
Indigent Care Collaboration

HIE Supports Community Collaboration

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ICC Mission

- Affordable access to effective healthcare for the uninsured in central Texas.
- ICC initiatives designed to give safety net providers collaborative tools
 - to undertake initiatives together
 - that none could do as effectively alone
 - that result in increased revenues or reduced costs
 - in providing health and mental health care to low income patients

Health Information Exchange ICC's ICare System

ICare Vision

Goal - fully operational, physician and user friendly system containing timely and complete data sufficient to support two primary uses – program evaluation and clinical care.

Aggregate Health Data Supports:

- Program Evaluation and Grant Requests
- Population Research / Planning Including Regional Care Profiling

Shared Health History Supports:

- Managing Chronic Conditions / Diseases
- Physicians in Understanding and Improving Clinical Care

Approaches to Adoption Metrics

- **Individual (point of care).** Usage by the clinician / caseworker for “the patient in front of them.” Typically, the clinician either accesses individual patient data him/herself, or has the relevant reports prepared in advance of the appointment by administrative or other clinical staff (e.g. Nursing staff).
- **Epidemiologic.** Potentially the area of greatest impact for improving health outcomes in the community.
- **Communication and Reporting Use.** Use of the ICare data for ICC member, community, and organizational reporting purposes.

ICare Snapshot: June 2007

- ◆ Over 60 locations: 13 hospitals, 50 clinics, 1 Mental Health Authority (with various community, state and residential facilities), 2 Physicians Networks.
- ◆ Over 550,000 patients (uninsured / underinsured).
- ◆ 2.9 Million encounters, from 2002 – present.
- ◆ More than 510,000 prescriptions.
- ◆ Data includes ICD-9, CPT-4, Provider, Payer.
- ◆ Encounter Types: Inpatient, Outpatient, ED, Lab, Call Center, Clinic Visits, Dental, Prescriptions.

Health Information Exchange: “HIE”

- Supports accountability – measuring results
- Decreases duplication of services
- Attacks fragmentation – coordinating care
- Provides individuals’ medical information to doctors, hospitals, nurses and other providers
- Provides aggregate data for community health measurement
- Helps patients learn self-management strategies.

EMR/PM/CHR Value to Clinics

- Each clinic environment is unique with different opportunities for potential savings
- Short-term savings reduced by short term impacts to productivity in the first year of any clinic roll out
- Long-term savings augmented by high value community benefits that stem from EMR/PM connection to CHR
- Community benefits include reduction of ED visits, duplicate immunizations, lab tests and other services.
- CHR/EMR chronic disease technology tools reduce ED visits and associated patient costs e.g. diabetes, asthma

