

THE FUTURE OF HEALTH CARE IN AUSTIN

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*Together let us beat this ample field,
Try what the open, what the covert yield.
— Alexander Pope, Essay on Man*

A CHANGING LANDSCAPE

Welcome to Austin.

Where music lives. And a creative force thrives. Deep in the heart of Texas.

In Travis County.

It's a place with a rich ethnic mix and a cultural diversity. And a place that's rapidly changing with the rapidly changing times.

And bubbling up from underneath it all, unfortunately, are rapidly growing problems. Years of population growth have brought with it a corresponding increase in the number of local residents who are either uninsured or underinsured. It's a fact that 25% of the people living and working here do so without health insurance. They just can't afford it.

And neither can Austin.

Because, while Austin and Travis County can boast of many things, there's one thing that it lacks — a Hospital District.

And what does that mean for the people of Austin and Travis County?

It means that everyone will pick up an increasingly expensive tab. As a rising number of residents delay care or seek non-urgent care in hospital emergency rooms, those ERs will continue to fill up with a growing number of indigent patients — and the hospitals will end up paying more and more for their care.

Which, of course, increases the cost for everyone.

It also creates a bottleneck in the ER with non-emergency, primary care patients. While, at the same time, actual emergency patients have to wait longer to get life-saving treatments.

It's certainly an uneasy situation — one that's putting a tremendous strain on the local health care safety net.

What else contributes to this uneasy situation?

Well, for one thing, there's insufficient capacity to meet demands for specialty care, dental care, and behavioral health services. Then there's limited service integration and little case management. Combine that with inadequate information systems and poor

linkage and coordination between different areas of the health care system, and you've got a situation that's in dire need of change.

These are the issues that Travis County safety net providers have been facing. And these are the issues that have been driving them together — in a quest to develop joint projects aimed at increasing access to quality health care for the area's uninsured, while lowering its costs.

It was under these conditions that they came together to form *Indigent Care Collaboration (ICC)*.

A COLLABORATIVE IS BORN

The *Indigent Care Collaboration (ICC)* was formed in the spring of 1997.

What exactly is the ICC?

It's a mechanism through which its members — the area's various safety net healthcare providers (twelve in total and each highlighted throughout these pages) — could develop joint projects with their fellow members. The goal is to increase access to — and lower the costs of — affordable, quality healthcare for the region's uninsured population.

It does this by promoting the integration of clinical systems and the reduction of administrative duplication.

The benefits are obvious. To patients, they are improved care, fewer duplicate medical tests, and an easier registration process. To providers, the benefits are lower costs and better reimbursements for patients who qualify for funding programs, like Medicaid.

The whole notion of forming the ICC to achieve this worthy goal is organic to the Austin area. For starters, it continues a history of collaborative efforts among providers, the government, the business community, and others.

ICC Member Profile **El Buen Samaritano**

Established in 1987. A primary care clinic funded primarily by Episcopal Health Charities. It provides primary healthcare to Spanish-speaking families who have limited access to healthcare — about 500 patient visits per month, 93% of which are by medically indigent uninsured patients.

Indeed, the regional health care providers had already developed a shared vision of ways to improve healthcare services for the uninsured in Hayes, Travis, and Williamson counties.

There was an existing commitment to a regional approach, as well as an active engagement in outreach efforts. It was apparent that the kind of collaboration that was needed for the ICC to work was already there.

And so it was only natural that the regional providers pursue strategies within the framework of the ICC that could make their goals more attainable. At the beginning, those goals were to:

- Develop continuing medical education programs.
- Integrate after-hours call systems.
- Adopt common eligibility protocols.
- More effectively integrate behavioral and dental health services into the health care system.

Building on the capabilities of individual safety net providers, as well as the collective strength of its membership, the ICC immediately began leading efforts to expand outreach and increase access to services — by reorganizing regional health care, expanding successful programs, and piloting new programs.

