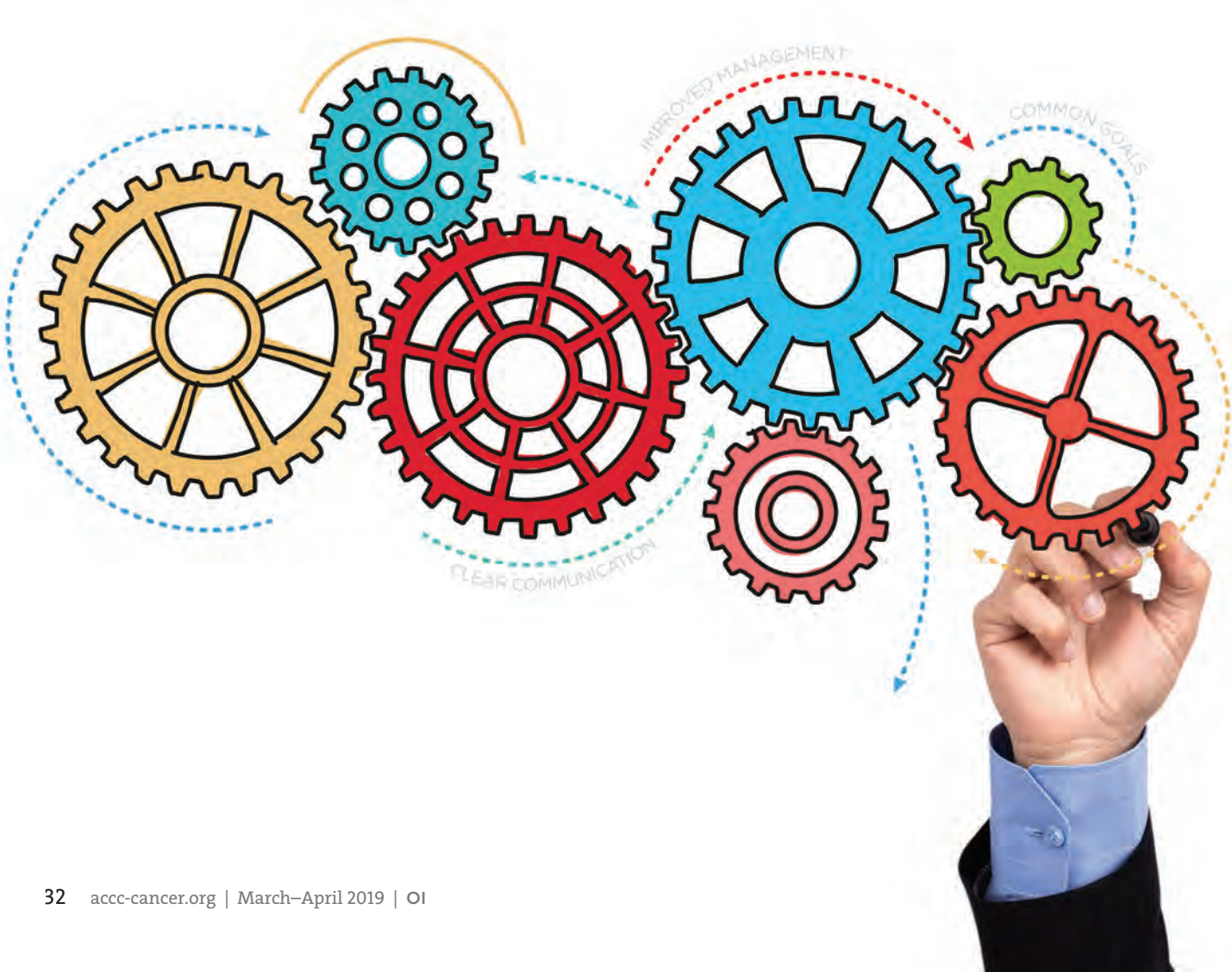
One Best Practice:
Streamlining Workflow, Unifying Staff, and Reducing Redundancy



BY ELIZABETH KOELKER, MHA, FACHE

In December 2016, Kettering Health Network opened a new five-story, 120,000 square foot cancer center on the campus of Kettering Medical Center, the network's flagship hospital. The community's response to the opening of the cancer center was overwhelming. More than 1,000 guests were present for the VIP ribbon cutting, and over 3,000 community members attended the public opening—even though it was scheduled on a wintry evening in the middle of the week.

