Introduction
Introduction

ACOs and HIEs: Strategic Intersection Point?

The story....

October, 2011
✓ March, 2010: The Patient Protection and Affordable Care Act (PPACA) signed into law
✓ CMS identifies two ACO programs: Pioneer ACO Program and Shared Savings Program (final rules published on November 2, 2011)

February, 2012
✓ Jan 1, 2012: Pioneer ACO Model: Performance period begins

December 23, 2013
✓ RFI from CMS about ACOs (AA)

Today: April 29, 2014
✓ Mixture of Pioneer and Shared Savings Programs in place
✓ January, 2014: Over 360 ACOs in place (Leavitt Partners states there are 488 as of July, 2013)
✓ End of 2014: Projected – 500 ACOs in place
ACOs and HIEs: Strategic Intersection Point?

The story… so we asked three questions:

✓ How will newly formed ACOs or any other emerging care delivery model underwrite the required technology to support care coordination?

✓ ACO participants may or may not include health systems that would have existing technology assets to support a new effort. Will newly formed ACOs have sufficient funding to support all operational requirements?

✓ Depending on the outcomes of ACOs, they may require a future exit strategy?
Introduction

ACOs and HIEs: Strategic Intersection Point?

Today’s healthcare landscape continues to provide numerous opportunities as well as challenges:

• **Industry Complexity and Challenges** related to Legislation and Compliance continue,

• **Evolving and Promising Care Delivery Models,**

• **Unexpected Partnerships** across all industry segments and sectors,

• **Sustainability remains in question** for Care Delivery Models, healthcare providers as well as HIEs, and ACOs, and

• **New Care Delivery Models** require more data / information (Need for resources for investment, implementation and on-going support)
ACOs and HIEs: Strategic Intersection Point?

Today’s Learning Goals:

- Current Trends
- Synergy between HIEs and ACOs
- The Future of HIEs
ACOs: Background Information I

**Definition: Accountable Care Organization (ACO)**
Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

The **goal of coordinated care** is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.

[Note: The definition of “ACO” bears a striking resemblance to the definition and history of “HMO,” a term coined in 1970. There is no current mechanism to retain an ACO population but the ACO is directly responsible for patient outcomes.]
ACOs: Background Information II

Information from a July, 2013 Survey of 488 ACOs conducted by Leavitt Partners:

- ACOs are now found in all 50 states plus the District of Columbia and Puerto Rico
- 52% of ACOs are dedicated to Medicare population (serves 5.3 M persons over 65 years of age or 1 in 8 recipients of Medicare; approximately 115,000 physicians serve in Medicare ACOs)
- 55 ACOs care for both Medicare and non-Medicare populations
- Some ACOs include employee populations, commercial ACOs, etc.

Four Types of Accountable Care Organizations (ACOs):
- Comprised of Smaller Physician Practices
- Comprised of Hospital / Hospitals
- Comprised of Integrated Hospital(s) and Physician Practices
- State-Specific in Support of Medicaid Populations
ACOs: Illinois

Many types of partnerships emerging to create an ACO:

- **Pioneer ACO: OSF Healthcare**
  “...The results specific for OSF HealthCare indicate we performed positively in that our results are better than our benchmark. We are trending in the right direction in terms of better coordinating the care of our sickest patients, improving their quality of life while concurrently reducing the total cost of care for all of our Pioneer ACO patients by nearly 1 percent,” according to Robert Sehring, Chief Ministry Services Officer for OSF Healthcare System.” (A-1)

- **Adventist Health Network and Cigna**: Adventist Health Network have launched a collaborative accountable care initiative to improve patient access to health care, enhance care coordination and achieve the “triple aim” of improved health, affordability and patient experience. The program became effective January 1, 2014 and is Cigna's first collaborative accountable care initiative to launch in Illinois.” (2)

- **Advocate Health Care and Blue Cross & Blue Shield of Illinois:** “Illinois' largest health network and largest health insurer have shown marked reductions or slower growth in the use of services as part of their 3-year-old accountable-care organization, an encouraging sign as providers and payers try to reduce the cost of care.” (3)
The Synergy of HIEs and ACOs

Various Types of ACO Relationships

ACOs Formed from Medical Practices Entering Relationships with Payers: (select examples)

