The Integration of Two Healthcare Systems: A Common Healthcare Problem

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The change in reimbursement mandated by the Affordable Care Act is causing a rapid consolidation of the marketplace as well as the delivery of clinical care in a team-based model. This case report examines the successful joining of two clinical teams concurrent with the merger of two healthcare organizations and discusses some of the difficulties encountered. A subsequent discussion focuses on the resolution: the need for physicians to embrace the team concept of healthcare delivery and for healthcare systems to facilitate this transition with team and leadership coaching.

KEY WORDS: Physician leadership coaching; healthcare management; team-based clinical care; healthcare system integration.

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BACKGROUND

Historically, doctors used hospitals as extensions of their offices to treat patients for more complicated procedures or after-hours emergencies. Although this was an alliance of shared interests, medical systems and physicians had different priorities, which frequently caused them to compete with one another. As healthcare changes from a reimbursement model based on fee-for-service to one of value-based purchasing, healthcare systems and physicians must become one entity in order to thrive.[1]

As the U.S. healthcare delivery system transitions from private practice to hospital-owned physician practices, there is a resultant shift to team-based healthcare delivery. Achieving transparent communication of a shared common vision is paramount for team-based care to succeed. Physicians are the leaders of these teams, which are composed of registered nurses, nurse practitioners, social workers, dieticians, and pharmacists. It is often difficult for these teams to work cohesively because historically physicians have practiced as independent, autonomous, standalone entities. A further obstacle to establishing effective team-based clinical delivery is physician lack of leadership skills. In fact, the skill set of a physician clinician is completely opposite that of a physician leader. For healthcare systems to thrive in the changing healthcare landscape, it is incumbent upon these systems to assist physicians not only to overcome their reluctance to relinquish their autonomy, but also to gain the leadership skills they need to become effective physician leaders.

This article presents the integration of two different offshoots of a healthcare organization—a multistate chain organization with the larger entity taking over its smaller and geographically neighboring counterpart. This involved the fusion of clinician teams that were already in place. Prior to the merger, the current teams have significant differences, making the merger even more difficult.

CASE PRESENTATION

In this case report, the daily struggle of administrators who manage physicians was exacerbated by the recent integration with a much smaller, local healthcare organization.

The initial larger organization will be referred to as Business 1 (B1), and the smaller organization, which became enveloped by B1, will be referred to as Business 2 (B2). Despite belonging to the same healthcare organization, there were significant differences between the two entities (Table 1). The first difference was in physician employment. Before the merger, B1 employed 32 physicians and 2 nurse practitioners, whereas B2 employed only 4 physicians. B2's remaining 98 physicians were contracted providers who maintained other employment, resulting in them covering B2 as a "fill in," or secondary to their main scope of work.

The second difference was in patient delivery systems. Prior to the merger, B1 was open access and had funding to cover specialized treatments that helped ease the patients' quality of life: treating the patient, not curing the disease. B1 admitted 24 hours a day, 7 days a week, 365 days a year.

Table 1. Comparison of Business 1 and Business 2

	Physician Employment	Patient Delivery Systems	Structure of Teams
Business 1	Employed 32 physicians and 2 nurse practitioners Only employed physicians, no contracted physicians	An open access facility with funding to cover specialized treatments Admitted patients 24/7/365	Counties divided into regions, led by regional director Three to four teams in each region, each with 60–70 patients Consisted of team manager, 4 or 5 RNs, 3 or 4 CNAs, 1 or 2 social workers, a chaplain, and a physician
Business 2	Employed 4 physicians and contracted 98 physicians	No special treatment care or funding Admitted patients Monday-Friday, 7 AM to 5 PM, and was closed on holidays	Counties divided up into large teams, managed by CNO, with 120–150 patients each Consisted of care group manager, 3 or 4 lead RNs, 3 or 4 LPNs, 3 or 4 CNAs, 1 or 2 social workers, and a chaplain Physicians worked outside of this geographically

CNAs, certified nursing assistants; CNO, chief nursing officer; LPNs, licenses practical nurses; RNs, registered nurses.

B1 employed its physicians as "employees." However, B2 did not have an open-access admission process. Admission was restricted to Monday through Friday, 7 AM to 5 PM. Additionally, B2 was closed on major holidays and frequently could not admit patients who needed complex care.

A third difference was in the structure of the healthcare team. B1's geographic area was two adjacent counties, which were divided into regions, with a regional director in charge of the clinical and administrative functions for patient care. Within each region, there were three or four teams, each with 60 to 70 patients, established geographically. Each team consisted of a nurse team manager, four or five registered nurses (RNs), three or four certified nursing assistants (CNAs), one or two social workers, a chaplain, and a physician. B2's structure was very different and encompassed only one county. The chief nursing officer managed all clinical and administrative functions for patient care. The county was divided up into four large teams with 120 to 150 patients each. Each team included a nurse care group manager, three or four lead RNs, three or four licensed practical nurses serving as comanagers, three or four CNAs, one or two social workers, and a chaplain. The physicians were shared among all the teams.