Southwest Ohio was excited and supportive of the new cancer center, but behind the scenes, the road to opening was bumpy. Discussions and planning of the cancer center spanned over a decade. A series of starts and stops, shifting scope and definitions, and conflicting expectations from key stakeholders made the initiative, at best, an interesting journey.

A Service Line Approach

In late 2013, Kettering Health Network chose to reorganize business operations by service lines—grouping care by the disease state (i.e., cardiology, oncology) rather than by department (i.e., diagnostics, surgery). Oncology was chosen as the first service line to deploy. Nearly all oncology physicians were already employed by the network, so it was perceived to be the "easiest" starting point. The project to build a cancer center had finally gotten off the ground with an approved strategy, design, and capital allocation. Now it was time for the oncology service line to unite and rebrand under the name Kettering Cancer Care.

When administrative leaders began evaluating the rollout of this new service line approach, it became evident that a massive overhaul of the oncology division would be required for successful implementation. The leadership team identified four major issues:

1. Division and internal competition between the employed oncology physician groups
2. Major communication deficits, both clinically and interpersonally
3. Inefficient management of resources, supplies, and operations
4. Insufficient infrastructure to meet the volume demands.

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It was imperative that the oncology service line unite and develop a single best practice for cancer business operations. We were charged with building a cancer center that could operate in a future "ideal" state when the present state of oncology operations was broken. By the end of the three-year transformation, we had built a new cancer center where all oncology practices in Kettering Health Network operate and collaborate. This, however, was more than a construction project; it required a massive cultural shift to increase engagement, efficiency, and create collaboration.

Challenge 1. Division and Competition Between Physician Groups

Prior to the service line overhaul, all physician groups operated independently: medical oncology practices were separate; gynecologic oncology was separate; radiation oncology was separate. These physicians did not even have one standing meeting on the calendar together. They were completely siloed.

Due to the siloed operations of the physician practices at the time, however, there was no cross-coverage for staffing. On any given day, one practice could be overstaffed and flexing employees to home while another practice one floor above was at critical staffing levels and in dire need of those highly specialized employees who were sent home.

This lack of unification alone would have been a challenge, but the situation was compounded by employed physicians competing against each other. This culture of competition and confrontation was so pervasive that some physicians would refer patients out of network for treatment to avoid sending a referral to a colleague in another oncology subspecialty. Division ensued over MD versus DO credentials; further conflict was born of the wide clinical variation between the practices. One group had an in-house pharmacy and pharmacist, another did not. One practice lacked basic technology like infusion pumps, while another group enjoyed the "luxurious" physician-nurse dyad model. Overwhelmingly, the lack of willingness to pool or share resources exacerbated all issues.

Challenge 2. Lack of Communication

Lack of communication between oncology physicians was difficult to tackle in and of itself; an even larger problem was the lack of communication to referring physicians and even emergency and hospital departments. There were no centralized or shared medical records. Some practices had brought their own electronic health records (EHRs) with them when they were acquired by Kettering Physician Network; others had no EHR and wrote everything, including chemotherapy orders, by hand. Because of this, when an oncology patient was sent to the emergency department or admitted to the hospital, collaborating physicians had no information regarding which chemotherapy or immunotherapy drugs the patient was on, recent labs or images, or any information at all regarding the patient's plan of care.

