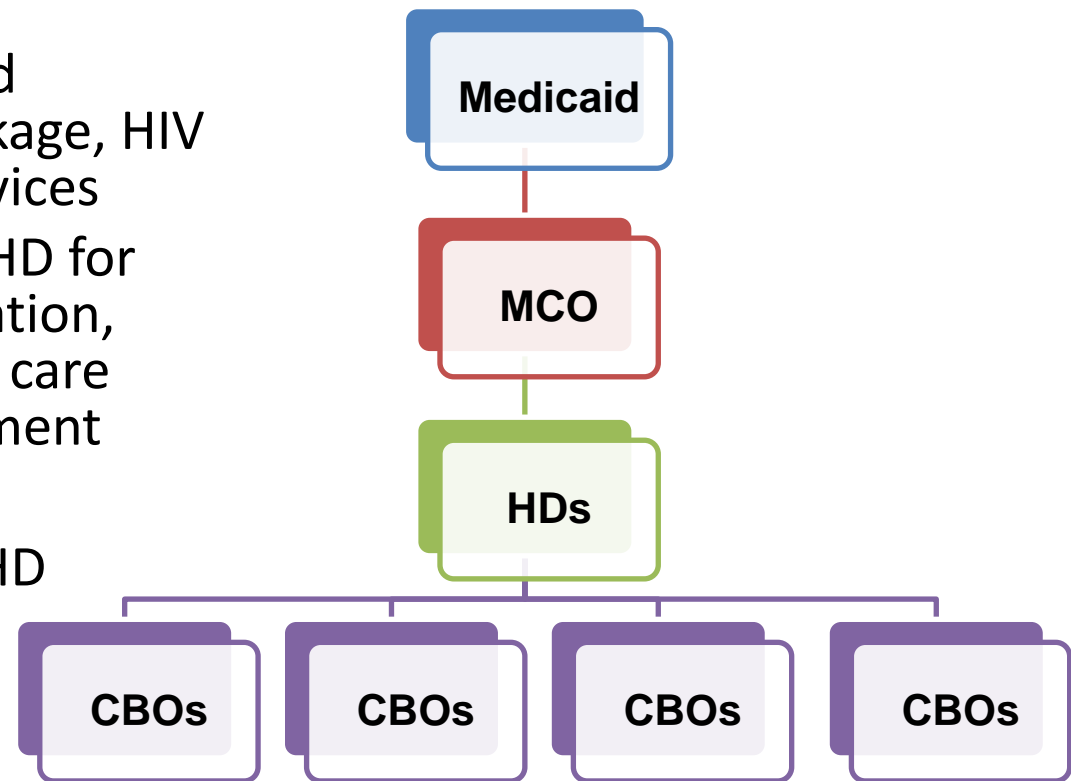
- HIV+ beneficiaries referred by Medicaid care management staff to HDs for HIV linkage, care, navigation, and other services

HD Contracts With MCO

- HIV counseling, rapid and confirmatory testing, linkage, HIV care, and preventive services
- CBOs sub-contract with HD for behavioral health, navigation, home visiting, retention, care management, reengagement

Delivery Model

- CBO staff embedded in HD setting or at CBO in rural or suburban settings



Marketing Strategy

- MI HDs have wide geographic coverage, local expertise, and established relationships with local healthcare providers
- CBOs are familiar with the communities and resources in which HIV+ beneficiaries live
- The care management staff of MCOs and QHPs are likely to be highly challenged in developing rapidly the resources already available through the HDs and CBOs



Marketing Strategy

- MI Medicaid and Department of Community Health (DCH) HIV/STD/Hepatitis program meet with State and local HDs and MCOs' medical directors and care management leadership
 - May include Medicaid MCOs and QHPs staff
- Before meeting, MI Medicaid calculates MCO HIV test rates, HIV and STD treatment rates, costs associated with HIV and STDs, and ROI if MCOs fund HIV services through HDs
- Before meeting, HDs prepare regional epi profiles documenting rates of community viral load and STDs, HD services HDs, and related materials
- DCH and HD staff identify key marketing messages for meeting presentations

Marketing Strategy

- Brief presentations made at the meeting by Medicaid, DCH, and HDs to MCO staff
- Follow-up regional or local meetings to discuss contracting and services to be provided via Medicaid and QHP contracting
- On-going quarterly meetings with MCO staff to identify ongoing areas of collaboration and address challenges
- MI Medicaid provides annual HIV and STD quality reports to MCOs to document their performance
- Continue to promote state-level communication between MI Medicaid and DCH HIV/STD/Hepatitis staff to keep up the momentum

Payment Model

- Subcontracts between MCOs and MDCH HDs
 - MDCH then subcontracts with CBOs, as with CDC and RWHAP-funded services
- MDCH HDs may negotiate sub-capitated contracts with MCOs, based on the covered services to be provided
- CBOs invoice MDCH per current contracts
- Payment rates negotiated between MDCH and CBOs
- No financial risk is borne by the CBO
- Services not covered by MCOs or QHPs can continue to be funded through CDC-funds
 - RWHAP payer of last resort policy must be addressed
- Down-side
 - Unclear how many CBOs can be supported by this model
 - Number of referrals per month may vary throughout the year, particularly in rural counties

Q and A



CBA for CBOs

Request CBA from CIS!

CIS Focus Areas

- Prevention with Positives
- Prevention with Negatives
- Organizational Development (including HIV financing)
- HIV testing

Directly CDC-Funded

If you are a CBO that receives direct funding from the CDC, request capacity building assistance using the CBA Request Information System (CRIS)

Indirectly or Not CDC-Funded

If you are a CBO that is not CDC-funded or indirectly funded, request the health department in your jurisdiction to submit a CBA request on their behalf

Contact: Melanie Graham, MSW, Melanie.graham@etr.org, (301) 379-1118

CBA for Health Departments

University of Washington Public Health Capacity Building Center provides capacity building assistance (CBA) to state, local, tribal and territorial health departments in the areas of:

- HIV testing
- Prevention with HIV-positive persons, with an emphasis on Data to Care
- Organizational development and management, including billing

Contact:

Becca Hutcheson
UW Public Health Capacity Building Center
(206) 897-5814, hutchbec@uw.edu

CBA for HD/ CBO Partnerships

- HD and CBO partnerships integral to HIV prevention service delivery
- HDs are encouraged to request support for their work with CBOs on HIV prevention activities (including billing & reimbursement)

Melanie Graham, MSW
Community Impact Solutions
Melanie.graham@etr.org
(301) 379-1118

Becca Hutcheson
UW Public Health Capacity Building Center
hutchbec@uw.edu
(206) 897-5814

Webinar Survey

- We would like to encourage you to complete the brief, but important, evaluation of today's webinar as you exit this session.
- We value your opinion in helping us to make this 4-part Webinar Series work for you.
- Thank you.

For Additional Information

Julia Hidalgo, ScD, MSW, MPH

Community Impact Solutions

Melanie.graham@etr.org

Beatriz Reyes

UW Public Health Capacity
Building Center and Cardea Services

breyes@cardeaservices.org



You can find this webinar recording on the CIS Website 24 hours after this presentation!

<http://www.etr.org/CIS/webinars/>