During the first phase of ICC's development there were several important goals that had to be met. First, they had to expand the degree of ICC participation throughout the

region. To do that, they needed to assess the size and scope of the uninsured problem. Then they could evaluate the existing system to see how it was — or was not — meeting the needs of this population.

According to Diana Resnik, ICC’s first President and current Treasurer, this was done “through an onerous process of combining information from unlike sources, extrapolating from state and national data, and conducting actuarial analysis and data review.”

Once that was accomplished, they had to develop alternative approaches for delivering and financing a new model of care.

It was necessary to analyze all these alternatives before creating an appropriate model that would work for the ICC. At the same time, the ICC had to work with state and local policy makers and legislators to support the needed changes. And lastly, they had to develop a method for evaluating the program.

And what would be the impact of all this restructuring?

Since this process is still unfolding, the ICC is looking ahead to the future. But the goal — which has already been met in other communities in the U.S. — is to increase the number of people with primary care medical homes. By coupling that with a greater availability of specialty consultations, the community will see a decrease in ER use and hospital admissions — and a subsequent reduction in the increase of health care costs.

This is a laudable goal — and one that can only be achieved by overcoming big hurdles.

ICC Member Profile
People’s Community Clinic

A private, non-profit primary care clinic that provides primary care and support services to 15,000 low-income uninsured and underserved adults and children, accounting for 60,000 visits, each year. It receives funding from St. David’s Foundation, the City of Austin, Travis County United Way, grants and donations, and patient revenue. It is also involved in a number of collaborative efforts with other non-profit organizations and providers, businesses, and community groups to improve access to services for the uninsured.

One such hurdle, according to ICC Executive Director, Paul Gionfriddo, is that “there’s been an uninformed attitude about the costs, liabilities and long-term implications of providing healthcare to the uninsured. The general population still perceives the uninsured to be a problem for the government; or it’s a problem created by ‘greedy insurance companies’ or the healthcare providers. And, unfortunately, in many places there continues to be a ‘blame the victim’ mentality from the general public.”

Misperceptions such as these are surely a big hurdle for the ICC to overcome.

Meanwhile, the costs of treating the uninsured continue to rise.

GETTING THE ICC UP TO SPEED

At the very beginning, the ICC worked as a “think tank.” Members included hospitals, health care networks, clinics, government agencies, non-profit organizations, individual providers, and others.

Taking the lead in forming the group in 1997 was Diana Resnik. Her deftness and tenacity in pulling together meetings, and generally moving the process forward, helped the group on its way to becoming a formal organization. At which time, she was elected ICC president.

By 2000, the more formal ICC was extending its membership to Williamson and Hays Counties — with each county having a representative on the Board of Directors.

“The ICC is particularly proud of its success in bringing Hays and Williamson County representatives into the ICC,” said Paul Gionfriddo. “This has resulted in a broader conceptual framework and a more regional approach to understanding and addressing problems of health care delivery and financing.”

ICC Member Profile

Community Care Services Department

Operates the Austin/Travis County Federally Qualified Health Centers. These community health centers provide customer-oriented, quality-driven, and cost-efficient medical and dental services for underserved individuals, to meet their health needs.

Brackenridge Hospital operated the first primary health care clinic for the indigent. As the demand for greater access to health care services for the indigent grew, three clinics were opened in the early 80s. Today, Community Health Centers include five city clinics, five county clinics, and one separate dental clinic. In 2001, the Community Health Centers’ federal status changed from “look alike” to being fully “Federally Qualified.”

Each year, the CHC system handles more than 125,000 medical encounters and serves more than 41,000 patients. More than 70% are at or below the Federal Poverty Level (FPL). Approximately 31% are uninsured, 24% have Medicaid/Medicaid managed care coverage, 45% are covered by MAP, Medicare, SCHIP, or other coverage.

At this time, the ICC was also expanding its exploration of critical long-term financing.

Because, as money was becoming available, the ICC was finding itself in a better position to help coalesce its initiatives. (Funding for the program has been largely provided by the federal government, along with matching foundation support.)

