

# Phase I Executive Report

## Designing the Future of Health Care in Whatcom County

A Progress Report from the Whatcom Alliance for Healthcare Access

### Introduction

*WAHA convenes providers, payers and community leaders to consider ACO options.*

Spurred by opportunities and challenges coming out of the 2010 federal health care legislation, the Whatcom Alliance for Health Care Access (WAHA) convened providers, payor and employer representatives, and other community leaders for the purpose of “designing the future of health care in Whatcom County.” A steering committee was formed along with three workgroups. One of the workgroups was focused on actual health delivery, another on health information exchange (IT systems), and the third on financial issues.

This white paper summarizes the work of these committees over the last six months and puts forth a vision for a clinically integrated, patient centered, care delivery system in Whatcom County. The paper defines what is meant by an Accountable Care Organization (ACO) and argues that we shift our thinking more toward becoming an “accountable community.” The concluding sections outline ways we could structure provider relationships to support the vision of an accountable community, and concludes with laying out next steps.

WAHA is a nonprofit 501(c) (3) organization with a mission to *connect community members to health care services, promote system improvements, and foster public engagement to develop sound healthcare policies.* The Leadership Board includes consumers and community leaders from the nonprofit, business and governmental sectors, as well as many local healthcare organizations. For a complete listing of participating individuals and their organizational affiliation see Appendix 1.

### For the sake of what

*An emerging vision of a clinically integrated, patient centered system of care.*

As noted above, the goal of the WAHA *Designing the Future* project is to create a clinically integrated health system, which is defined as a tightly linked group of providers working together to share accountability for equitable access to high quality, cost effective healthcare services for the people of Whatcom County.

The cost of care will be measured on a per capita basis, and outcomes reported on a community level. The system will be held accountable to meet performance measures for both cost and quality of care. Financial compensation will depend, at least in part, on achieving these targets.

The current health care delivery system does not fully address the needs of the Whatcom County community. The aim of the delivery system reform being undertaken is to decrease fragmentation of care, improve patient engagement with their own health, facilitate communication between the patient and the health care community, and ultimately, to improve the health of all Whatcom County residents. This is expressed in the Triple Aim: 1) Improve the health of the Whatcom population; 2) Improve our local patients' experience of care; and 3) Reduce per capita costs of health care locally.

### **Building a system that works for patients**

The Steering Committee spent considerable time articulating principles that reflect the shared values underlying this work. They can be summarized in the following ten points:

*The system would be organized into "medical homes", care coordination provided across care settings, and digital health information available to providers and patients when and where needed.*

#### **1. Care should be organized around patient-centered medical homes.**

- The medical home is a personal provider who has a whole person orientation.
- Care in the medical home is team based, i.e. physicians and nurse practitioners provide care in conjunction with care coordinators among others
- All medical homes meet the NCQA criteria.

#### **2. Coordination is a hallmark of the system.**

- Those who coordinate care document the care provided with the aim of informing all others in the care system.
- Health information exchange systems are used to ensure that patient information navigates optimally through the whole system.
- Medical homes consistently arrange and support chronic disease management.
- There is a Community Case Management system that serves as a referral resource for the cohort of patients with the most co-morbid conditions.

#### **3. The patients experience care in all settings as collaborative and patient centered.**

- Care is planned between providers to be seamless.
- Clinic operations center on meeting the patient's needs.
- Care is coordinated across all settings, including nursing homes, hospitals, and clinics.

#### **4. Care seeks to activate patients.**

- The system supports and encourages self-management by engaged consumers.

