In September 2013 Wilmington Health was named an honoree for the American Medical Group Foundation’s 2013 Acclaim Award for its initiative “High Performance: Ready, Set, Change.” Here are some highlights from their achievements.
Wilmington Health’s drive to become a high-performing health system (HPHS) began over five years ago by taking a programmatic approach involving a three-part system of change including direction setting by our leadership, process improvement at the ground level, and a redesign of the most elemental processes throughout the organization.

A priority was given to paying careful attention to metrics, analysis, and critical assessment of each innovation and how these changes may affect the total cost of care. Only by understanding each of these aspects at work was the organization able to pragmatically and intelligently design a future approach to the provision of health care.

Additionally, Wilmington Health leadership began to put greater focus on creating a culture of change within the organization, understanding that this is the most powerful tool in any transformative process. Included were new and improved support systems for staff and providers and development of an inspirational approach to leading the entire team to provide patient-centered health care.

In July 2012, Wilmington Health partnered with Blue Cross and Blue Shield of North Carolina to form an ACO agreement. This was the first insurer-provider accountable care organization in the region. Currently Wilmington Health providers participate in the Medicare Shared Savings Program (MSSP) through Physicians Healthcare Collaborative (PHC), a Wilmington Health subsidiary.

Wilmington Health leadership began to put greater focus on creating a culture of change within the organization.

In May 2013, Wilmington Health released data that showed a three-year trend of substantial savings to the Medicare system and improved healthcare outcomes for patients seen by Wilmington Health providers versus other healthcare providers across the country. The data was collected and analyzed from the past three years’ worth of Medicare participants’ claims. In 2012, Wilmington Health showed an average total yearly expenditure by a Medicare patient at $7,019, down 11.7% from the organization’s 2010 numbers and $2,844 less than all other recent MSSP participants, a 28.8% savings.

In addition to tracking financial improvements, Medicare also provides data on a variety of healthcare quality measures. Examples of quality measures from the Medicare data that confirm the superior performance by Wilmington Health to its peer group include: a 37.6% lower Patient Hospitalization Rate (per 1,000 person years), a 38.6% lower Emergency Department Visit Rate (per 1,000 person years), and 20.5% lower 30-day Hospital Readmission Rate (per 1,000 discharges).

Challenges

Wilmington Health is an independent, physician-owned, physician-governed, multispecialty group practice of more than 150 providers. The organization began a journey towards becoming a HPHS in earnest in 2008. At that time, the group was stagnating and shrinking. Although an early adopter of an electronic medical record (EMR), it could best be described as a consolidated group of physicians practicing mostly independently within the confines of a single tax ID. It had a “circle the wagons” mentality and suffered from poor relationships with the only hospital in the market as well as several independent practices. Its revenue and numbers of new patients were shrinking and its physician and staff turnover were unacceptably high.

The seven-physician Board of Directors determined it was time for a change. They brought in an outside consultant to evaluate Board function and received less than satisfactory feedback in the process. The Board adopted a corrective action plan that included the replacement of its current leadership and the development of the organization’s first mission and vision statement in its 40-year history.

In early 2009 Wilmington Health sent several representatives to the AMGA national conference, a turning point for the organization. One of the keynote speakers, Dr. Donald Berwick, spoke of the elements of the “Triple Aim” and the end of the healthcare system as we knew it. This resonated with the organization’s leadership, who recognized it as an opportunity and began diligently educating themselves.
on what would be necessary to thrive in this new world order. Dr. Berwick described the need for an “integrator,” an entity that accepts responsibility for all three components of the Triple Aim for a specified population. In late 2009 Wilmington Health set out to be the integrator.

It is impossible to become accountable to the Triple Aim and not move towards high performance. By 2011 the organization needed to retool its mission statement and had outgrown its vision statement.

Mission: “Wilmington Health is committed to using collaborative, evidence-based medicine in providing the highest quality of care to the patients we serve.”

Vision: “We aspire to be the most trusted partner in health care. We pledge to transform the delivery system. We will continually develop collaborative and innovative solutions that demonstrate quality, reduce the cost of care, and improve the patient experience.”

Cultural Change

Wilmington Health’s transformation could not be directed from the established leadership of the organization. It has required the development of leadership at all levels of the organization mobilized through a formalized program of change.