As the ICC began to develop its initiatives, it was also becoming apparent that they had to create a more formal structure within which to implement and monitor its efforts. As a result, the ICC was organized as a Texas Uniform Unincorporated Nonprofit Association (TUUNA).

Now a more formal ICC was able to participate in the Robert Wood Johnson Foundation (RWJ) *Communities in Charge* grant project.

The RWJ *Communities in Charge* program was a tremendous opportunity for ICC to move its organization to a new phase of development and begin building capacity. “The RWJ grant forced the group to set priorities and work on specific areas,” acknowledged Ms. Resnik.

This opportunity, plus the ICC's work the previous year, set the stage for developing a regional infrastructure to help coordinate planning, public awareness, and program administration.

Initial efforts were aimed at impacting uninsured individuals with incomes at or below 200% of the Federal Poverty Level (FPL) — estimated at 173,000 people for 2000 — and employees of businesses that do not provide health benefits — estimated at 140,000 people, including dependents.

Rolling Up The Sleeves

To help the ICC determine the best way to align services and coordinate efforts, considerable time was spent trying to create a “model” or conceptual framework.

The ICC Board met every two weeks, from 2000 into the Spring of 2001, to develop the strategic plan through consensus. It was a big commitment of high-level people, which was key to the development of the plan.

The political climate of the region didn't make this task an easy one. It was difficult to speak about a health district model to a group of public officials and decision makers who preferred to hear about how just *one single program* helped keep the uninsured healthy or helped keep costs for emergency care down.

Therefore, it was quickly understood that they needed a strategy of incremental change — based on proven successes — that they could slowly build upon.

So they developed a set of key elements for an ideal system and then defined the first elements for collaborative work within the ICC.

The timeline for the planning process was ambitious and activities took longer than expected. It wasn't easy to schedule meetings that would have 100% attendance from busy leaders or to move the process forward systematically in research, problem-solving and consensus-building.

At the same time, meeting quarterly were ICC's steering committee members, comprised of a large group of elected officials and public opinion leaders in the region. Members actively participated in lively discussions about health care issues that were emerging. This turned out to be a yearlong planning process. And it was this process that helped the ICC become very effective in increasing “buy-in” from local officials and decision makers.

ICC Member Profile **Planned Parenthood of the Texas Capital Region**

A private, non-profit organization bringing preventative primary care and family planning services to the uninsured — providing reproductive and sexual health services to about 18,000 patients per year in four clinics.

All of the clinics accept Medicaid and have a sliding fee scale. One provides fully subsidized services to uninsured clients below 100% of FPL. Another 15,000 people participate in community-based education programs.

Funding comes from a variety of sources, including the federal government, client fees, and local contributions.

Fixing The Glitches

Growth never happens without encountering a few dilemmas, however. And, every step of the way, the ICC has been willing to identify and acknowledge the challenges that it has uncovered while moving forward.

It was an ambitious learning adventure. The twelve ICC members became more informed about the actual needs and utilization patterns of the uninsured — and about organizing the community for success.

In the yearlong planning effort, the ICC had developed a strong coalition of healthcare

ICC Member Profile
Central Texas Medical Center

A novel, public-private graduate medical education partnership through which medical residents provide services for indigent patients in community clinics and local hospitals.

Located in Hays County, it serves approximately 2,210 medically indigent patients yearly. There are no private health clinics providing care for the medically indigent in Hays County.

providers — as well as a strategic direction. It developed a business plan outlining priorities for the next year. And it detailed action plans and an organizational structure that could accomplish short-term goals.

Then, in April 2001, the ICC took the important step of hiring a full-time Executive Director, Paul Gionfriddo.

Mr. Gionfriddo came with exemplary health care and policy experience. It was his job to implement ICC's strategic plan. To do this, he brought with him six years of nonprofit management experience as executive director of a health and human services advocacy organization in Connecticut.

Also under his belt were years of experience as a public health/public policy consultant, as well as years in public office — as mayor, as a state representative, and, at various times, as chair or co-chair of legislative health committees and subcommittees.