- Patients have access to their own electronic health records.
  - Patient satisfaction is consistently measured and used to improve care processes
5. ***Patients have access to care when they need/want it.***
- Doctor's offices know who needs a visit and contact patients to schedule an appointment.
  - Patients have 24/7 continuous access to their medical home via phone, e-mail, or in person visits.
  - Patients have online access to support services, including scheduling, medical records, and test results.
6. ***The care coordination system supports patients and families as they engage in improving their own health.***
- Evidence-based disease management programs are available in the community for key conditions identified through the analytic system.
  - All consumers have made conscious choices about their end-of-life experience and these wishes are respected.
  - Community programs to enable learning healthy behaviors are available and well integrated into the delivery system.
7. ***We seek a delivery system to serve the whole community, inclusive of linguistic and cultural diversity, and all socio-economic backgrounds.***
- Our efforts are oriented toward members of our community from all cultural and demographic backgrounds.
  - Inclusiveness requires cultural and linguistic sensitivity as well as active efforts in measuring and reducing disparities.
8. ***Quality is consistently measured and care is evidence based.***
- Quality is consistently measured, adjusting for risk where feasible, and rapid response occurs when discrepancies are noted.
  - Providers know how they compare to others within their practice and nationally.
  - Providers are supported as they aim to improve the quality of the care they provide.
  - Quality performance is also measured at the population level.
9. ***The financial structure of the system must create aligned incentives to achieve the Triple Aim.***
- Payment reinforces accountability for: 1) quality care and 2) cost reduction
  - Payment will transition from fees-for-service to new methods

**10. The future system will be accountable, transparent, and function in a culture of continuous quality improvement.**

- Data will be used to measure progress toward system goals.
- Governance will be transparent and inclusive of consumer needs.

**Evolution of the ACO concept**

Signed into law in March 2010, the Affordable Care Act (ACA), mainly addresses the problem of the high number of uninsured in the U.S. Embedded in this legislation, however, are the seeds of efforts to also reform the delivery system and the financial incentives that have fueled the rising cost of health care in America. One such delivery and financial reform promoted in this legislation is the concept of the Accountable Care Organization (ACO).

The roots of the ACO concept can be found in three threads. Researchers have long been able to demonstrate that certain integrated and coordinated systems of care, such as the Mayo Clinic, the Geisinger Clinic, Kaiser Permanente, and the Cleveland Clinic, produce better health outcomes and they do so at lower per capita costs than mainstream medicine. Second, beginning in the 1980s, research began to show that some geographic regions in the U.S. were far less expensive than others. For example, in a recent year, Medicare spent \$17,274 per beneficiary in Miami, but only \$6,370 in Eugene, Oregon. Furthermore, these lower cost areas were more likely to have better health outcomes. Third, in 2005, the Medicare program began a multi-year pilot study that paid ten clinics across the country to serve as precursor ACOs. One of these 10 was the Everett Clinic. Though much is still being learned, results were encouraging enough that the ACO concept found its way into the health reform legislation.

**What is an Accountable Care Organization (ACO)?**

An ACO is a tightly linked group of providers working together to share accountability for the quality and cost of care they provide to a defined population of patients. All ACOs share the following characteristics:

- Patient centered medical homes are at the core of the ACO concept
- Care is well coordinated between providers, allowing consumers to experience a clear pathway through their care experience.
- Consumers are not required to obtain care within the ACO. This is a distinguishing factor between an ACO and a health maintenance organization (HMO)
- Cost and quality are consistently measured, and the ACO's providers are held accountable for meeting pre-defined cost and quality targets.
- Financial incentives are used to reinforce attainment of

*Integrated systems of care tend to produce better outcomes at less cost.*

accountability goals; the exact nature of these incentives varies widely between types of ACOs.

*The ACO described in the Affordable Care Act is focused on Medicare patients. There are other kinds of ACOs aimed at providing care for different populations under contract with payers other than Medicare.*

In the Accountable Care Act, an ACO has a more specific definition and applies only to Medicare. Medicare calls it the “Shared Savings Program” because its financial incentives involve giving ACOs bonuses if cost and quality targets are met. However, State Medicaid programs, many commercial insurers, and organized provider groups are also developing their own flavor of ACO.