To integrate B2, B1 reviewed all 134 potential B2 physicians, ultimately employing 42 of them. Additionally, three nurse practitioners from B2 joined B1. The yearly contracts for the remaining clinicians were not renewed, resulting in them no longer being employed by either B2 or B1.

In the new team structure dictated by the merger, each team received one or two physicians, based on either geographical coverage or type of patient location (i.e., home versus assisted living facility or skilled nursing facility) (Figure 1). This is the first major difference: B2 physicians had never been assigned to teams before; they had always shared the geographic area among themselves as their own team apart from the rest of the clinicians. For instance, Team 1 is responsible for all skilled nursing facilities in a portion of its assigned geographic area. Physician A prior to the merger would be assigned to the Area A patients, whereas Physician B would be assigned to the Area B patients. However, Team 2 is structured based on different characteristics. Team 2 is divided up within each area, but includes both patients at home (private residence) and those living in assisted living facilities. Physician C is assigned to the home patients, whereas Physician D is assigned to the patients in the assisted living facilities. As has become clear, the new structure is very complex and difficult to understand, even for the physicians. For most changes, B2 yielded to the standards of B1. However, the way in which the physicians were assigned to patients is the only aspect where both businesses had to adapt to a new standard.

In the beginning stages of this merger, while most physicians were cooperative, many were quite the opposite. Physicians became frustrated with the new team-based delivery model because the model was different from either of the prior models of B1 and B2. Not only did both B1 and B2 physicians feel lost in the new delivery model, but they also were unhappy about having the way they practice dictated to them, such as patient visitation schedules. In addition, the new layers of bureaucracy, dictated by the integration model, which were new to both B1 and B2 physicians, limited their ability to make quick decisions. Ultimately, the more frustrated and disgruntled physicians resigned.

The administrators, trying to cater to the specific needs and requests of physicians, felt trapped, as they also needed to meet the business needs. Even though

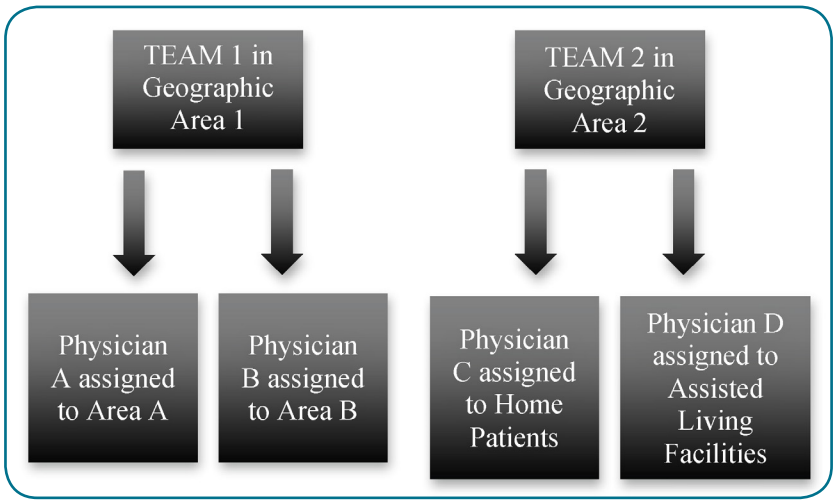

Figure 1. Healthcare delivery model after the merger.

management communicated the integration changes in weekly meetings, clinicians still perceived the administration as dictating policy, thus limiting their independence. Select newly employed former B2 physicians and staff would bypass the new chain of command by seeking solace from their prior B2 administration. This undermining of the administration of B1 resulted in animosity between B1 and B2 administrators as well as B1 administrator animosity toward B2 physicians and staff.

Now, over a year later, the integration problems have been resolved, but not without conflicts and resignations along the way. The organization now works as one entity, under one administration. For the most part, the transition leadership was driven to address problems and adjust business practices accordingly, after the problems occurred. As the practice manager stated, "that sense of unhappiness or insecurity in dealing with the unknown and making up stories for what they think is happening, instead of asking leadership those difficult questions, has been a challenge for certain percentage of the staff." The administration felt that even though there were weekly communications, the staff still felt uncertain in their job security and loyalty, ultimately affecting the cohesiveness of the new, combined organization's structure and culture as a whole.

DISCUSSION

This case report illustrates one of the changes subsequent to the Affordable Care Act by highlighting the dilemma of physician leadership in healthcare system integration.