Mr. Gionfriddo's abundance of knowledge was instrumental in helping to solve the kinds of problems you'd find in any community that's dealing with health care. As well as the particular changing circumstances that Texas was facing: there was a new HIPAA law that was going into effect, which had to be addressed.

THE WORK EVOLVES

Working with Austin’s mayor, the ICC has been supporting the launch of a community-wide effort to promote the creation of a regional Health Financing District. Such a hospital district could bring in the kind of money needed to finance initiatives that the ICC seeks to develop.

Says Seton COO, Pat Hayes, “Because of the unique situation here, we want a health care district that would build incrementally on the services that now exist,” with a focus on five areas:

- Primary care expansions
- Mental health
- ER/trauma
- Specialty physicians
- Infrastructure

Ms. Hayes added that she’d like to see more money going to things like Project Access, which “is leveraging more service than anything else right now.”

Once the important issue of the Health Financing District was brought to a coalition of business and community leaders, the ICC was then freed to work on other elements in the strategic plan — organizing care, reducing costs, expanding access, and bringing in additional revenue to the safety net.

And it all evolved over two years into a set of initiatives.

THE INITIATIVES

MPI/CDR — Master Patient Index/Clinical Database Repository. The foundation database and the glue that holds a lot of the initiatives together.

MPI combines all the information from a patient in one place, under that person’s name.

CDR holds a patient’s encounters from the different entities.

With the MPI/CDR, the ICC has been able to advance its timeframe — putting them years ahead of where they would be without it.

The ICC could have purchased the hardware and developed proprietary software. But what they did instead was to contract with an Application Services Provider (ASP) to take on this load.

According to Paul Gionfriddo, “we could have developed a kind of system that would have been owned and operated by the ICC. But with [ICC Technology Project Manager] Carol Tamayo’s guidance we moved away

from that position. We didn't want to have to maintain the hardware and software.”

And that has helped ensure that the ICC remains a small, flexible team.

Medicaider — an online tool originally designed by Network Sciences, LLC, to determine qualification for Medicaid, SSI, and SCHIP programs. Through Network Sciences, the ICC had it customized to include state and local charitable programs, such as the local SCHIP outreach program, and Insure-A-Kid, with which ICC is contracting to do follow-up with eligible people to make sure they complete their assistance applications.

ICC members can also use Medicaider to determine whether individuals qualify for a wider variety of programs, including Project Access.

Since the ICC began using Medicaider, almost 20% of patients screened (who were initially identified as uninsured) proved eligible for Medicaid/SCHIP/SSI. Since the ICC added all of its local programs, over 90% have been shown to qualify for at least one charitable program.

Project Access — Project Access is a volunteer physician initiative run by the Travis County Medical Society (TCMS). Private practice MDs make a commitment to assist safety net providers in serving uninsured people. They do this by volunteering to see a specified number of people each year — either in their offices or in volunteer clinics.

According to Project Access Director, Cliff Ames, “What Project Access does is come in and provide care for another subset of people that fall outside the lines. We cover people who make too much money to be covered by the others — or who work for a company that provides no health care.”

Almost 500 physicians volunteered to participate during the first “round” of recruitment, and nearly 300 of these volunteered to see patients in their own offices. (The Medical Society handles the appointments in order to lift burden from MDs. Other ICC members can refer patients to Project Access using the Medicaider tool.) Primary Care physicians who participate pledge to see up to 10 patients per year — and specialists pledge to see up to 20.

When the ICC decided that Project Access would be a good program, the Travis County Medical Society was not yet a member. So the ICC members, rather than trying to impose the program on the community (and

ICC Member Profile

Travis County Medical Society

A component society of the Texas Medical Association — a statewide professional organization of licensed physicians. It is a voluntary organization with about 2,000 members, which includes approximately 90% of the physicians practicing in the greater Austin area.