Meaningful cultural transformation leads ultimately to behavior changes and capability changes through the entire organization. It requires the establishment of a (new) common language, shared experiences and learning, shared (new) organizational values, and ultimately interdependence within the members of the organization to meet the new vision.

Wilmington Health’s programmatic approach to the redirection of the organization involves a three-part system of change. Each part has to be engaged at the appropriate time but ultimately all three have to be working and deployed simultaneously. The three components include:

- Top-Down Direction Setting
- Bottom-Up Process Improvement
- Core Process Redesign

Top-Down Direction Setting comes from the established leadership of the organization and is vital to set direction and goals, develop focus and energy, and create the capabilities and conditions required for change. Bottom-Up Process Improvement allows involvement of any and all members of the organization to take part in the change process which is essential to achieve the engagement that will be needed. Core Process Redesign takes the new capabilities, new information, lessons learned, and completely new ideas and combines these in ways not done before by the organization. This component in the change transformation has the most potent ability to create breakthrough improvements (see Figure 1).
Wilmington Health’s approach has been a long-term proposition. They recognized early on that cultural transformation would take years. They conducted surveys to gauge readiness to move forward and understand where they had more work to do (see Figure 2). The development of leadership core competencies took nearly two years. During that time, they developed overall direction and focused on some quick successes. By 2010 they felt ready to implement the Bottom-Up Process Improvement component and even begin some Core Process Redesigning activities.

Following are some of the developments, approaches, and innovations Wilmington Health has focused on through these stages.

**Care Coordination**

The organization partnered with a regional university to implement a PharmD program to assist with the coordination and reconciliation of patient medications as well as to provide for an educational resource to the patients and providers. This has improved patient compliance with therapies and is expected to have an impact on the quality of care and the health outcomes.

The Pediatrics Division developed a foster child outreach program that has dramatically increased compliance with preventative care in this at-risk population.

The Family Medicine Division and the Endocrinology Division have developed a “Family Fit Program” (an after-hours program for the entire family focusing on exercise and healthy eating habits) as well as an intensive dietary program designed to engage the patients in the management of their weight and chronic conditions such as diabetes. The HMR weight loss program has an average weight loss of over 50 pounds.

A series of innovations has been initiated around transitions of care, including making the EMR available to the ER physicians; creating an “ER hotline” to enhance the ability to see ER patients quickly in the office and hopefully prevent a “soft” admission; a care extender directly involved in transitions; a CHF outreach clinic that sees every CHF patient admitted to the hospital; and a complete re-tooling of communication lines between inpatient and outpatient physicians.

The Quality Assurance Committee has done extensive work standardizing the approach to the surveillance and notification systems surrounding mammography thereby enhancing safe-practices in this crucial area of medicine. Patient satisfaction around these changes was shown to be very high.
Communication between the inpatient and outpatient settings is a longstanding challenge (in fact, quite magnified in the era of hospitalists). The CMO and the Hospitalist Division Chief meet each week to review every lapse in communication, brainstorm where the breakdown occurred, and work directly with the involved physicians to keep them aware and find permanent solutions.

An outreach CHF clinic (using data-mining capabilities to identify the highest-risk patients) has been established with current staff members in the division of Internal Medicine with no additional staffing or space utilized. Several outcomes are being looked for including a reduction in cost, and an enabled CHF population.

Pediatricians remain very attentive with Pediatric Asthma Action plans, and this is improving patient literacy and compliance.

Ongoing educational events monthly improve the medical literacy of staff members and secondarily communication with patients.

Organized System of Care

The first stage of the bottom-up process improvement program implementation was to get the staff involved. They were included in the strategic planning process and several of their suggestions were implemented. The innovations implemented during this phase increased the organization’s ability to operate as an organized system of care. Several specialties were added to the practice to complete a core group of integrated services.

To help remove inherent barriers to receiving medical care, in the past four years Wilmington Health has opened two convenient care clinics, two urgent care centers, an all-day walk-in clinic at the main facility, as well as open-access scheduling in all primary care sites.

In 2010, all staff was trained in Lean and began implementing several different Lean projects.

Accountability

In 2012, Wilmington Health applied for and was accepted into the Medicare Shared Savings Program with a
January 2013 start. The organization also developed one of the first commercial accountable care organizations (ACOs) in the state with Blue Cross Blue Shield.

