Region I IPP June Meeting
June 4, 2012

Lab Subcommittee Meeting

Participants
Gary Budnick (CT)
Arthur Kazianis (MA, Chair)
Tracy Stiles (MA)
Jemelie Bessette (ME)
Carol Loring (NH) – by phone
Bob Ireland (RI)
Eunice Froeliger (VT)

A. Billing and reimbursement capacity
    a. Rhode Island
        i. Bill anyone who has insurance
        ii. If they don't provide insurance, provider gets the bill
        iii. There is a list of preferred vendors (otherwise goes out to bid) who do billing
            1. New England Medical Billing is vendor
    b. Vermont
        i. Does pretty much the same thing
        ii. Helps because Director of Health Surveillance used to keep track of expenditures from lab and amount of revenue brought in
        iii. Can bill Medicaid and 3rd parties – can't bill Medicare
            1. Was only a problem when there was an elderly man who needed testing, but couldn't bill Medicare
    c. Massachusetts
        i. Doesn't bill for CT/GC
    d. Maine
        i. Doesn't bill third parties, but bill to facility, which reimburses
        ii. Keep track of revenue so they can get re-allocated from general fund
    e. Connecticut
        i. Have lab budget from state
        ii. Except for newborn screening, all revenue goes into general fund
        iii. Asked if they wanted to participate in billing training
            1. Was an effort to get people to buy-in
        iv. The idea of subcontracting the billing out is appealing
    f. Update on National Center for Public Health Labs
        i. With APHL did a survey of billing practices, found a huge diversity in billing practices
        ii. Responses from 25 or 26 states – 13 said they could keep revenues from lab that they billed for
            1. Most who had retained revenues recommended other states try that

2. Other considerations – would state cut funding if have revenue account? Would there be push back from other labs in area if they sense competition?
    a. APHL leadership keep pushing states to come up with uniform decisions on core services provided by public health labs, but needs in different states are diverse (therefore, hard to make services consistent across states)
        i. E.g. Montana has consortium with North/South Dakota and Wyoming – do a lot of clinical testing, because there are few clinical labs in these states
        ii. This is different in New England, where there are many other labs to do this kind of testing
iii. Many lab directors said they had to go before legislators to get retained revenue accounts and raise prices – barrier
iv. Most labs with third party billing contractors recommended this
v. Not having a LIMS system was a barrier to billing
vi. Eventually, there will be a report from APHL

B. Update on Future of IPP
    a. This will be the last Advisory Board meeting (in its current iteration)
    b. The lab component of IPP is not explicitly included
    c. JSI is including the lab in its proposal
        i. Would like to meet every year, though called for every other year
    d. Focuses
        i. Billing and reimbursement
        ii. Assurance
        iii. Best practices
    e. There won't be any more prevalence monitoring data collection and reporting
    f. If getting funding for lab supplies and positions, will likely continue until 2013
        i. MA has 1.5 lab positions funded by IPP
        ii. VT lab doesn't get money from IPP
        iii. RI only gets a little bit of testing money (it will be a hit, but not lethal)
        iv. ME has some testing but no positions funded by IPP
        v. NH has re-agents but no positions funded by IPP
    g. Maybe can figure out how to cobble together other funding?
    h. Private labs will not provide as much surveillance information, e.g. demographics, denominator of tests conducted
    i. Lab representatives provide valuable consult on the testing process
C. New Hampshire Hep C Outbreak
    a. NH lab not attending because of the outbreak
    b. First came to their attention two weeks ago
    c. Got a call from CDC to see if public health lab could look at whether Hep C cases were related
        i. 3 patients in seacoast area of NH were identified as having acute Hep C
        ii. Clinicians noted that patients didn't have typical risk factors, but they had gone through the cardiac catheter lab
        iii. Contacted over 500 patients who have been in lab, drawing blood, sending samples to public health lab to test
            1. Running PCR on patients since March 1st to test antibodies

2. Any specimen that's positive is being sequenced to see if they're part of the cluster
3. Lab has received over 300 specimens so far
4. Have identified 22 positives so far

iv. Thinking of expanding pool of people to collect specimens from
v. The lab doesn't know if it's getting federal funding help yet

d. Hep C isn't a reportable disease in NH – want to change this
e. Epis are asking how we can tell who is the source of the infection (i.e. can you tell how long someone has been infected with the virus)
    i. At CDC, do a quazi-species analysis – make serial dilutions and amplify multiple allaplots (?) to get many clones of the virus
        1. A person who's been infected longer has more variants of the virus in his body
        2. CDC is doing this analysis on positive specimens
f. Are any of the other states' public health labs running HCV tests?
    i. None
g. NH is paying attention to chain of custody, but not in the same way it would be with bioterrorism
    i. NH should think about making sure that specimens are secure, handled properly, etc.
    ii. Made sure everyone running tests was up to date on proficiency testing
    iii. Must think ahead re: legal liability