Members have joined together to share medical knowledge and raise the standard of medical care in Texas. Other goals include assistance in enacting and enforcing medical practice and public health laws in Texas and informing the public of important medical issues.

understanding that a successful Project Access model was based on management by the County Medical Society), reached out to the Travis County Medical Society and asked that they consider it.

It's unusual for hospitals and health centers to reach out to private physicians and ask for help. But that's a special part of the ICC story. Still more special is the fact that the Travis County Medical Society agreed to take their members to Asheville, NC, to visit with officials there — and come back convinced that they could make the program successful in Austin.

In December, 2001, the ICC invited the Travis County Medical Society to join the ICC Board, which it did. And nearly 500 physicians pledged to participate in the program. Most likely because they were recruited by peers, through their own organization — not by other ICC members. They saw this as a win-win situation for everyone. “The patients would benefit — and the community would benefit, since the patients would not be a drain on the system,” said Mr. Ames, adding “Our job was much easier because the ICC was already getting doctors and hospitals together.”

Disease Management — Diabetes was chosen as an initiative because this disease is so prevalent in Texas and in the Austin area. (Diabetes is very prevalent among Hispanics.) Internet-based software is used as a tool to share information about the patient's care. If that information has been added into this tool, the different providers can see what care has been given to an individual patient.

A second disease management initiative for the ICC was Mental Health. This because it was becoming clear that improving mental health management in primary care settings could also reduce the need to hospitalize patients with mental illness.

Pharmacy — Partners have developed a common, approved drug list (not yet finalized), so they can purchase those drugs in bulk and get discounts. It would allow different providers to network so that the patients can have greater access to pharmaceuticals. They can also network with retail pharmacies to provide prescriptions.

They've also developed a structure to spin off from the ICC, called the Medication Purchasing Alliance of Central Texas (M-PACT). This is helping to implement even more creative collaborative efforts among members. It has also enabled the ICC to work with the Federal Government to develop an Alternative Methods Demonstration Program initiative. According to Sandy Coe-Simmons, “this is the Fed's attempt at coming up with creative ways to get pharmaceuticals to uninsured patients — to increase access.”

Right now, if someone went to an ER, got a prescription, and brought it to another health center to be filled, it would have to be rewritten by that other provider. With this initiative, a patient can have a prescription written by one health center and filled at another. Or a patient can bypass all of them and go

to a contracted local chain. This allows agencies to interact in new ways and expand access to prescriptions.

In addition to the initiatives, the City of Austin and Seton agreed to expansions of MAP and Seton Care Plus. Both as a commitment to the ICC members and to RWJ — and to show their collaboration. Each committed to adding 2000 people to these programs — and each exceeded their targets.

Medical Assistance Program (MAP) — a unique city-county program that purchases coverage for a core package of health care services through a network of contracted providers, which includes:

- emergency care
- hospital service
- physician care (including primary and specialty care)
- diagnostic services
- home health
- durable medical equipment
- prescription drugs
- dental care

Travis County residents with family incomes below 100% of the Federal Poverty Level (FPL) and disabled and elderly individuals below 200% of FPL are eligible for the program.

MAP was established by the City of Austin in 1978 and since 1995 has been integrated with county medical assistance programs under the direction of Austin-Travis County Health and Human Services Department (HHSD).

Seton Care Plus — a Seton charitable program for uninsured patients. Patients who are enrolled in Seton Care Plus get the same benefits that other uninsured patients get. However, by getting lower co-pays for preventive and primary care services and higher co-pays for non-emergency ED use, they are encouraged to use the health care system more effectively. The purpose of the program is to see over time whether the introduction of managed care principles changes behavior in an uninsured population. Seton Care Plus is being transitioned to I-Care/Seton Community Clinics, so that it won't be confused in the future with a formal insurance program.

ICC Member Profile
Austin/Travis County
Health and Human Services
Department (HHSD)

A joint city-county agency that provides primary care, social, and environmental health services for the City of Austin and Travis County.

HHSD is responsible for administering a number of programs, including the Medical Assistance Program (MAP) as well as the city-county community health centers.