It is important to note what is stopping this teamwork, which is, as a result, negatively affecting the cohesiveness of a care team and their quality of care. The major reported problem is communication. In a 2004 report, an "analysis of 2,455 sentinel events reports to the Joint Commission for Hospital Accreditation revealed that the primary root causes in over 70% [of patient dissatisfaction cases] was [physician] communication failure."[2] Many of these cases also resulted in patient harm. The same report points out that briefings are important in many other life-determining careers: law enforcement, aviation, and the military. So why are briefings not more present in clinical medicine? The article offers up the "SBAR" model for briefing: **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation. We hypothesize that this type of clear, concise, emotionally unclouded way for clinicians to communicate would improve not only their intergroup relationships, but also patient care. They must use precise and critical language and have situational awareness.[2]

While they held weekly meetings as soon as the new system "went live," it might have been beneficial to have meetings before the official change in structure took effect. Training sessions were held, but not to the degree where physicians were able to get to know each other, and understand their new roles. This would have helped them acclimate earlier. Our suggestion is for both the administrators and the physicians to work to improve this problem. The administrators must stop playing the "blame game." It is easy, and often common, for administrators to blame the lack of physician alignment on the physicians. However, it is incumbent upon the administrators to align the historically independent-minded physicians with their vision of patient-centered healthcare delivery. They must develop the physicians into leaders through executive business and leadership coaching.[1]

It is pertinent that administrators *listen to* what the clinicians have to say, as they are the frontline staff dealing with patient care daily. If clinicians do not feel involved in decision making, they will not feel valued or respected. The suggestion is to involve clinicians fully in an integration such as this, asking for input throughout the formation stages, not afterward at the weekly meetings. The only solution to the problem of physicians' hostility toward the

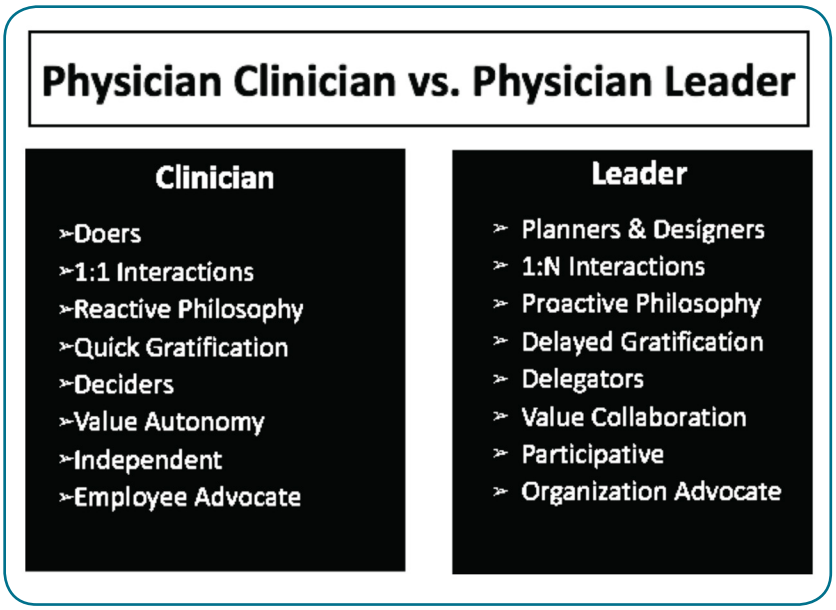

Figure 2. Qualities of a physician clinician versus a physician leader.

administration is actually involving them in the organization's management processes.

The physicians, on the other hand, must be willing to work with the administrators and step out of their silo into a team. Communication, the most important element, fosters teamwork, the second most important element. There is a delicate balance between a physician as a leader, and a physician as a team player. Physicians must be able to switch back and forth from autonomous, decision-making physicians when in the operating room or patient room, to strategic team players when discussing cases and delegation of work with their team (Figure 2). Once physicians prove their leadership qualities, administrators will then want to include them for their invaluable, cooperative advice in more situations than just integration. Once physicians model teamwork with their colleagues, they are allowing for more thought-out, well-rounded decisions centered entirely on patient care.[3]

Recognizing that effective teamwork improves patient safety, the Institute of Medicine, the Joint Commission, and the Agency for Healthcare Research and Quality have put a large emphasis on teamwork. Although it is difficult to measure clinical teamwork, the two key markers are individual physician competence and the effectiveness of the team as a whole.[4] These key measures require transparent and fluid communications among all clinicians and professional guidance and assistance from administrators.

CONCLUSION

As the U. S. healthcare system gravitates toward team-based clinical care, a physician and healthcare organization adjustment must take place. These changes will not be made seamlessly, however, and facilitation is required. Administrators must hold many training sessions, where reflections, opinions, and constructive criticisms can be discussed. Team building and leadership coaching are critical drivers to align physicians and administration to reach a common goal. It is incumbent upon the administration to assist the physicians in enhancing their leadership and communication skill sets.

For clinicians to be able to communicate among team members, there must be a facilitated adaption to the care group model. Successfully working in clinician teams can improve patient care as well as patient satisfaction, which will maximize healthcare revenue. It is important to note that every organization is unique and must reevaluate to apply the learnings from their successes and failures. It is not a question of why the United States is making this move, but, rather, how to bring all clinicians and administrators to a common vision.

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