D. Lab Updates
    a. Vermont
        i. Finished all design document plans for new lab
            1. Hold-up now is permits
            2. Will co-locate with UVM research facility (building a new lab)
            3. Will be a good opportunity
            4. Starting to write protocols for post-docs, etc. to be in that lab space
        ii. Testing for CT and GC has gone way down
            1. Moving to not repeating at all (in the next week or two)
    b. Connecticut
        i. Still in the old/current lab
            1. Some other labs (e.g. TB lab) have moved
            2. Hold-up on moving into new lab because of inspection delays
            3. Have to revise some protocols given new lab setup and space
        ii. CT testing is stable right now
            1. 30-33 K, a quarter of which is PPSNE
            2. Stopped all repeat testing (most recently stopped GC repeat testing)
            3. Using XTR on Viper and there is no more low-positive and high-positive (all just positive)
                a. Save $5 or 6 K not repeating
        iii. Get probably $80K for test kits and one position from CSPS grant
            1. IPP changes will be a hit
            2. Can have non-profits buy test kits: Program calls in order to BD, BD bills clients, and kits get sent to public health lab – helps maintain funding
        iv. Did environmental screening/cleaning because had a high positivity string
            1. Now specimens are testing in expected range

c. Rhode Island
    i. In process of getting RFP going to do feasibility study for a new building
        1. Not sure if they'll revamp their building or build a new one
        2. Medical examiner's office will likely stay with public health lab
    ii. Talking to GenProbe about upgrading to a Panther
        1. Hopefully numbers won't drop too much
    iii. CT testing is stable
d. New Hampshire
    i. Carol worked on a plan to validate a pooling method
        1. Have not yet pursued validation because need to work on LIMS first
        2. Maybe will happen sometime this year
    ii. Hoping for a web portal for specimen submission
        1. Public health lab IT is worried about security
    iii. May have an increase in CT/GC testing, because have money in budget to do more testing – invited many other sites to apply and be part of IPP
        1. One or two additional sites coming on board as of July 1st
        2. Will do webinar training on specimen submission
    iv. Family Planning program has some money for CT/GC testing, so may have other sites come on board (though not through IPP)
    v. Still doing repeat testing
e. Maine
    i. Things are pretty much the same
    ii. There are private sector labs in Maine that do water testing and are complaining about competition
        1. Public health lab is waiting to hear if lab will have to change
    iii. CT and GC testing is stable
    iv. Starting to do validation process for urine
        1. GenProbe hasn't done it yet
        2. Collecting positives in-house to do in-house validation for the Panther
        3. Jemelie will give Bob validation panel for oral and anal specimens
    v. Doing 4th generation of HIV testing (since December-ish)
        1. Using BioRad and Ebolus machine (already had the instrument)
    vi. Maine still repeats CT and GC (not Jemelie's decision)
f. Massachusetts
    i. CT/GC testing has been pretty stable
        1. Have not lost any submitting agencies this past year (for CT/GC testing)
    ii. No recent contamination issues
    iii. Don't do repeat testing (stopped over a year ago)
        1. Has streamlined the process
    iv. Have had discussions of cost-effectiveness of CT only testing (have talked about eliminating CT only)
        1. Would further simplify lab process
    v. Close to 4th generation HIV testing
        1. Will use BioRad antigen test in manual format

E. Other Comments/Notes
    a. New testing guidelines (not yet out) may give support to Maine decision makers re: repeat testing
    b. Three labs are BD, three are GenProbe

c. MA had recent discussion/training on specimen handling outside the lab
    i. Easy to contaminate urine tubes when transferring from cup to BD-specific UPT tube
    ii. Set up training protocol at the lab – had mock-urine in urine cups with disposable pipetters and urine tubes
    iii. Provided instruction on transferring urine and minimizing contamination
    iv. Thought this was important because have seen opportunities for contamination in clinics
    v. Connecticut wants to do a similar training
    vi. There is a fluorescent substance that you can use to identify handling of specimens

F. Next Steps
    a. Once Connecticut lab is all moved in, all other lab representatives could come down to visit and perhaps all meet (outside of IPP)