HEALTH CARE ON A NETWORK STRING

By hooking onto a shared IT network, rural community health centers have been able to improve patient care and drive down administrative costs

BY MICHAEL FITZGERALD

Reader ROI

- How sharing IT resources can save money and improve patient care
- Why collaboration provides hope for financially strapped clinics
- How a Florida CIO sold a billing system to doctors in New Mexico

La Casa de Buena Salud Family Health Center lies more than 200 miles east of Albuquerque, N.M. Its remoteness and limited resources made it a perfect candidate to join the Health Choice Network and share IT resources.

DR. MAXSIMO TORRES WAS STEAMED. SEFERINO MONTANO, THE CEO OF HIS RURAL NEW MEXICO HEALTH CENTER, HAD
just told him that the center was thinking about

signing over control of its systems to a com-

munity health center network headquartered

in Florida.

"Set, are you crazy?" Torres recalls asking.

"We can't give up control of our records to some

by group in Florida."

Torres's immediate concern was the poten-
tial loss of privacy for the 15,000 patients seen
every year at the La Casa de Buena Salud Fam-
ily Health Center, a four-clinic group based in
Portales, N.M. As La Casa's medical director,
Torres was also worried about IT support. He
routinely spent two to three hours a night after-
hours entering data into the system. And Florida
was a long way from New Mexico if he needed to
tip someone on the shoulder for IT help.

Costs were also on his mind. In the winter of
1996, La Casa was struggling and had no money
to spend on extra IT services.

But Torres needn't have worried. A trip to
Florida to see the system in action was all it took
to calm his fears. Today, thanks to the Florida
Health Choice Network's IT, his clinics have an
up-to-date patient management and billing sys-
tem, better technology (including handhelds
for the doctors) and improved support.

Three days, Torres almost never stays late,
and he has been able to cut average patient vis-
its by more than an hour, down to 32 minutes.

"Patients complain that they don't have time
to read these books" in the waiting room, he says,
smiling. "Torres doesn't hand out praise easily,
but he's very pleased with Health Choice's hon-
esty and effort. "Every time they say they'll do
something, they come back and give it their best
shot," he says.

And for the first time in several years, La
Casa is in a solid financial footing, thanks to its
improved billing processes and the ability to
share resources across the network. Health
Choice spends about 2.5 percent of its budget on
IT, as opposed to 4 percent for most health-
care providers. By collaborating, its 23 clinics
in New Mexico, Utah and Florida have a $180
million budget to work from, as opposed to the
$1.5 million to $25 million each group of clinics
could afford on its own. The strength of this net-
worked system recently won Health Choice's
runner-up status for CEO's Enterprise Value
Award in 2004.

There's more good news in the offing. At a
time when health-care costs continue to bal-
loon, when medical errors and fragmented
records continue to pose hazards to health, the
digitization of prescription practices and
patient records is being proposed as one cure
for a sick health-care system. The problem is:
How can financially strapped health-care oper-
ations pay for it?

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By linking their fortunes to a larger network, Torres's small clinics will soon be using a computerized order-entry system to order lab tests and drug prescriptions. This will cut the time it takes to get lab results from an average of three days to as little as four hours, and reduce the likelihood of medication errors stemming from illegible physician handwriting. Indeed, several of Health Choice Network's clinics in Florida already have these systems, and several clinics in Florida are planning to store more patient data online in an electronic medical records system.

Dr. Sam Eshkowitz, who oversees the community health center program for the U.S. Health Resources and Service Administration, calls the network "a perfect example" of how centralized purchasing and financial systems can help health organizations treat patients more effectively. He hopes more community health centers (CHCs) will follow in Health Choice's footsteps.

"They're one of our major leaders," Eshkowitz says.

MAKING THE WHOLE RICHER THAN THE PARTS

Community health centers were formed during President Lyndon Johnson's War on Poverty to help poor people get decent medical care. They are funded through a variety of federal and state grants, as well as through patient copays. Today, there are 699 CHCs, which number about 3,600 clinics and treat roughly 12 million patients a year. On average, less than half of the patients who use these centers are insured. (Of the 200,000 patients seen in the Health Choice Network in Florida, between 30 percent and 55 percent don't have insurance.)

In the late '90s and early '90s, FHOs emerged in direct competition with community health centers for federal Medicaid dollars, putting many of these centers out of business. Of those still in existence by the year 2000, a substantial number were small standalone facilities that could not afford the latest in medical equipment or back-office technology for billing and operations. Each center was run locally, with its own board, CEO and medical

Dr. Maximo Torres, medical director of La Casa, was initially opposed to joining a community health network headquartered thousands of miles away in Miami.

NEW MEXICO NEEDED IT—FLORIDA NEEDED MONEY

In 1999, Kearns and Health Choice CEO Bobby Cooke were talking about the need to expand their IT systems and add electronic medical records to their services. However, they didn't want to ask existing members for more money. Around that time, they met David Reddy, the CEO of the New Mexico Network, a group of 10 CHCs. He had heard about Health Choice's cutting-edge IT, and decided that it would be easier for his group to contract out for its systems and services rather than try to build new ones internally.

The resemblance of some of the New Mexico centers played a role in Reddy's thinking. Portales, home of La Casa de Buen Hombre, sits less than 200 miles east of Albuquerque, and the landscape is mostly scrubbed and pine trees, which give way to grassless dunes and farmland with heavy irrigation. Most of the towns look like fossilized broncosaurus herds. Cell phones don't work out there. The town of

11,000 is dominated by a cathedral-like 13-story grain silo that sticks in the middle of it. There's one country hospital, which holds 22 beds. Seriously ill people must make the long drive to Albuquerque, or to Lubbock, Texas. So Reddy, a Massachusetts native, had come to New Mexico as a Volunteers in Service to America member in 1974. He got involved in starting up a community health center and eventually became the New Mexico's chief executive officer.