The cooperative effort between city and county government to create and operate a single Health and Human Services Department is unique and is evidence of the culture of collaboration in the region.

The ICC Takes A Holistic Approach

After discovering that many of the uninsured or low-income people who showed up at safety net providers had behavioral health problems that were often going unrecognized or undertreated, the ICC began efforts to integrate some behavioral health services with primary care services.

And so because of the ICC, another unique collaboration began: working with the Austin Travis County Mental Health/Mental Rehabilitation Center (ATCMHMR) to include these patients in all ICC initiatives.

ICC Member Profile

Austin/Travis County Mental Health Mental Retardation Center (ATCMHMR)

Designated by the state as the local mental health authority, ATCMHMR manages a substance abuse treatment provider network, and (with a private affiliate) operates the STAR Medicaid managed care and CHIP network for an 8-county area.

Established in 1967, it provides community-based mental health, mental retardation and substance abuse services to adults and children who are most severely disabled and who are most in need of services.

Services include information and referral, psychiatric evaluation, 24-hour crisis intervention, medication support, inpatient treatment, employment and vocational services, care coordination, service coordination, family support and respite care, housing, supported living and residential services.

As a result, the local Hogg Foundation awarded the ICC a three-year grant, beginning February 2002, to support a Mental Health/Primary Care pilot at three City of Austin clinics.

In another example of a wonderful collaboration, dental health providers have been an integral part of the ICC since its inception. As a result of this holistic approach, what began initially as an informal forum quickly evolved into a platform to create a more coordinated and integrated system of services.

Take Dental Sealant Day, for instance. Every year in February, there are three locations where 300 or so children can get their teeth checked and sealed by dentists, clinicians and other administrative personnel, who offer their services free. About 2 or 3 years ago “this became part of *our* mission because one of our partners had been doing it,” says Ms. Coe-Simmons. “Now it’s a real collaborative effort.”

IMPLEMENTING THE INITIATIVES

Overcoming Data Problems Bit By Bit

One of the most difficult problems to overcome occurred early in the process — and it involved data. In the attempt to compare and consolidate information about the demographics and utilization patterns of the uninsured and underinsured, the ICC would need to interface with at least a dozen different electronic databases (from the 12 providers) in their current and planned states and bring it all together in a standardized manner.

So the ICC had to make the commitment to its members that they would not have to do double data entry of health information.

That’s when it was decided that they would go the ASP (Application Services Provider) route. Which meant they had to find an outside company with software and tech management skills to develop these interfaces.

ICC Member Profile **Volunteer Healthcare Clinic**

A primary care clinic providing primary care, specialty care, and prescription drugs for the working poor who meet the income guidelines. All clinical services are donated by physicians, clinicians, and other area health care providers. A number of sources, including private donations, United Way, and the Seton Healthcare Network support basic clinic operating needs.

Serves as a walk-in primary care clinic on Tuesday and Thursday evenings and an appointment-only chronic disease management clinic on Monday evenings.

One way to speed up the process of moving forward was by doing things simultaneously. The ICC started using the “design-build model.” And that was key to its success.

For instance, when the ICC began initiating disease management for the diabetic population, they took it out of the MPI/CDR so that more patient data could be entered more quickly. The result was the ICC wouldn’t have to wait a full couple of years for the MPI/CDR to be built before moving forward. This “design-build “ approach was borrowed from construction industry practices. Using this approach, projects are fast-tracked by moving ahead and building some aspects of the construction while still designing others.

The data dilemmas that the ICC faced led Seton to apply for — and be awarded — a grant from the HRSA Community Access Program. This funded a critical element of the collaborative.

The grant helped ICC providers and partners develop a regionally shared web-based information system as a way to compile standardized information about population, utilization of service, and cost factors related to caring for the medically indigent.

The ICC, through this grant, began taking a leadership role in coordinating MIS (Management Information System) activities of all the major health care providers in the region.