Challenge 3. Inefficient Management of Resources

Prior to 2013, the oncology service line director had changed four times in four years—a lack of consistent administrative leadership resulted in a lack of efficient management. Oncology employees have a high level of specialization, training, and education required to work with this specific group of patients who may be emotionally fragile. Nurses require specialized education and training to administer chemotherapy, and other certifications and qualifications are regulated to ensure a high-quality cancer care department. In cancer care, you cannot just "float" staff or pull from a general labor resource pool.

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Challenge 4. No Infrastructure for Growth

All of these issues were compounded by a lack of necessary infrastructure. When each physician practice was acquired, they were placed, separately, in office space that was retrofitted to try to accommodate the unique needs of cancer patients. Chemotherapy treatment can involve a 30-minute injection, but it also can be a grueling six-hour day of transfusions. Because each practice was placed in a space that was not designed specifically for cancer patients, they had no choice but to offer infusion services in one big open room with recliners that all faced each other. There were not even curtains to separate the patient chairs. If a patient began experiencing a reaction or side effects while receiving treatment, a nurse would bring a foldout screen to try to provide some privacy. To compound the issue, there was no space for a family member or support person to join the patient during treatment. At one point, some of the practices were setting up folding chairs in an adjacent hallway to access ports or administer an injection because the number of daily patients surpassed the availability of infusion chairs.

Unfortunately, the rate of cancer is rising in southwest Ohio, along with an aging population. Cancer incidence is climbing, underscoring a need to expand care. However, even if every other challenge could be solved to streamline operational inefficiencies, we did not have the infrastructure required for the inevitable growth in the community.

Outlining the Goals

We first approached this overhaul by identifying the need for a cultural shift to a network, or single best practice, approach. Instead of each practice operating independently, we needed to:

- Reduce clinical variation
- Define industry standards
- Move forward together on practicing standards

Kettering Health Network aims to be known for being the best in the marketplace for care, so we first had to define what it took to be the best and then achieve and even surpass that level of quality.

Because of the longstanding division between physician practices, we came to understand that the way to achieve a real shift in mindset would be to restructure practice-level leadership. Up until this point, everyone held titles that were specific to their practice—that is, each practice had its own manager and leadership structure. In the new model, job descriptions, titles, and responsibilities reflected a network or service line-wide role. Manager A was given responsibility for cancer infusion across the network; manager B was in charge of oncology clinics across the network; manager C would be in charge of the business offices for oncology across the network. We wanted to do away with the siloed mindset. Everyone would have responsibility and accountability for multiple sites and locations. We could no longer afford to operate under an "everyone-for-themselves" mentality.

We also knew that communication between practices and hospitals was essential. The practices would have to transition to a centralized EHR. Even though this might make physicians less efficient in their charting initially, and even though there was some perception that the software might not be as optimal for use in an oncology setting as their current system, translating the EHR to the hospital was not optional. At the time, physicians were paid under a productivity model, so their ability to see more patients translated to more income. In attempts to minimize the disruption to their workflow and to ensure that the solution we were proposing was one that could garner buy-in, the decision was made to "freeze" physician productivity at a base-store rate for a set period of time to enable physicians to contribute to building the new EHR. People are more likely to support what they help build, and we took this mindset to heart and attempted to engage the physicians, pharmacists, and clinical care team in a real way, encouraging them to directly plan and build their future.

But the catalyst for real change came in recognizing the dire need for a new cancer building. Volume, incidence, and market share were dramatically increasing, but we had nowhere to put the patients. People from every area came together to provide input on the design of a new cancer center: physicians, nurses, clinicians, administrative leaders, cancer patients, cancer survivors, and loved ones. We needed to design a future space that would not only achieve but surpass the industry standard for care and privacy.

The transition to a new physical space provided the perfect opportunity to begin implementing "one best practice." The variation for completing a task and the ever-shifting expectations that changed from physician to physician left the staff with stress and anxiety, making more inadvertent errors and performing with decreased productivity. For example, at the start of this project, there were 49 different patient appointment types that schedulers could make for cancer patients. It was too confusing; we needed to define one streamlined way of working and make expectations clear.