### **From Accountable Care Organization to Accountable Care Community**

Here in Whatcom County, discussions of ACO development began with the standard, nationwide conceptualizations of ACOs. However, these discussions have evolved. Below are a number of key attributes distinguishing our approach:

*Organizing beyond providers, taking a whole community approach to realizing the vision.*

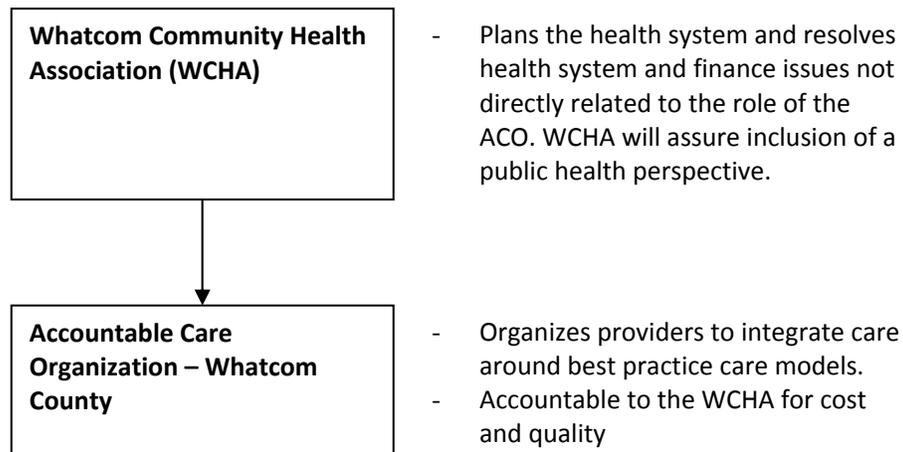
- **Community-based**: The future Whatcom system will be a community-wide endeavor, while most ACOs are formed by provider groups such as hospitals. Here the idea is ultimately to create a community governing structure that also involves business, consumers, local government, and public health interests.
- **Multi-payor**: The Whatcom concept includes Medicaid, Medicare, commercial patients, self-insured groups, and even the uninsured. More typically, ACOs have targeted discrete patient groups. For example, the Medicare Shared Savings program applies only to Medicare.
- **Cooperative or collaborative**: The Whatcom system is designed to be collaborative. There will most likely only be one ACO in the area. In contrast, most ACOs are designed to compete with other ACOs.
- **Broad definition of health**: Although not at all incompatible with mainstream ACO models, the Whatcom approach incorporates a broad definition of health compared to other models. This broad definition envisions interventions that focus on social determinants of health, reflecting approaches more common in the public health sector. Thus the Whatcom County Public Health Department is involved in the formative discussions.

In summary, the Whatcom approach could be characterized as an **Accountable Care Community** as opposed to an Accountable Care Organization.

The Steering Committee came to believe that two levels of organization would be needed: one to plan and organize the entire community's health system and to establish community values and performance targets, and one to accept accountability, as a provider group, for achieving those targets by delivering health care at an agreed upon per capita cost.

*The idea is to create a community health association that would transform WAHA and Hinet<sup>1</sup> into a community based planning and information utility that would provide support for the ACO activities.*

The Whatcom Community Health Association (WCHA) would serve as the community based organizing entity and would combine the current functions of WAHA and Hinet<sup>1</sup> while adding new functions. The ACO itself will be a newly formed LLC of healthcare providers organized for the purpose of better coordinating care for enrollees.



The Whatcom Community Health Association (WCHA) would have the following defining characteristics:

- it is a planning and stewardship organization; it does not provide health services;
- it aggregates public and private dollars, where appropriate, on behalf of all clients;
- it is a steward for the health of the whole community, assuring that cost, quality and service targets are met;
- it administers health analytics and brings a public health perspective to the enterprise;
- it provides information technology through HInet, an existing corporation that covers hardware, software integration, interoperability, and claims maintenance;
- it provides or arranges for care coordination;
- it especially protects the most vulnerable members of the community by working to assure them access to the system.