ICC’s ongoing efforts will be financed through continuing support from HRSA, the RWJ Foundation matching funds and in-kind contributions from Ascension Health and ICC

partners, as well as savings from more efficient care management, increased prevention, and a decrease in inappropriate use of emergency and acute care services. (Ascension matched the HRSA CAP grant with an award of \$900,000, which was payable over a three-year period.)

Redefining the Wheel

The ICC hit upon some legal snags in the summer of 2001. Knowing that they were going to need consent forms, they got a legal team together. Paul Gionfriddo set up an attorney workgroup. The members contributed their lawyers. And the team met every month or so to deal with the issues.

They had to figure out a system that could operate under existing Texas law as well as the anticipated HIPAA requirements that would be in force 15 months later. “There’s been a considerable amount of legal time and talent gathered around the table to help us get through those issues,” maintained Mr. Gionfriddo. “We had a lawyer for the city who was saying that, even under state law, this could be an ‘organized health care arrangement’ — that we would need no consent, no authorization for patients to share

information back and forth. Then we had lawyers saying ‘we think we need consents from patients.’ Our lawyer, who felt we needed some form of authorization or consent, thought initially we could have a ‘chain of trust’ agreement that would work from member to member.”

ICC Member Profile **Seton Healthcare Network**

A not-for-profit organization and a leading provider of healthcare services in Central Texas, serving an 11-county population of 1.4 million. As the region’s largest community service organization, Seton contributed more than \$103 million, serving 203,000 people in Central Texas through charity care and community-benefit activities. In addition to three community clinics, Seton operates seven hospitals including the city-owned Brackenridge Hospital (Austin’s traditional safety net facility), Seton Medical Center, Seton Northwest Hospital, and Children’s Hospital of Austin.

Seton is a member of Ascension Health, the largest not-for-profit health network in the U.S. It originated in Austin in 1902 as a 40-bed hospital and has grown over a century to a network of more than 20 hospitals and healthcare facilities across Central Texas.

Deborah Hiser, of the law firm of Hilters & Watkins, represented the ICC on these issues and also helped them get set up as an incorporated 501C3 non-profit. With her background in civil rights litigation and privacy issues, her experience was perfect for the ICC. Said Ms.

Hiser, “I did a lot of research about how, under Texas law, we could share information between the members. And Texas has an exception to the confidential communication: if you’re a physician or a provider and you’re disclosing *to qualified personnel for program evaluation*. Hospitals have an exception if they’re disclosing *to an agent*. So we all agreed to use to use that exception and enter into disclosures with the clinics and the physicians under the ‘qualified personnel.’ And then with the hospitals as their agents.”

What the ICC finally hit upon was a consensus approach that they called their “spokes on a wheel” — with ICC at the hub and all of its members on the outside. An agreement was devised between the ICC and the participating members — the ICC was now being treated as a separate entity with separate legal council — whereby participating members would be able to share information with the ICC as a business partner without having to get patient consent or authorization.

The agreement also stipulated that none of the information would be shared back out with any other member until the patients themselves, through the signing of authorizations, directed that the information could go around the outside of the “wagon wheel.”

When a patient signs the authorization, they would allow the sharing of information among all 12 members at the same time, in the same way. Everybody had to agree that there would be a uniform authorization — it would be an ICC authorization — that would be signed everywhere vs. each member having their own authorization or consent forms.

“How did we assess the degree of acceptance/rejection of this authorization system?” asked Sandy Coe-Simmons. “We developed a short Q&A and FAQ sheet. On the back, if the patient didn’t want to sign they were asked to give the reason why.”

Ms. Coe-Simmons added, “Seton started incorporating this FAQ sheet into their eligibility paperwork. So for them it had become a part of the rescreening, re-eligibility process.”

“Of course, patients do not have to sign. And Seton does not deny care if they don’t,” explained Ms. Coe-Simmons. “When we rolled it out at the city clinics, we started in one of their Adult Primary Care Units and watched how the front desk explained it to the patients. They expressed it to them in terms of fewer ‘pinpricks’ and other negatives. It was presented to them as benefit driven.”