Wilmington Health installed a data analytics package to mine the EMR called Humedica MinedShare (now Optum One Population Analytics) and joined AMGA’s Anceta Collaborative. Participation in the Anceta Collaborative has been enlightening and stimulating. They have been able to compare metrics with other groups, learn from best practices, and generate a deeper understanding of the challenges of measuring quality in medicine.

Although they have achieved 100% meaningful use of the EMR for the first two years of stage 1, Wilmington Health has recognized an inability for the current EMR to meet future needs in data transparency and population health. Consequently, they are immersed in the task of moving to a new EMR.
Part B: Clinic-Wide Data Transparency

Primary Care 2012 Clinical Quality Measures: Alternate Core Set – Influenza Immunization

(12% Improvement)

Primary Care 2012 Clinical Quality Measures: Additional Clinical Quality Measures – Pneumococcal Vaccination

(3.7% Improvement)

These are the graphs and the format that we share with complete transparency to all pertinent providers. It represents the first time our providers have been able to look at population statistics for their patients.
Figure 7
Patient Satisfaction

Rating by Survey Question – All Providers

(Average of Each Question – All Providers)

<table>
<thead>
<tr>
<th>Question</th>
<th>Current Survey</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>4.73</td>
<td>4.69</td>
</tr>
<tr>
<td>2.</td>
<td>4.46</td>
<td>4.51</td>
</tr>
<tr>
<td>3.</td>
<td>4.36</td>
<td>4.27</td>
</tr>
<tr>
<td>4.</td>
<td>4.42</td>
<td>4.33</td>
</tr>
<tr>
<td>5.</td>
<td>4.82</td>
<td>4.81</td>
</tr>
<tr>
<td>6.</td>
<td>4.82</td>
<td>4.80</td>
</tr>
<tr>
<td>7.</td>
<td>4.75</td>
<td>4.72</td>
</tr>
<tr>
<td>8.</td>
<td>4.48</td>
<td>4.32</td>
</tr>
<tr>
<td>9.</td>
<td>4.42</td>
<td>4.39</td>
</tr>
<tr>
<td>10.</td>
<td>4.48</td>
<td>4.44</td>
</tr>
</tbody>
</table>

National average is based on Southwind statistics

Survey Questions
1. How would you rate the friendliness and helpfulness of the staff?
2. How would you rate the comfort of the waiting area?
3. How would you rate how long you had to wait in the waiting area?
4. How would you rate how long you had to wait in the exam room?
5. How would you rate the personal manner (courtesy, respect, sensitivity, friendliness) of the doctor?
6. How would you rate the skills (thoroughness, carefulness, competence) of the doctor?
7. What is the likelihood of you recommending the doctor to your friends or family?
8. How would you rate getting an appointment as soon as you wanted?
9. When you called the office, how would you rate getting the help or advice you need?
10. Considering all aspects of the office, would you say that you are completely satisfied, very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

Quality Measurement and Improvement, Technology, and Evidence-Based Medicine

In 2012, the organization developed the Quality Demonstration Project (QDP), a purposeful process of establishing core process redesign efforts into distinct scientific experiments. It uses information technology and evidence-based medicine as the drivers and is central to their Core Process Redesign efforts.

All information technologies (Point-of-Service technology, EMR reporting software, Data Registries Software, and the EMR, itself) are brought under scrutiny in the QDP. The Anceta Collaborative is central to this program and assists with their evolution to understand and successfully deploy quality metrics and population health approaches. The QDP is unique in approach because it isolates the various components of the transformation process and is providing invaluable information on the most efficient way to deploy scarce resources.

Evidence-based medicine reminders are embedded in all IT solutions. These include pharmacy interaction notices, gaps in care notices, notifications when it appears providers have departed from evidence-based guidelines in treatment for multiple diseases including Congestive Heart Failure, Coronary Artery Disease, Diabetes, Hypertension, Hyperlipidemia, notifications on preventative health gaps in care, and notifications of gaps in immunizations.
Efficient Provision of Services

Wilmington Health is achieving improvements in all areas of measurement while absorbing the cost of transformation in day-to-day operations and maintaining an overhead structure that is significantly below their peer group. Annual costs per physician are $120,000 below their peer group of MGMA Better Performing Practices.