<sup>1</sup> HInet is an inclusive, secure, community-wide, healthcare intranet in Whatcom County. Using various broadband technologies, it connects hospital, payors, physician offices, and community health services. It also provides connection to the Internet

*Delivery System  
Development should be the  
initial priority.*

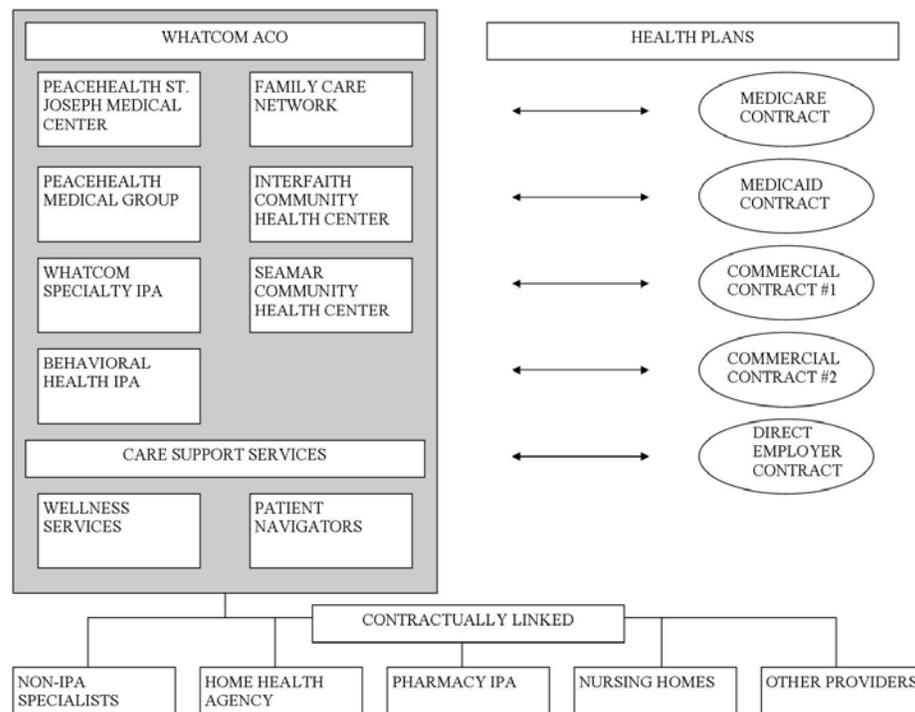
The WCHA is ultimately envisioned as a non-profit public/private corporation such as a public facilities district. Initially, WAHA and HInet will assume the public accountability and coordinative roles envisioned for WCHA. The community plan is to 1) build the necessary delivery system infrastructure; 2) pilot demonstrations of managing the health of selected populations; and 3) add functions and structure to the WCHA beyond the medical care roles of the ACO.

*Functions of the provider  
ACO, and the types of  
relationships it would  
maintain*

The Accountable Care Organization Whatcom (ACO-W) would have the following defining characteristics:

- it is a delivery system composed of providers;
- its prime function is to integrate care to improve quality and drive down costs.

The figure below is *not* intended to be a definitive blueprint, but rather to illustrate how the ACO-W might be structured.



*The ACO would be  
dedicated to clinical  
integration and  
improving quality and  
reducing costs.*

The purpose of the ACO-W would be limited to the business of running an ACO. The ACO would have the authority to negotiate and implement quality and outcome targets for defined populations and to hold participating organizational providers accountable for achieving those targets. The organization will have the duty to set its own mission and vision statements and will have the ability to conduct strategic planning for its ACO line of business.

The ACO would have the shared authority to set overall population per

member per month expense targets and the authority to hold participating organizational providers accountable for achieving these targets. The ACO will have a Board of Directors with a defined meeting frequency, a method for populating the Board, and a specific authority and scope of responsibility reserved to the Board.

*The relationship between the ACO and the community association has not been completely defined.*

The nature of the relationship between WCHA and ACO-W has not yet been completely defined. What is clear is the desire to form a community based entity that in addition to providing services for the ACO (e.g. care coordination, and analytics), would also be the vehicle for assuring meaningful community accountability. How this is done might include aggregating funds or otherwise organizing the system as a whole. These are issues that remain to be discussed by the steering committee.