- Core Physicians (NH) and Cigna (January, 2014)
- Baton Rouge Clinic (LA) and Cigna (March, 2014)
- Martin’s Point Health Care of Portland (ME) and Aetna
- New Haven Community Medical Group (CT) and Aetna
- WESTMED Medical Group (NY) and UnitedHealthcare (November, 2013)
- Sansum Clinic (CA) and Anthem Blue Cross (February, 2014)
- Esse Health (MO) and Anthem Blue Cross (March, 2014)
- Miramont Family Medicine (CO) and Humana (March, 2014)

“Although the program is designed to align the incentives of hospitals and physicians around keeping people healthy, more than half of ACOs are led by doctors’ practices and leave out hospitals entirely. “Some had come with the hypothesis that those who formed ACOs … would be led by hospital-dominated systems,” Jon Blum, principal deputy administrator at the Centers for Medicare & Medicaid Services, told reporters in January [2014]. “Quite the opposite has happened.” “ (B)
The Synergy of HIEs and ACOs

What Challenges Will ACOs Face?

The information and data challenges are numerous for ACOs:
- Financial Benchmarks
- Quality Benchmarks
- Compliance with CMS, OIG and DOJ requirements
- Reconciliation / Risk Adjustment (Measure/Stratify)
- Contracting (CMS, private or other payers)
- Trending
- Predictive Analytics
- Contracting with Payers
- Contracting with Suppliers / Vendors
- Care Coordination
- Managing Providers
ACOs: Information Technology Requirements

What Information Technology Is Needed by ACOs?

Recent report from IDC Health Insights:

- “Population management tools,
- Computerized physician order entry,
- Admission, discharge and transfer,
- Billing,
- Practice Management,
- Enrollment,
- Care management…
- Analytics for performance measurement, patient identification and stratification.
- Workflow applications that include the ability to create and manage care plans, track events and scheduling.
- Patient engagement tools. In the future, these efforts likely will include more than a portal, including other channels such as texting to engage patients.”

Beginning of 2014 = 360 ACOs
End of 2014 (Projected) = 500 ACOs
Current Trends

ACOs: Statistics

Just 6% of Americans Enrolled in ACOs (5)
January 30, 2014
(Note: Data about covered lives varies widely among states (per recent Health Affairs blog post).
David Muhlestein, PhD and Leavitt Partners estimate that just 6 percent of the nation's population is enrolled in an ACO.
Examples include:
- Oregon: 27% of its population in an ACO (reason: Medicaid ACO movement),
- Alaska, Iowa, Massachusetts, Maine, New Hampshire, Rhode Island, Utah and Vermont: more than 10% population in an ACO, and
- Alabama, Georgia, South Dakota, Oklahoma and Wyoming: 2% or less of their populations in an ACO.

13 Statistics on Technology Costs for ACOs (6)
January 30, 2014
- Accountable care organizations' start-up costs average $2 million over the first 12 months, according to a report from the National Association of ACOs.
- Technology accounts for a large percentage of start-up costs, as the average ACO spends almost $900,000 on IT.
Current Trends

Transition to ACO

“The transition to accountable care is expensive: organizations beginning the ACO journey need to make significant investments to develop the infrastructure and resources needed. They also need to reduce costs and utilization through improved chronic disease management and health outcomes. However, considering the infrastructure investments required, few providers can afford to sacrifice revenues from reduced utilization without being compensated for the additional care management programs and a portion of the savings these efforts generate.” (C)
ACOs: Studies

- Roanoke, Va., serves 18 counties and 6 cities in western Virginia and southern West Virginia
- 600 employed physicians / over 60 specialties
- Practice sites: 195 / Primary care visits: 850,000 (2012)
- Medicare Shared Savings Program (MSSP): January, 2013; plus commercial ACO with Aetna (5,000), and self-insured employees (17,000)

Biggest ACO Challenges to Date:

“The first has been getting the data. And you need to understand that that may not be the easiest process. It was in fact very frustrating with Medicare. And even with Medicare, in terms of claims data, we were not prepared to bring in that data right away, on our end. So we’ve really learned a lot, and quite honestly, I think we underestimated the amount of time, and the complexity, involved in bringing claims and clinical data together in the enterprise data warehouse, and making that useful information. ....”