In hindsight, it was a relatively simple and elegant approach that got the ICC through a huge hurdle. But it was not anticipated even three months earlier. “We knew legal issues had to be dealt with, but we really had no idea what the solution would be or how it would come about,” said Mr. Gionfriddo, “and so it really took a good six months of work from the lawyers. They spent a great time of time and effort working through the problems that the ICC faced and had to overcome.”

Had the ICC not kept the lawyers and the legal representatives together in a couple of rooms — and consequently forcing everyone involved to think all the problems through — it’s unlikely that they would have ever come up with the creative ways that they did to work around these various issues. And if that were not done, they’d probably now have a system that nobody would be using — because nobody could be authorized.

Another benefit of the ICC having a collaborative structure in place was that unforeseen problems that occasionally bubbled up could be solved quickly and easily. For example, St. David’s, as part of the Columbia HCA system, had privacy and confidentiality requirements that the ICC had to satisfy: no doctor or provider could have access

ICC Member Profile
St. David’s Health Care Partnership

A partnership between the not-for-profit St. David’s HealthCare System and HCA-The Healthcare Company, the nation’s largest provider of health care. The Partnership operates a hospital network including St. David’s Hospital, South Austin Hospital, Round Rock Hospital (Williamson County), and North Austin Hospital as well as outpatient surgery centers, a rehabilitation center, a psychiatric facility and occupational health centers.

The hospitals of the partnership have a long history of serving the residents of Central Texas with outstanding health care, as well as through community involvement.

internally to their patient’s health records unless the doctor was serving that person *at that time*.

The solution to that problem was that, since the Travis County Medical Society is involved with the ICC via Project Access, the physicians can have access through the Medical Society. Then no matter where they are — whether at St. David’s or in their own offices — they can access the ICC system through the Travis County Medical Society authorization.

Tackling the Business Problem

As the ICC began to solve the legal problems and were close to a resolution around the technical issues in 2002, they began to recognize that the members didn’t have any processes in place that would enable them to make use of the MPI/CDR, even to feed

ICC Member Profile
Williamson County and Cities Health District

The Health District has provided public health services to Williamson County since 1943. The agency was known as the Williamson County Health Department until 1989 when it was officially organized as a health district.

The District resulted from a cooperative agreement among the governing bodies of the cities of Cedar Park, Georgetown, Round Rock, and Taylor and the Williamson County Commissioners’ Court.

Its mission is to protect and promote the health of the people of Williamson County. The administrative authority for the Health District is the Board of Health.

Funding comes from contributions from the member governments, Texas Department of Health contracts, client fees, Medicaid and Medicare reimbursement, United Way contributions, and other grants, contracts, and contributions.

information in or to get information back out of it.

So the ICC helped members put into place the business operations essential for people to take authorizations from patients — and handle the front and back ends of the authorizing process. This enabled the providers, and others, at those sites to see the information and make use of it.

According to Mr. Gionfriddo, “At that time, we

sat down with about 35 people and, in essence, said ‘the tech stuff is 90% done, the legal stuff 50% done, but with business operations we’re only 10% done.’”

What was created from that group of 35 people was what was called a “FIT” — a *Fast-track Implementation Team*. This team met every other week to work out operations issues and today continues to meet monthly.

THE ROAD AHEAD

So, what does the future hold for the City of Austin and Travis County in terms of health care?

Well, if the folks at ICC keep doing what they've been doing, the future can only be brighter.

It won't be easy. It certainly hasn't been so far.

But through the kind of creative thinking they've fostered — and through their tenacity and dedication — the ICC has shown that smart solutions are indeed possible. And that, by helping the region's health care providers, government agencies, and non-profit organizations work together in common cause, they have shown how everyone can benefit greatly.

The result of all this great effort is that the people of Austin and Travis County stand a better chance of holding down the increasing costs in health care that come from the growing numbers of the uninsured.

And that's a goal that's both worthy and wise.