### **How do anti-trust laws affect a community health system approach?**

*Questions regarding anti-trust laws*

Eventually a legal review will need to be undertaken to assure that any ACO meets the relevant anti-trust laws. This white paper is not intended to replace that review.

In general, the anti-trust statutes intend to protect consumers from: 1) practices that restrict free trade; 2) abusive behaviors such as predatory pricing; and 3) mergers and similar practices that concentrate market power

The regulations governing Medicare ACOS, as one example, require a mandatory Federal Trade Commission/Department of Justice review for Medicare ACOs in areas where the proposed provider group has a market share greater than 50%.

Potential anti-trust mitigation in the Whatcom model has been contemplated. First, the ACO will be subject to some degree of community level governance and accountability through the WCHA. Second, the proposed ACO will have a high level of clinical integration. Third, the Whatcom ACO, while composed of independent organizations, will also have a high degree of financial integration in its provider payment system. Fourth, rule of reason analysis may class Whatcom as a rural area in which competing care systems are not practical given the scale of the community.

### **Assessing the gaps, building the bridge**

*"It always seems impossible until it's done."* Nelson Mandela

*Essential elements of any ACO are missing*

The Steering Committee recognizes that much of the infrastructure to achieve the performance expectation and reduce ACO performance risk is not yet in place. The missing pieces include:

- Fully compliant patient-centered medical homes

- An integrated care coordination system
- Certain supporting IT capabilities
- Analytic capabilities

To build the capacity to address these gaps the Steering Committee has recommended a phased development of ACO-like capabilities according to the following timeline.

**General Timeline for Creating an Accountable Care Community**

The “Transforming Health Care in Whatcom County Project” has recently completed its Phase I work. The aim of Phase I was to come to an agreement within the Whatcom community on high level concepts of a future, more effective and efficient health care delivery system. The goals of Phase II, which is about to begin, are to create the necessary health system infrastructure while preparing for a demonstration project in mid-2012.

*Timeline for filling in the missing pieces*

12/2010	7/2011	7/2011 – 6/2012	7/2012	7/2012 – 6/2014	7/2014
Phase I Initiate feasibility assessments	Stakeholder agreement to keep moving forward	Build initial PCMH, Care Coordination, & IT capabilities	Initial small pilot(s) launches	Continue building infrastructure	Dem Project (10,000+ enrollees)

The overall implementation concept is that the community will a) commit to developing core delivery system and IT capabilities between now and mid-2014, while b) launching and testing one or more limited pilot projects starting in mid-2012.

**Candidate populations for early pilot projects (mid-2012)**

*Setting forth a development framework that calls for a learning collaborative, grant opportunities, and further research*

- Dual Eligible Citizens (Medicare/Medicaid)**
  - Pro: - Large potential savings and poor outcomes for patients
  - State & Federal interest
  - Con: - Exact program structure unknown
- Self-Insured / PeaceHealth SJMC, school system or other entity**
  - Pro: - Savings drop 100% to bottom line
  - Con: - Part of a large system
- Individual Insured Product**
  - Pro: - Rate setting done at County level
  - Con: - Actuarially unstable population

Staff does not recommend for initial pilot:

- Medicare Shared Savings Program

- Commercially insured
- Medicaid

### **Implementation plan sketch**

#### 1. Preparation for pilot projects (listed above)

- What:** Prepare the infrastructure needed to enter into a pilot program; create necessary legal infrastructure; create an independent actuarial review of dual eligible claim data
- When:** Begin upon securing funding from community stakeholders
- How:** Develop task force groups to oversee Phase II projects with Steering Committee guidance

#### 2. Patient-Centered Medical Homes (PCMH)

- What:** Implement a collaborative which will bring all participating primary care providers (medical and behavioral) to NCQA PCMH standards within three years.
- When:** Begin upon securing funding (hopefully second half of 2011) and complete by mid-2014.
- How:** Possible third party payor funding geared to development. Local funding collaborative (about \$100,000).

