BECKER'S
HOSPITAL REVIEW

Sponsored by:
TEAMHealth®

How one southern health system created capacity without adding a single bed

In the typical hospital, clinical service lines operate autonomously. At best, these service lines are independent operatives. At worst, they are warring factions. The truth is the typical hospital is simply not set up for symbiosis.

However, hospitals can keep the peace between their service lines – becoming nimbler and collectively building momentum toward the same goals – with a simple strategy: service line integration. Integrating key service lines can improve performance within each respective line and help the hospital achieve clinical, operational and financial goals.

This was the case for one Alabama-based health system which officially began the integration of its hospital and emergency medicine lines in April 2018. In just a few months, health system leadership had already made measurable progress in reducing length of stay, expanding emergency department and hospital bed capacity, and improving patient and clinician satisfaction.

What follows is an overview of one health system's decision to integrate, the key steps that went into the process and how it has measured success so far.

Why integrate hospital and emergency medicine

Hospital medicine and emergency medicine are natural partners. The emergency department functions as the hospital's front door and decisions the care team makes in that threshold can determine a patient's entire episode of care. The hospital medicine team is equally vital, functioning as the main team to oversee a patient's care after admission. Together, these two teams dictate almost the entire patient care experience inside the hospital.

However, hospital medicine and emergency medicine can have an adversarial relationship. When the two service lines operate independently, emergency medicine physicians are incentivized to push tests and other costs into the inpatient environment, while physicians on the inpatient side may feel the emergency department didn't do enough legwork to determine the root cause for a patient's admission. If hospital medicine is backed up ordering additional tests, patient length of stay can drag out, ultimately causing a backlog in the ED. In this worst-case-scenario, the ED can hemorrhage potential hospital revenue: Patients may leave unseen, or the ED may have to go on diversion and route ambulances elsewhere. Meanwhile, patients who experience long wait times and duplicative services are unlikely to give positive experience scores, which can damage the hospital in the long-run.

Hospital medicine and emergency medicine teams can often end up at odds prior to integration, according to Jeremy Lindley, DO, a TeamHealth emergency medicine system medical director. Dr. Lindley started as an emergency medicine physician before migrating into leadership as a medical director, ultimately moving up to oversee five EDs within a regional system as part of TeamHealth, a hospital staffing firm based in Knoxville, Tenn.

At the time, this Alabama health system employed its hospital medicine group. While they did a great job, their leadership and goals were not aligned with the emergency medicine group, which was managed by TeamHealth, according to Dr. Lindley. Patients were not discharged fast enough, creating a backlog, increasing waiting times and stunting capacity.

The service lines needed to be integrated. "Hospital performance can definitely be improved by clinical integration because the emergency medicine providers and the hospital medicine providers share the same goals and same metrics, and they both have an interest in pulling the patient as quickly as possible out of the ED into the appropriate hospital setting," Dr. Lindley said.

However, initial attempts to integrate organically were unsuccessful. In April, the system decided to officially integrate both service lines under the management of TeamHealth. "There is value in having one solutions company manage both service lines because they are so closely integrated and really control the flow of admission to the hospital," Dr. Lindley said. "Integration creates capacity, decreases waste and also improves clinical outcomes."

The system hired Amit Kachalia, MD, system medical director and facility medical director of TeamHealth Hospitalist Services, as Dr. Lindley's counterpart on the hospital medicine side. "Any work we've done on integration has been a direct result of [Dr. Kachalia's] hard work, leadership and innovation," Dr. Lindley said.

The integration removed inefficiencies from the backend of the ED, ultimately allowing the hospital to increase patient volumes. Integration also sparked a massive change in motivation and collaboration among the physicians, according to Dr. Kachalia. "This caused a huge paradigm shift in our perception at the hospital. [Hospital medicine was] considered a group that was really toxic," Dr. Kachalia said. "After this change, this group was perceived to be one of the nicest groups to work with."

Drs. Kachalia and Lindley broke down how they managed this transformation from toxic to collaborative into a few simple steps.

3 keys to successful service line integration

Both leaders identified the following three components as essential to success:

1. Leadership with a clear vision. "The only way this works is leadership," Dr. Lindley said. "Dr. Kachalia took the hospital medicine group – the same group that's been there, no new players, same providers – and changed the way they think."