The efficient provision of services is the ultimate measure of an organization’s ability to operate as a HPHS. Wilmington Health is demonstrating improved quality, reduced costs, and improved experience of care.

When reviewing their initial performance regarding cost metrics from the MSSP ACO data, Wilmington Health noted several important trends. In the last three-year period (2010-2012), data shows clear efficiencies in total cost compared to ACO cohorts and a cost trend that is favorably decreasing each year (see Figure 3). Data show both a lower and negatively trending expenditure curve in each major category of cost including hospitalizations, COPD admissions, CHF admissions, and 30-day readmissions just to highlight a few (See Figure 4).

Wilmington Health has worked diligently on the standardization of utilization of the EMR throughout the clinic. They have successfully met the goals for Meaningful Use in 100% of eligible providers in the clinic for both the first and second years of stage 1, and 100% compliance with PQRS metrics have been reported the past four years running. All providers are meeting the criteria required for e-prescribing credit.

Wilmington Health invested in several tools to enhance the quality of care being delivered, including a point-of-service tool to assist the physicians in recognizing gaps in care as well as departures from evidence-based medicine. Additionally, they have invested in EMR reporting tools to alert physicians to how they are performing in general regarding their compliance with preventative measures. Lastly, they have invested in a registries tool to assist physicians in the care of specific populations of patients such as the diabetic, hypertensive, and hyperlipidemic populations.

Part of the QDP is looking at the effects of full transparency in preventative care metrics. Wilmington Health is routinely and systematically providing metrics to providers on a host of preventative measures as defined by well-accepted evidence-based medicine guidelines, and over time monitoring for improvements. In the first 9-12 months they have seen significant improvement in the demonstrated quality of care in preventative measures (see Figures 5-6) and anticipate that this improvement will eventually translate into a lowering of the total cost of care.

Another part of QDP is to track clinic-wide and individual performance on quality metrics trended over time post the initiation of a compensation change tying a portion of compensation to the achievement of quality metrics. Currently, this work is at the compensation committee level and specific metrics as well as amounts to put at risk are under deliberation. They will be moving the compensation system from 100% productivity to a more “balanced scorecard” approach.

Wilmington Health’s ACO will also be tracking metrics over time including the 33 quality metrics required by CMS, Cost and Utilization metrics for the attributed patients, and sites of service utilization so that they can better understand cost differences in the community.

The practice has been deeply interested in the patient experience for many years. They routinely survey patients and present the feedback to all providers every six months (see Figure 7). Performance in patient satisfaction is slated to become part of the compensation system.

These actions have impacted the populations served in several significant ways: reduction in the cost of care, and improvement in the quality, outcomes, and experience of care—all done through engagement and deliberate effort. This work however, is only a prerequisite for true accountability. Through formal and informal collaborations, Wilmington Health is positively influencing others in their pursuit to care for the populations they serve—one step closer to becoming the integrator.

Conclusion

Today Wilmington Health is well established in its journey to become a HPHS. It is a participant in the Medicare Shared Savings Program and has established the regions’ first commercial ACO with Blue Cross Blue Shield. The relationship with the hospital is dramatically improved and the organization values the hospital as a true partner, with one of the organization’s board members serving as Chief of Staff.

If they have learned anything along the way, it is probably that it is impossible to communicate too much. Communication, the sharing of ideas, and the inclusion of everyone in the conversation are the cornerstones to a successful transformation.

There are many challenges ahead in accomplishing the new vision. There are still significant problems with transparency in the industry. Clinical and claims data aggregation across a still-fragmented continuum remains a few years off. Evolving reimbursement methodologies will require Wilmington Health stretch itself across multiple payment incentives for several years. However, Wilmington Health believes the transfor-
mative work they are doing now will enable them to overcome these challenges and more.

Whether or not an ACO, HPHS, or some other approach not yet conceived becomes the new direction for all in health care, the current focus on coordination, collaboration, quality, service, and a willingness to be good stewards of limited healthcare dollars should speed all healthcare organizations towards their ultimate mission to serve their most precious interest—patients.

Adapted from the 2013 Acclaim Award Application from Wilmington Health submitted by Jeffry G. James, M.B.A., chief executive officer.