#### 3. Care Coordination

- What:** Create complete care coordination system with six sub-systems as described by the Delivery System Task Force.
- When:** Begin in the last half of 2011. Complete by mid-2014.
- How:** Secure major funding, including a Community-Based Care Transitions Program (Section 3026).

#### 4. Health Information Exchange (HIE)

- What:** Staff an HIE Task Force that will develop detailed HIE requirements and select a product or approach that can implement HIE. Complete install of qualifying EMRs
- When:** HIE selection process late 2011  
HIE install mid to late 2012
- How:** Half of funding secured from Hinet. Funding for software purchasing likely to come from loans, estimated up to \$1 million.

#### 5. Analytic Systems

- What:** Software and hiring of analytic personnel
- When:** On completion of HIE install

**How:** Funding source unknown; at least \$500,000.

6. Community Organizing Group for Health (COGH)

**What:** Support Community Member Task Force which will coordinate consumer input to the ACO and related reforms

**When:** Begin meetings in fall of 2011.

**How:** Funding from City of Bellingham and local community stakeholders.

7. Behavioral Health Integration

**What:** Support a Behavioral Health Integration Task Force that will recommend concrete actions to integrate behavioral and physical health into a “whole person” approach

**When:** Begin meetings in fall of 2011.

**How:** Funding from key community stakeholders

**For more information:**

*Contact information*

Larry Thompson, Executive Director  
Whatcom Alliance for Healthcare Access  
lathompson@hinet.org  
(360) 788-6537



## APPENDIX 1

### Membership of the Project Steering Committee and Task Force Groups from Phase I

#### The Project Steering Committee

	<b>Name</b>	<b>Role, Title, Organization</b>
1	Sue Sharpe (Chair)	Consumer, Executive Director, St. Luke's Foundation
2	Rud Browne	Business, Founder and Chairman, The Ryzex Group
3	Desmond Skubi, CNM, MSN	Provider, Executive Director, Interfaith Community Health Center
4	Kathy Kershner	Local government, County Councilwoman, Whatcom County Council
5	Kelli Linville	Policy, Former State Representative
6	David Lynch, MD	Primary Care, Vice-President for Clinical Process Improvement and Business Development, Family Care Network
7	Ken Oplinger	Business, President and CEO, Bellingham/Whatcom Chamber of Commerce & Industry
8	Chris Phillips	Provider, Director for Community Affairs and Strategic Communications, PeaceHealth St. Joseph Medical Center
9	Marc Pierson, MD	Provider, Vice President of Quality and Clinical Information, PeaceHealth St. Joseph Medical Center
10	Roben Selditz	Insurance, Regional Administrator, Group Health Cooperative
11	Chris Sprowl, MD, MMM	Provider, Vice President, PeaceHealth Medical Group
12	Stephen Woods, MD	Specialty Care, Provider, Northwest Gastroenterology

#### Delivery System Design Task Force

	<b>Name</b>	<b>Title, Organization</b>
1	Stephen Gockley, JD (Chair)	Senior Attorney, Northwest Justice Project
2	Ione Adams, MD, MPH	Clinical Director, Sea Mar Community Health Center
3	Victoria Doerper	Executive Director, Northwest Regional Council
4	Linda McCarthy	Executive Director, Mt Baker Planned Parenthood
5	Bill Mahoney, PhD	Health Metrics Expert
6	Chris Phillips	Director for Community Affairs and Strategic Communications, PeaceHealth St. Joseph Medical Center
7	Bertha Safford, MD	Vice President of Medical Quality Assurance, Family Care Network
8	Roben Selditz	Regional Administrator, Group Health Cooperative
9	Desmond Skubi, CNM, MSN	Executive Director, Interfaith Community Health Center
10	Chris Sprowl, MD, MMM	Vice President, PeaceHealth Medical Group
11	Dean Wight	Executive Director, Whatcom Counseling and Psychiatric Clinic
12	Stephen Woods, MD	Provider, Northwest Gastroenterology