Stephen Morgan, M.D.
Senior Vice-President and CMIO
Carilion Clinic (VA)
“We can do national healthcare exchange in three years (2017).... The nation’s healthcare data will be freed...I know that this is possible. I have seen [health information exchange] in every part of our country...” 

A growing number of studies are available that demonstrate the impact of HIEs, both on patient care quality and savings generated by sharing patient information.
Current Trends

HIEs: Studies

Statewide Health Information Network of New York (SHIN-NY) (10)
- Single consent form for both behavioral and health information

- “National Survey: a significant number of adults have comorbid physical health and behavioral health conditions. Nearly 70% of adults with mental illness have co-occurring medical conditions, while 29% of adults with physical health conditions have comorbid mental illness. Rates of high blood pressure, asthma, diabetes, heart disease and stroke are higher for individuals with mental illness than for those without mental illness. Comorbid behavioral health and physical health conditions are also costly.” (11)

- “New York’s Medicaid program: 82% of potentially preventable 30-day hospital readmissions were for persons with behavioral health conditions, costing the state $665 million. Nearly 60% of those readmissions were due to physical health conditions.”
HIEs: Studies

A Private HIE (12)
- 1 hospital, 3 nursing homes, 70 remote sites including 40 of physician practices, a home care facility, and a regional lab with international ties
- 4 different EHRs
- HIE branded: u.Net Connect
- Connection to Rochester regional health information (RHIO – public HIE) / able to gather data from the other two health systems in the area
- 01/23/14: Unity & Rochester General Health System file Certificate of Need (CON)
- Impact on Diabetic population: 3300 patients participated in program. Results: hemoglobin a1c levels are averaging below 9% (reduction of 15%) in 65 days.
  [Average time for population improvement typically 12 to 18 months]
Current Trends

HIEs: Studies

A Private HIE Supporting an ACO

- 4 Hospitals, 4 Outpatient Centers, 3 Urgent Care Centers, 280+ Employed Physicians, 308 Skilled Nursing Beds, 2 Home Health Agencies, 9 Ambulatory Surgery Centers, 3 Fitness Centers
- Sponsor of Regional HIE
- January, 2013: Contract with CMS for an ACO (13,700 lives)
- Other Contracts added at this point in time
- HIE now has 700,000 unique patients
- More improvements to support both the health systems and the VirtuaCare ACO: Care Coordination and Engagement tools in place, predictive modeling, clinical analytics to measure outcomes, expansion of home monitoring, patient portal for 2 way communication and social media outlet (http://www.virtuabroadcastnetwork.org/)

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Most Impactful Barriers to Widespread HIE

1. Breadth and pace of change required of stakeholders (96%)
2. Cost (96%)
3. **HIE financial sustainability** (95%)
4. Privacy and security (95%)
5. EHR vendor readiness (94%)
6. Lack of interoperability (93%)
HIEs: Studies

Health Information Exchanges: 10 Pitfalls (15)
1. Underutilization of HIE portal by physicians (47%)
2. Equating HIE interoperability as just a tech issue (44%)
3. Trusting HIE to take care of security, consent issues (34%)
4. Having architecture and strategic priorities out of sync (33%)
5. Lacking a clear mission for HIE (27%)
6. Waiting to implement analytics, data management solutions until maturation (26%)
7. Using HIE to solve physician alignment, patient engagement problems (24%)
8. Identifying which practices to connect first (24%)
9. Rushing to get practices connected to share orders, lab (23%)
10. Thinking HIE solutions are all the same (13%)
Current Trends

HIEs: Collaborative Relationships

Mid-States Consortium of Health Information Organizations (16)

Goal: Collaborate to address data exchange challenges across regional and state lines

- Colorado Regional Health Information Organization
- Community Health Information Collaborative (MN)
- Coordinated Care Oklahoma
- Health Information Network Of Arizona
- HealthShare, Montana, Inc.
- Idaho Health Data Exchange
- Iowa Health Information Network
- Kansas Health Information Network, Inc.
- Missouri Health Connection
- MyHealth Access Network, Inc. (OK)
- Nebraska Health Information Initiative
- North Dakota Health Information Network
- Quality Health Network (Colorado)
- South Dakota Health Link at DOH
- Southeast Texas Health System
- SMRTNET (OK)