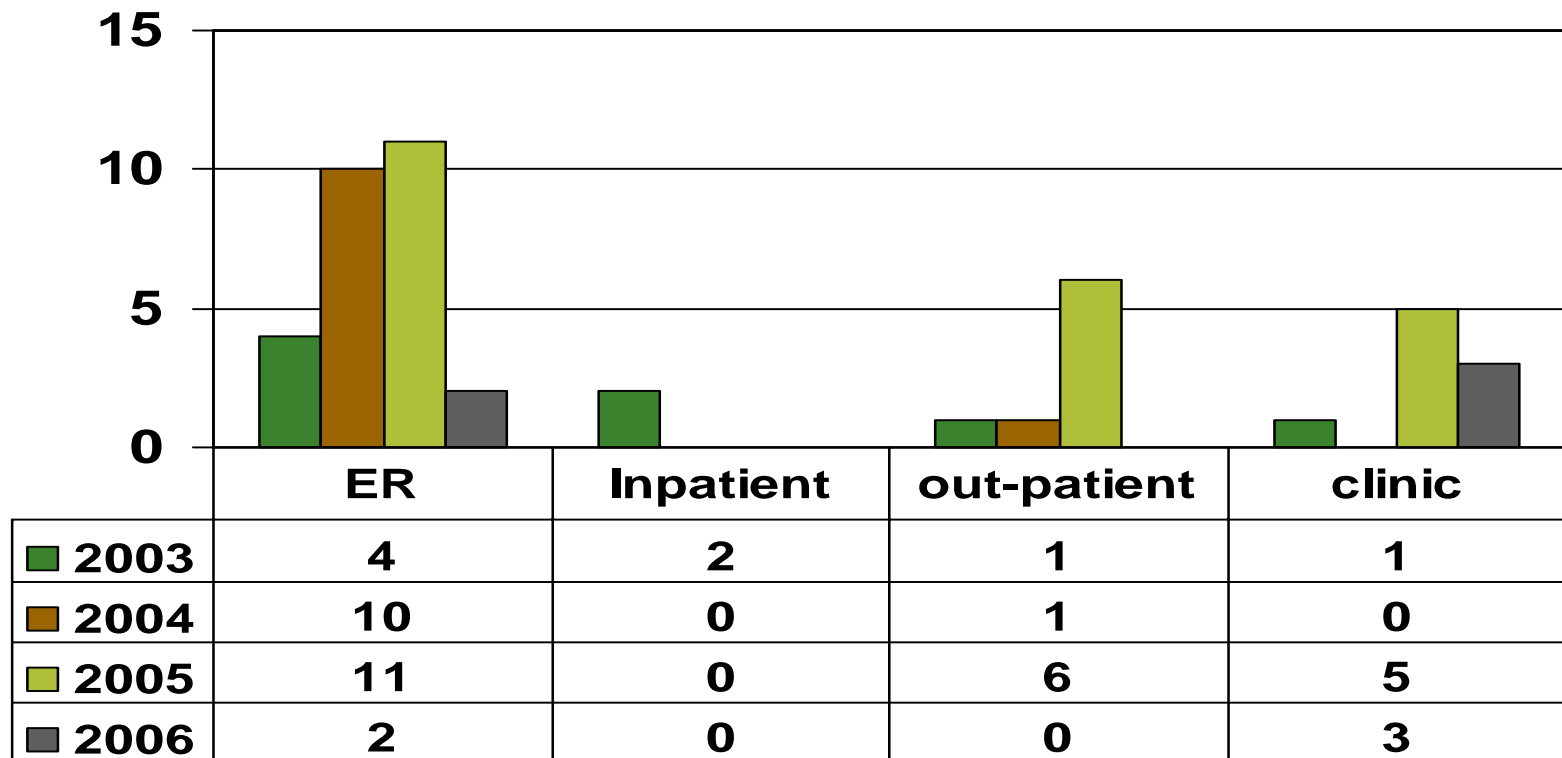
EMR/PM/CHR Value to Clinics

- Community rewards can be harder to quantify
- Benefits and costs are not necessarily evenly matched between payers and providers.
- Example: disease management improvements that minimize ED visits accrue financial benefits to hospitals that do not necessarily flow back to clinics and may result in increased costs to the clinic

ROI Examples

Patient Results Based on ICare Data

- Pharmacist started working with 44 year old, African American male (Type 2 diabetes, asthma) on 12/28/05



Potential Budget Impact - PharmCare

Asthma Cohort N = 956 Patients ¹	Number of Units (Days/Encounters)	Pilot Program % Change in Use ²	Total Cost ³
Inpatient days	539	(100%)	(583,737)
ED encounters	1,123	(58.6%)	(\$167,132)
Clinic encounters	1,023	40.9%	\$21,318
OPD encounters	635	58.8%	\$94,742
Net Cost/Savings – based on 2004 Medicaid rates			(\$634,809)

¹Patients with at least one ED encounter or inpatient admission, primary diagnosis of asthma (ICD 9:493.x) in CY 2006.

²Percent change in utilization observed in pilot PharmCare Program. Figures in () reflect reduction in use.

³Total cost calculated by multiplying net difference in use (days/encounters) by unit cost in dollars. Unit costs based on proxy pricing using 2004 Medicaid reimbursement values. Inpatient = \$1,083; ED = \$254; Clinic = \$51; OPD = \$254

⁴Inpatient days and ED encounters excluded obstetric-related visits

Value of Eligibility Screening

Metric – MedData PAP Screening	Cumulative* April 2007
Total number of applications sent	47,245
Total unduplicated patients who applied for PAP meds	5,250
Total number of prescriptions filled	34,056
Total unduplicated patients receiving PAP meds	3,887
Total AWP Value of PAP Meds**	\$10,407,975

***Some members do not always verify that patients received drugs, so # prescriptions filled, # pts who received meds, and AWP values are either not reported, or are under-reported.*

**Cumulative data represents all the data since each site's inception into the shared ICC database in MDS as of 12/05 (Earliest inception date: 6/9/04).*

Value of Eligibility Screening

Metric – Medicaider Screening	CY 2006
¹Medicaider patients with active 3rd party coverage	8,349
²Patient sample matched with ICare encounters	1,834
³Total Value for Matched Sample	\$4.8 Million
³Total Projected Value – Unmatched Patients	\$13.4 Million
³Total ROI – Matched and Non-Matched Patients	\$18.2 Million