"In the CHC world, you get these lone wolf, Ms.-and-Pa. organizations," he says. "They're nice, but they're not viable. They're not clinic wise; if he could link Fort Myers and Miami across the Everglades, he could link any place. He had not, however, thought about giving thousands of afrosmiles to New Mexico. But he liked the idea of augmenting the extra funds he needed to pay the network IT capabilities without raising fees for current members.

Talks between New Mexico and Florida began in earnest in December 1998. The most serious challenge was convincing community health center boards in New Mexico to cede control of their systems to Florida outsiders. It had been difficult enough for them to segue to the local autonomy needed to form the New Mexico Network in the first place, and the idea of having patient information and other data stored in Florida was not appealing. Reddy pointed out that storing data locally

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y linking to a larger network, doctors at the remote New Mexico clinics will soon be able to use a state-of-the-art computerized order-entry system to order lab tests and drug prescriptions. 
Collaboration

one IT staff person (none has more than three) who is backed up by Kearns and his staff. The Florida IT group also handles support and training and development for all other centers in the network. All centers rely on Kearns and his staff to deal with ongoing issues (such as compliance with the Health Insurance Portability and Accountability Act), instead of each having to spend the time sending their way through the mire of federal regulations.

HOW TO MAKE COLLABORATION WORK

Roddy says his faith in the Health Choice Network has been rewarded. The clinics are now financially stable, including La Casa. They can now benchmark things such as doctors are putting in the right codes for treatment, how they compare to their peers, and if they're following the recommended protocols for treating chronic diseases.

The collaboration has also worked well for Health Care and Keans, whose overall IT staff now numbers 17, versus three before expansion. Adding New Mexico and Utah has meant increasing his help desk staff from two to five, making it easier to cover the extended hours needed to support the Western states. Based largely on its IT track record, Health Choice received a four-year, $4.4 million grant in September 2003 to move the Florida centers to electronic medical records and electronic dental records. That project is moving out of the pilot phase at three Florida facilities. Over the next three to four years, all the clinics will get them, with three New Mexico clinics scheduled to be the first phase online by the end of this year.

Part of Keams's success in selling these new systems to the network's doctors and nurses is his "go slow, train well" approach. He takes care not to overwhelm staff with too much technology all at once. For instance, with the ongoing rollout of electronic medical records, each center begins with the prescription and lab report modules—relatively straightforward ways to get used to paperless systems. After several months, more records shift online, and so on until the whole system is in place. Several clinics in Florida are currently paperless, with doctors and nurses doing everything electronically. All the Florida centers should be paperless by December 2007, Keams says.

Thus far, bonding together has helped all the centers in the Health Choice Network see more patients, and it has generated around $2 million in grants, while saving an estimated $4 million a year over what it would cost for each center to hire staff and maintain comparable systems.

"I couldn't have imagined a more successful outcome," Roddy says. The Health Choice model has worked so well, he notes, that federal officials think that it may provide a model for CHCs throughout the country.

Dr. Maximo Torres would agree. During a recent conference call with Health Choice executives, La Casa's medical director, asked as Keams's help getting La Casa's X-ray machine back up and running so that doctors there can digitally transmit images received in Albuquerque and elsewhere. (Transmitting X-rays by the old-fashioned way, by film, cost the center too much time and money, forcing them to send patients hundreds of miles away for X-rays.) Digital transmission, Torres suggests, would be much cheaper and substantially reduce the time it takes to diagnose and treat patients.

"We don't use the system now, but we'd really like to hook it into Medical Manager," Torres says.

Kearns sounds intrigued. He promises to look into the idea. This is a new and potentially useful territory for the network. And the finds it especially gratifying that Torres, once suspicious of the Floridians, is now pushing the technological envelope for them.

Kevin Keams, CIO of the Health Choice Network, has been successful in selling new IT systems to doctors and nurses in large part because of his "go slow, train well" approach.

Learn More About Shared Services

IT collaboration happens on many scales. Telena, a $31 billion global enterprise with 41 business units, is spending approximately $200 million on its LT. SAMED SERVICES organization. Telefonica about 40 business units. Pfizer is an extreme. Go to www.cio.com/ poll.

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Case Closed

How to Make—and Sell—the Business Case for Internet Protocol Communications

AFTER YEARS OF DEVELOPMENT, Internet protocol (IP) communications solutions are finally ready for prime time. This question is, how do you get them into the enterprise?

No one disputes the technological merits of Voice over IP (VoIP) and video and audio conferencing IP communications' core functions. They have obvious value to business and technology executives. VoIP especially is gaining critical mass: according to "Corporate VoIP Market, 2004-2009", a study by Telemedia Group, business spending on VoIP will rise from nearly $1 billion this year to $5.5 billion in 2008. As such high-profile carriers as AT&T, Cablevision, MCI and Verizon start to offer VoIP packages, market momentum should only increase.

But gaining corporate buy-in for technology purchases is not as simple as it was in the cash-rich late 1990s, when Y2K and the Internet boom gave CIOs nearly unfettered license to spend. Now, with greater scrutiny of technology spending, IT leaders need to build a rock-solid business case that is based on the benefits and cost savings IP communications can bring to the enterprise. "When the IT spending environment is a little loose, then cases based on features and functionality are more likely to be approved," says Bill Helforn, a partner at Bain & Company, the San Francisco-based management consulting firm. "When it's tighter, cases really need to be based on cost reductions."

Game Plan

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