This process did not go perfectly; there was resistance, there were breakdowns, and not every physician or staff member stayed. But we could not allow our measure of success to become confused or misled; it was acceptable for employees or physicians to self-select out of the new service line model. We were building a culture of patient-focused care that needed to set the industry standard for the very best.

Taking Action: From Disparate to Unified

As we embarked on building a new facility, it became clear that we would not be able to accomplish this feat without working as a unified team. The need for a new physical space served as the impetus for change. We began to eliminate legacy practices to create a single, multidisciplinary group of Kettering Cancer Care. In the planning process for the construction of the cancer center, we created a patient advisory council to ensure patient-centered care, designed by patients for patients.

We cross-trained all staff to work at every location throughout the network to maximize productivity. Despite initial resistance, we started seeing increased volume due to decreased internal competition and greater access to care. As we continued to move forward, our team engaged with Process Excellence, our internal consultants and experts on LEAN initiatives, a set of processes and philosophies that aim to reduce waste and create maximum value for patients, to guide and advise on the project design and future state of the operational workflow. Eventually, in June 2016, six months prior to opening Kettering Cancer Center, we launched

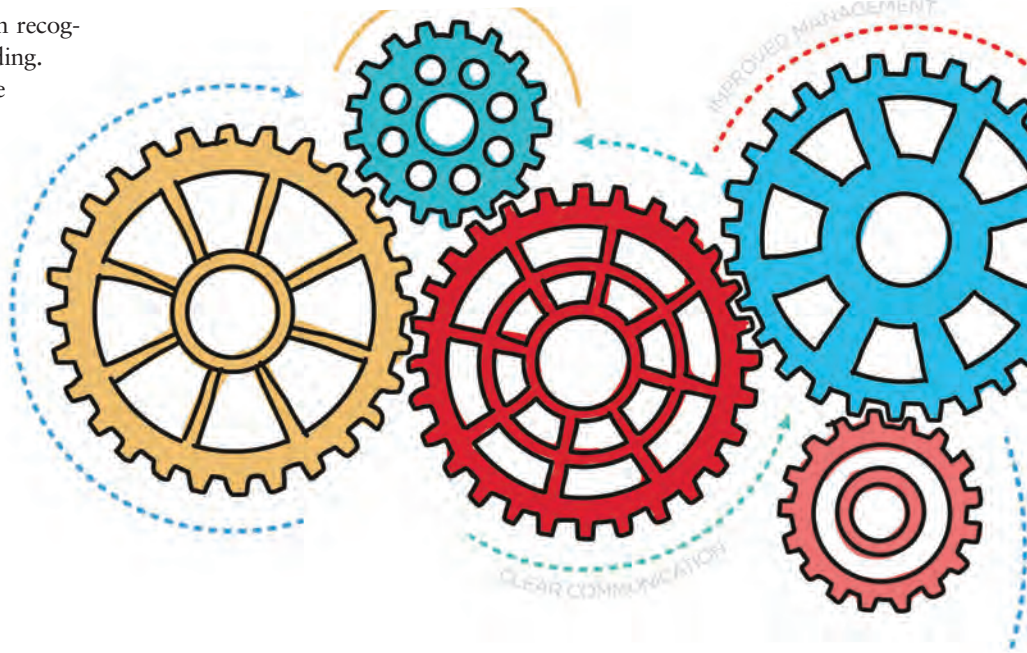
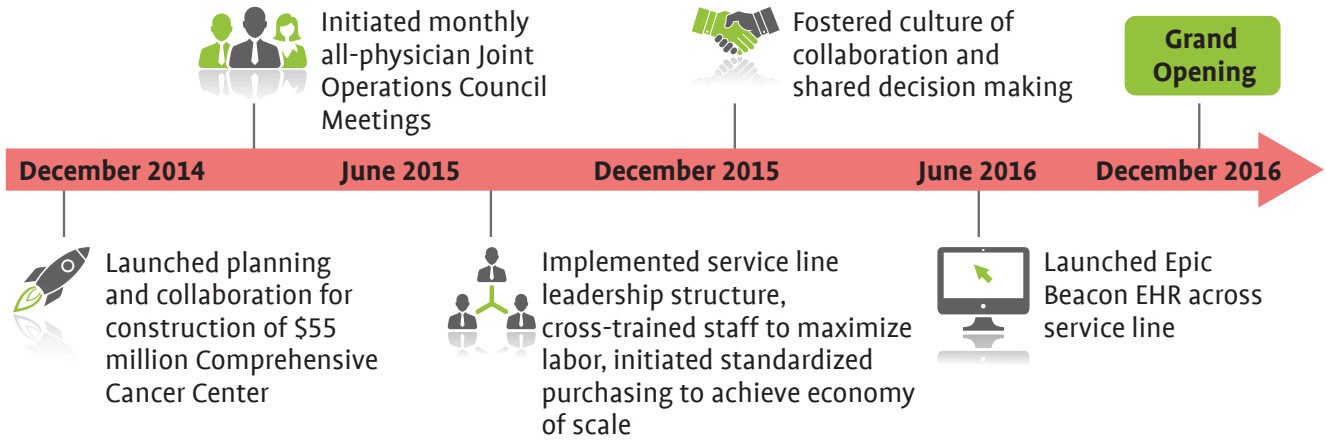