¹Patients screened as eligible for 3rd party payor using Medicaider software – Medicaid, County Indigent, CHIP, SSI

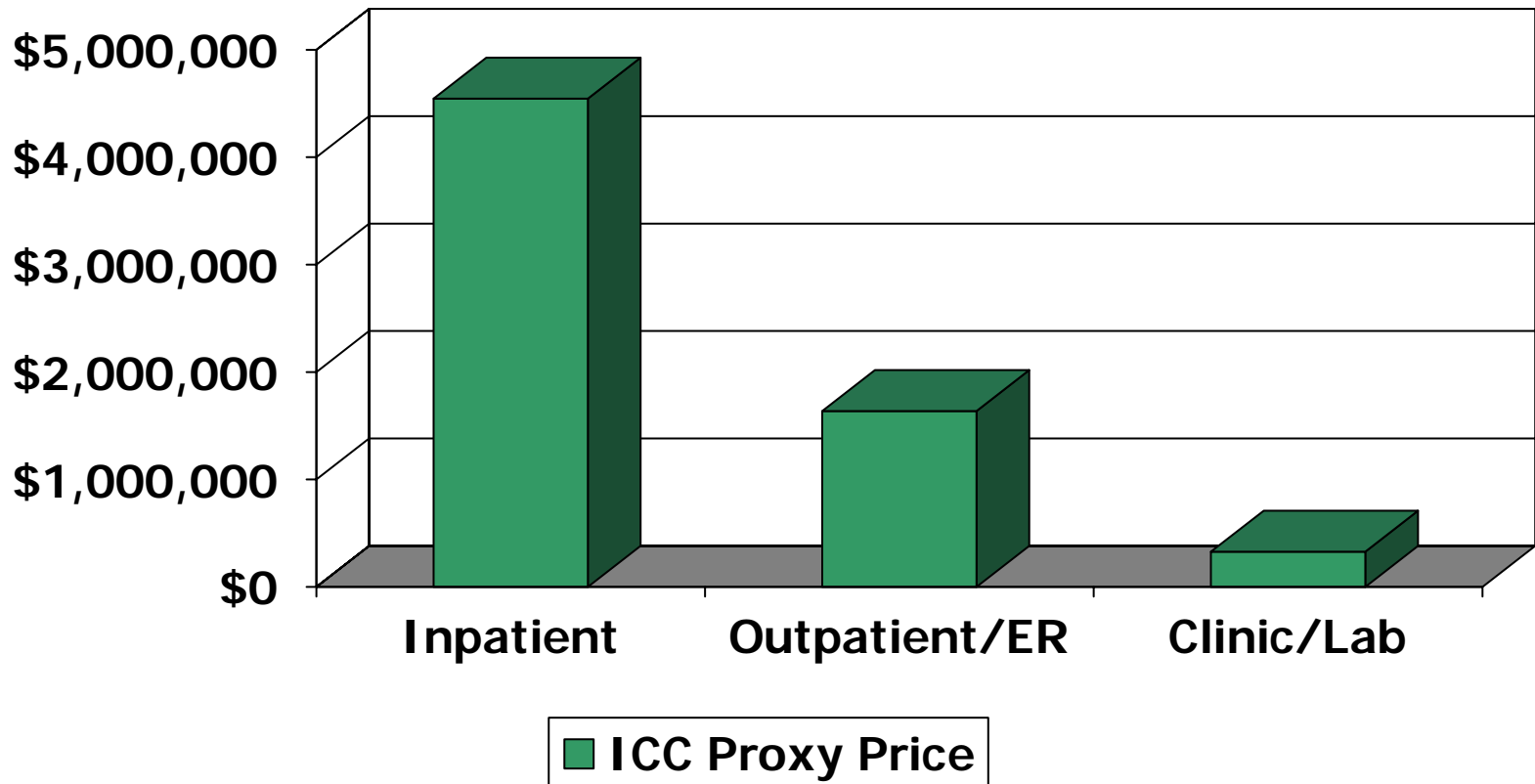
²Unduplicated patients with ICare encounter within Medicaider entitlement effective dates in a clinic, lab, outpatient, emergency room, or inpatient.

³Value calculated using Medicaid proxy pricing methodology.

Clinic avg \$ / patient = \$210; Inpatient avg \$ / patient = \$8.199; Outpatient/ER avg \$ / patient = \$863

Burden of Asthma in CY 06:

\$6.5 million*



*Proxy Pricing based on 2004 Blue Ribbon Medicaid file matched to ICD-9 Diagnosis Codes related to Asthma (493) in CY 06. N= 7,300 patients with 11,800 encounters.