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There has been substantial growth in the number and type of HIEs around the country. There now are 255 HIE initiatives at the state, regional, and local levels. But ten of them closed in the last year (2012)… More worrisome is the fact that only 10 percent (24 in all) report they have a sustainable business model.” (17)

**Note:**
- Today, there is no official registry of HIEs in the U.S.
- Reporting is only achieved through self-reporting by the HIEs.
- Today, there are no consistent benchmarks and/or standards across all HIEs.
- As certification of HIEs is established, there will be an added cost for this effort. There are preliminary steps toward certification. (see slide 51)
The Synergy of HIEs and ACOs
The Synergy of HIEs and ACOs

What Can HIEs Provide to Their Community or Geography?

Data Services By Constituency

- Consumers and/or Caregivers
  - Personal Health Records
  - De-identified, Longitudinal Clinical Data

- Physicians
  - Results Reporting
  - Secure Document Sharing
  - Clinical Decision Support
  - Credentialing
  - Eligibility Checking

- Researchers
  - De-identified, Longitudinal Clinical Data

- Laboratory
  - Clinical Messaging
  - Orders

- Payers
  - Clinical Quality Measurements
  - Claims Adjudication
  - Secure Document Transfer

- Public Health
  - Needs Assessment
  - Biosurveillance
  - Reportable Conditions
  - Results Delivery
If we are to coordinate care regardless of the type of Care Delivery model or care setting, face-to-face or virtual, then identifying a vehicle to cross those “boundaries” is critical to bend the healthcare “cost curve”.

The Synergy of HIEs and ACOs

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In 2012, we said...

“...it is our opinion that consideration of Health Information Exchanges (HIEs) is a viable approach and vehicle to accelerate operationalization of an ACO while expanding current Information Technology to support ACO requirements. In addition, the HIE, depending on geography, can provide a variety of services and or products that will support your ACO efforts. Given the high costs related to ACOs and further analysis in 2011 which pointed to underestimates by the Centers for Medicare and Medicaid (CMS), hospital or health systems CEOs will want to identify approaches that can better identify investment levels and address how various healthcare organizations might leverage required technology both short-term and long-term.”  (19)
Care or clinical processes, Medical Technology and Information Technology are further entwined and co-dependent, within and across healthcare settings.
In 2012, and furthermore...

“.... The successful ACO will have systems that digitize and automate the flow of data within the four walls as well as beyond into the community.

For Chief Executive Officers and Chief Medical Officers who are actively engaged in conversations about the feasibility and sustainability of an ACO, it will be important to investigate whether a local or regional Health Information Exchange (HIE) may be an integral component in mapping out a potential solution in support of their ACO. It is worth an effort to reflect on the goals of an ACO and putting this in context with the operational infrastructure that will be required when bringing together various healthcare entities to participate in this type of organization. Ultimately the aim of the ACO is to reduce cost, improve quality and enhance the patient’s experience. “ (20)
The Synergy of HIEs and ACOs

HIEs and the Potential Breadth of Their Services

HIEs Can Provide ACOs …

- **Trusted/Neutral Organizational Governance** established as not-for-profit, 501(C) organizations
- **Regional connectivity** to various healthcare facilities/providers and other health related facilities
- **Policies and Procedures ensuring HIPAA Compliance** including **Meaningful Use** (MU) Requirements
- Redundant and scalable **infrastructure** to support real time access to data and allow for **disaster recovery** to maintain connectivity
- Audit Repository and Risk Management to ensure **data security** and **privacy**
- **Interoperability** across disparate systems
- **Data analytics**
- **Scalable** on-ramp and **options for participants** that are in differing stages of automation
- Ability to offer **economical solutions** especially for physician practices and clinics that may lack group purchasing options
The Future Of HIEs
What Is the Future of HIEs?

- Sustainability of Public, Public-Private, and Private HIEs remain in question
- Rise of Private HIEs
- Some Private HIEs are supporting their own ACOs (Medicare and Other Populations)
- Less than traditional partnerships being formed
- Successful HIEs Offer a Variety of Outsourced Services

[e.g. since 2012, HealthBridge offers outsourced HIE services (X); MiHIN will offer its Health Provider Directory to ETHN (Y)]
The Future of HIEs

HIEs of the Future...a Überg-Utility?