Dr. Kachalia said he approached it as follows: Create a vision of the ideal integration, map a path to reach that vision and communicate it clearly to the whole team. "If the team doesn't buy in, most of the processes we do will not yield results," he said.

Dr. Kachalia stuck by this vision and encouraged the providers to do so as well, even though every day was not perfect, according to Dr. Lindley. The strategy paid off. "When you can tell that someone is an expert in this particular field, they have humbleness and passion about a vision … it's really hard not to follow," Dr. Lindley said. "He leads by engaging and enlisting his team to move this goal and vision forward."

2. Buy-in from hospital administration. Buy-in from the top was essential to the integration plan, according to Dr. Kachalia, who has championed similar projects at other facilities. The service lines should be integrated right up to the C-suite. Leaders of both lines should co-present joint proposals to hospital leadership, and back those proposals with benchmark data and thorough explanations.

Luckily, health system leadership was on board with the project from the start. Steve Schwartz, DO, TeamHealth's Southeast Group president, planted the seeds of integration and has been working to position the organization to integrate service lines for years, according to Dr. Lindley. Integrating hospital medicine and emergency medicine under one management company was a natural progression of this plan.

3. Clinician engagement and cultural optimization. "The emergency medicine physicians and hospital medicine physicians had to be willing to accept change," Dr. Lindley said. "People don't like change. It makes them fearful. It upsets the balance."

Integrating culture takes time and requires collaboration from leadership. "What generally happens is those two groups [aren't used to] collaborating and work as two separate teams," Dr. Kachalia said. "Once we have good leadership in place on both sides, the next point is to make sure engagement of the clinicians can be generated."

Beyond communicating and exemplifying the shared vision, Drs. Kachalia and Lindley also engaged Dr. Bryan Ballentine, associate system medical director, to organize social events so physicians from both sides could get to know each other better on a personal level. The events Dr. Ballentine organized improved communication and collaboration, and as a result, leaders from both groups were able to resolve issues by working together and participated in critical conversations. These small gestures added up to create a feeling of unity, so each physician felt like a partner with an equal hand in outcomes.

"[Dr. Kachalia] took the culture of the existing group and made it a 'yes' culture, where [physicians] want to be helpful, want the next admission, want the next transfer," Dr. Lindley said.

Shared metrics for shared goals

The service lines not only adopted shared goals and challenges, but also assumed congruent metrics for success. These metrics included the decision to admit to departure time for ER patients, ER length of stay for admitted and discharged patients, patient experience scores and clinician satisfaction. The service lines also began to collaborate on initiatives like antibiotic stewardship and proper opioid administration.

Tracking these metrics helped the groups better align their systems and wring out inefficiencies. For example, before the integration, hospital medicine was staffed heavily during the day and significantly less at night. This didn't align well with patient arrival patterns in the ED. Noticing this need, Dr. Kachalia upped hospital medicine coverage from noon to midnight. "By matching the hospital medicine staffing, the capacity for admissions and the burden of work has decreased, particularly for the [staff] who work at night. It's been a huge win and the ER docs are so grateful," Dr. Lindley said.

The integration has dramatically improved clinician satisfaction in both the ED and the hospital. Although hospital medicine physicians were initially apprehensive, the integration was quick to drive results in throughput and efficiency. Patients are discharged faster, more beds are available and the ER is able to accommodate more ambulances.

"Now that we are several months into this and it's obvious to everyone that we definitely moved the needle on satisfaction and length of stay and also the needle on morale and work environment, the hospital medicine group would say very positive, favorable things about this integration," Dr. Lindley said.

The positive results of integration have also translated into financial gains for the hospital. "This is a huge win for the hospital," Dr. Kachalia said. "The hospital wanted to close a unit down so they could do some repair work. They were able to close it early by a few months because of reductions in length of stay and a lot of other efficiencies that have resulted in the hospital."

Conclusion

As demonstrated by these early successes, as well as successes experienced at other TeamHealth integrated sites across the country, clinical integration of central service lines like emergency medicine and hospital medicine can have a dramatic effect on a hospital's performance from a clinical, operational and financial standpoint.

While the process is not easy, if an organization selects strong leaders to build consensus around a vision, integration can be hugely successful in making hospitals more efficient. Creating a streamlined, coordinated team enables the organization to maximize profits in today's healthcare environment, improve outcomes for patients and create an overall superior experience.

"Now that I've experienced this at my facility, I wouldn't want it any other way," Dr. Lindley said. ■