## Using Information Technology to Manage Care Task Force

	<b>Name</b>	<b>Title, Organization</b>
1	Dean Wight (Chair)	Executive Director, Whatcom Counseling and Psychiatric Clinic
2	Darian Allen	Manager Analytic Technology, PeaceHealth Medical Group
3	Brian Ecker	Director of Operations, Family Care Network
4	Michael Geist, MD	Medical Director Informatics, PeaceHealth Medical Group
5	Lori Nichols	Director, Whatcom Health Information Network (Hinet) and Shared Care Plan
6	Andreas Macke, MBA	Owner G-42 Systems and IT Consultant
7	Bill Mahoney, PhD	Health Metrics Expert
8	Byron Manering, MSW	Executive Director, Brigid Collins Family Support Center
9	Michael Massanari, MD, MS	Executive Director and Director of Research, Critical Junctures Institute
10	Larry Thompson	Executive Director, Whatcom Alliance for Healthcare Access
11	Andrew Verneuil, MD	Provider, Bellingham Ear, Nose and Throat

## Financial Issues Task Force

	<b>Name</b>	<b>Title, Organization</b>
1	Jim Stevens. MBA, CPA (Chair)	Employee Benefits Specialist, The Unity Group
2	Paul Baron	Regence Blue Shield
3	David Lynch, MD	Vice-President for Clinical Process Improvement and Business Development, Family Care Network
4	Michael Mallory, MD	Provider, OB-GYM Bellingham
5	Heidi Nelson, MHA	Associate Director, Provider Contracting at Group Health
6	Sue Sharpe	Executive Director, St. Luke's Foundation
7	Nancy Tieman	Vice President Business Development and Strategy, Innovation and Development, PeaceHealth Medical Group
8	Dean Wight	Executive Director, Whatcom Counseling and Psychiatric Clinic
9	Dewey Desler	Deputy Administrator, Whatcom County
10	Keith Tromberg	Chief Financial Officer, Mount Baker Imaging

## **APPENDIX 2**

### **Evolution of Health System Governance**

Pages 5 to 8 of the Executive Summary describe the basic leadership concepts and the structure for the future Whatcom health system. Briefly, a two level system with an ACO comprised of providers and a broader community Board is envisioned.

The need for the ACO structure to actually deliver health care has been clear throughout this community discussion. However, the exact purpose and role of WCHA has been the subject of greater discussion and diverse opinion.

#### Underlying Rationale for the Whatcom Community Health Association (WCHA)

Fundamentally WCHA will serve three broad purposes that the Steering Committee has confirmed as necessary to achieve the community vision.

1. Provide a vehicle for the community to participate in governing the health system.
  - i. Direct governance involvement by consumers and business is clearly envisioned in the community's health system principles (pages 2 to 3 of the Executive Summary).
2. WCHA provides a vehicle for addressing many community health issues that would not be a core focus of the ACO. For example:
  - i. Overall system performance, policy, planning
  - ii. Fostering pilots and demonstration projects of emerging health care needs
  - iii. Broad health care development beyond the roles of the medical providers in the ACO
  - iv. Community health data systems
3. WCHA and its consumer oversight will be essential features in creating an accountable system that mitigates ant-trust risk
  - i. A single delivery system is envisioned

#### Timing of Governance Evolution

Early on the Steering Committee agreed that governance should follow functional need and should exist only where needed to achieve fundamental purposes. Since the Whatcom health system itself will be evolving, this suggests a parallel evolution for the governance function.

The Steering Committee believes that the community's initial work should focus on delivery system and IT improvement. The timeline on page 8 shows the general plan for development of the system. The following implications emerge from that timeline.

- The formal incorporation of the ACO will be needed by mid- to late-2012 in order to provide a vehicle through which to implement the pilot projects.
- Within the 2011 to 2014 time frame WAHA will continue to play the community convening, planning and developmental roles it has assumed to date, as well as facilitate transparency in community engagement.
- By some point in 2014-2016 the maturity of the delivery system development will require a WCHA-like structure. As well, at the level of activity envisioned, the current WAHA governing structure will be inadequate for the size and complexity of the Whatcom community's needs.