Mercedes Benz Museum (Stuttgart, Germany)
The Future of HIEs

Care Delivery Models Such As ACOs Will Continue to Evolve....

- Sustainability over time remains in question,
- Seek economies of scale,
- Purchasing power required,
- Patient management through analytics is critical to manage a population
- Resource requirements are numerous to launch (operations, staff, technology, applications, etc.)
The Future of HIEs

Industry voices today...

“…things are getting more difficult, rather than less, in HIE as everyone is trying to find a sustainability model. ‘I think the solution for these HIEs is really their partnerships with accountable care organizations (ACOs).… part of our sustainability strategy is to really connect with these ACOs, because we can charge a per-connection fee,’ he says, ‘and in some of the smaller ACOs, the HIE can even be the analytics partner as well.’”

Chuck Podesta
Senior Vice-President and CIO
Fletcher Allen Health Care (VT)

“…The success of ACOs, patient-centered medical homes (PCMHs), and bundled payments all will be reliant on interoperable HIE systems across the entire continuum of care, agrees Gilman….”

Tony Gilman
Chief Executive Officer
Texas Health Services Authority (THSA)
"Together, these projects signify a new period in American health care, one of "radical experimentation. There’s going to be a period of 10, 20, 50 years in which we’re going to be trying to figure out how to deliver health care that’s affordable without consuming too many…resources. This experiment is really interesting."

Tom Baker, JD
William Maul Measey Professor of Law and Health Sciences
University of Pennsylvania Law School
We welcome your comments or questions.

Thank you for your attention today.
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Slide 4: (AA) Center for Medicare and Medicaid Innovation: Request for Information: Evolution of ACO Initiatives at CMS

**AGENCY**: Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION**: Request for Information (RFI)

**SUMMARY**
The Centers for Medicare & Medicaid Services (CMS) are seeking input on the following areas related to the evolution of Accountable Care Organization (ACO) initiatives.

1. A second round of applications for the current Pioneer ACO Model
2. New ACO models that encourage greater care integration and financial accountability

**DATES**: *Comment Date*: To be assured consideration, comments must be received by March 1, 2014.

**ADDRESSES**: Comments should be submitted electronically through the CMS Innovation Center’s web page at: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

**FOR FURTHER INFORMATION CONTACT**: PioneerACO@cms

Slide 9: The first wave of ACOs included 23 Pioneer ACOs. It is interesting to note that 8 of the 23 Pioneer ACOs were located in the Midwest. Additional details about these ACOs can be found at the following URL: [http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/](http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/).
Introduction


Pioneer ACOs (source: https://data.cms.gov/dataset/Pioneer-ACO/izub-xmpg)
- Allina Hospitals and Clinics (MN and western WI)
- Atrius Health (eastern and central MA)
- Banner Health Network (Phoenix, AZ)
- Beacon Health, LLC (central, eastern and northern Maine)
- Bellin-ThedaCare Healthcare Partners (northeast WI)
- Beth Israel Deaconess Physician Organization (eastern MA)
- Brown & Toland Medical Group (San Francisco Bay area, CA)
- Dartmouth Hitchcock ACO (NH and eastern VT)
- Fairview Health Services (Minneapolis MN metropolitan area)
- Franciscan Alliance (central IN and Indianapolis)
- Genesys PHO (southeastern MI)
- Heritage California ACO (southern, central and coastal CA)
- Michigan Pioneer ACO (southeastern MI)
- Monarch HealthCare ACO (Orange County, CA)
- Montefiore ACO (NYC-Bronx – and lower Westchester County, NY)
- Mount Auburn Cambridge Independent Practice Association (eastern MA)
- OSF Healthcare (central IL)
- Park Nicollet Health Services (Minneapolis MN metropolitan area)
- Partners Healthcare (eastern MA)
- Renaissance Medical Management Company (southeastern PA)
- Sharp Healthcare ACO (San Diego County, CA)
- Steward Healthcare Network, Inc. (eastern MA)
- Trinity Pioneer ACO (northwest central IA)
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Current Trends


Slide 10  (A) Peterson, Matthew; Muhlestein, David, and Gardner, Paul. “Growth and Dispersion of Accountable Care Organizations: August 2013 Update”, study by Leavitt Partners, August of 2013, pp. 5, 6, 8, and 9.


http://www.modernhealthcare.com/article/20140122/INFO/301229994?AllowView=VDl3UXk1TzRDUGFClxzS0M0M3hlMEtyalVVZEErST0=&utm_source=link-20140122-INFOR-301229994&utm_medium=email&utm_campaign=mdaily&utm_name=top

Advocate Health Care and Blue Cross & Blue Shield of Illinois started their ACO, called AdvocateCare, three years ago aiming to better align financial incentives between the two mammoth organizations. The utilization trends, which Blue Cross provided to Crain's, provide a glimpse into the progress of one of the country's first and largest commercial ACOs…”
**Bibliography**

**Current Trends**  *(continued)*

Slide 11  


Advocate Health Care and Blue Cross & Blue Shield of Illinois started their ACO, called AdvocateCare, three years ago aiming to better align financial incentives between the two mammoth organizations. The utilization trends, which Blue Cross provided to Crain's, provide a glimpse into the progress of one of the country's first and largest commercial ACOs…”

Slide 12  


“Critical to the program's benefits are the clinical care coordinator and practice-based registered nurses, employed by Core Physicians, who will help patients with chronic conditions or other health challenges navigate the health care system. The **care coordinators are aligned with a team of Cigna case managers to ensure a high degree of collaboration** between the medical group and Cigna, which will ultimately provide a better experience for the individual…**Cigna will compensate Core Physicians for the medical and care coordination services it provides.** Additionally, Core Physicians may be **rewarded through a “pay for value” structure if it meets targets for improving quality and lowering medical costs.**”

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Example of ACO and Payer Announcements:


“Anthem Blue Cross (Anthem) announced today that Sansum Clinic will join its Enhanced Personal Health Care Program, Anthem’s Accountable Care Organization (ACO) program which helps members with two or more chronic conditions improve their overall health through enhanced coordination of health care

In fact, individuals who buy their health insurance through the exchange in the Santa Barbara region will have access to Sansum Clinic’s ACO if they meet program criteria…”


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Current Trends (continued)


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Web site for the Marshfield Clinic: www.marshfieldclinic.org

Slide 18  (7) Leadership Biographies: Dr. Karen B. DeSalvo, MD, MPH, MSc
http://www.healthit.gov/newsroom/dr-karen-desalvo-md

http://www.clinical-innovation.com/topics/health-information-exchange/state-hies-analytics-post-hitech-world

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http://www.kiran-consortium.com/thought-leadership.html

http://www.kiran-consortium.com/thought-leadership.html
The Synergy of HIEs and ACOs  (continued)

Slide 34  (X) Web Site for HealthBridge.  They are leveraging their experience in building their HIE and offering a variety of services to HIEs in the market.
http://www.healthbridge.org/WhatWeDo/Projects/CollaboratingCommunities.aspx


http://www.healthcare-informatics.com/article/health-information-exchange-moving-forward-or-stuck-neutral


Additional Reference Material


-  ACO chart with identified savings:  http://healthaffairs.org/blog/wp-content/uploads/Table-11.jpg


“Illinois Health Partners ACO LLC is one of 123 new ACOs nationwide announced this month by the Centers for Medicare and Medicaid. organization backed by DuPage Medical Group Ltd, and Edward Hospital and Health Services to manage the health of about 50,000 Medicare beneficiaries under an arrangement designed to create incentives to cut costs. The DuPage Medical-Edward venture is a subsidiary of Illinois Health Partners, a network formed by the physicians group and Naperville-based hospital in 2011 that manages more than 100,000 patients insured by Blue Cross & Blue Shield of Illinois and Humana Inc. shared savings model… (Harvey, IL) Ingalls Care Network LLC is only taking on about 6,100 Medicare beneficiaries as the hospital.”
Providers can now look for certification seals for proof of “plug and play” interoperability compliance of EHRs and other HIT systems.

Source: NeHC ONC HIE Governance Update, May 10, 2013
http://www.nationalehealth.org/GovernanceUpdate