Figure 1. Timeline of One Best Practice Model



Epic Beacon, an EHR system, to increase efficiency in locating records and improve communication with collaborating physicians. It was made clear to physicians that there would be no space built for physical records in the new cancer center—the EHR was the new standard. Figure 1, above, is a timeline of the journey to our One Best Practice Model.

The Impact: Streamlined Operations, Increased Volume, Decreased Competition

Kettering Cancer Center opened in December 2016. The oncology service line achieved our five-year growth projection in the first five months. In a year and a half, we have had to add nine additional physicians to the oncology service line just to keep pace with the demand for care.

Volume of consults per week has significantly increased and, with it, efficiency has also increased. In the clinic and infusion setting, volume has grown 28 percent with the addition of eight full-time equivalents. Breast cancer screening and imaging volume is up 38 percent to date with the addition of only 0.7 full-time equivalents. The streamlining of clinical operations and processes has allowed us to accommodate for this growth while achieving economy of scale.

When designing the cancer center, we implemented monthly meetings to discuss the process development and design of the cancer center. Those meetings have since evolved to focus on clinical operations, patient satisfaction, and quality metrics. We formulated an oncology quality review team led by physicians. There are now medical directors for each area—radiation oncology, medical oncology, surgical oncology, etc.—who are empowered to make decisions representing their divisions.

The changes we made were important for improved quality of care, but they also were vital in transforming the internal culture. Employee and physician engagement is currently at an all-time high, because we have fostered pride, ownership, and accountability. Our employee engagement has moved from the 54th percentile to the 87th percentile. In turn, patient satisfaction is now in the 90th percentile.

The First Example of Unification

Like many healthcare networks across the country, Kettering Health Network has a color-coded uniform that represents roles on the care team. Nursing wears blue; environmental services wears tan; therapy wears purple; etc. Prior to moving into Kettering Cancer Center, employees expressed a desire for their own color of uniform to represent cancer care. This kind of request had been presented to the executive leadership team before by other service lines and divisions and it had never been granted.

As executive director for oncology, my top priorities were the creation of the service line and construction of the new cancer center. I told employees that if they gathered the data—go to Human Resources, find out the parameters, achieve consensus among yourselves, and come up with the proposal—then I would lobby to the executive team for this change. But this had to be their project. I would advocate for them, but it was their project to undertake. This was the first project in years that employees came together for.

After they presented me with their findings, I scheduled a meeting to pitch the idea to the executives in the network knowing that several other divisions had asked for the same result with no success, emphasizing our focus on building a new culture. Not only did the executive team grant the request, but they provided a stipend for every employee to purchase a new Kettering Cancer Care uniform. By the time we moved into the new building, each employee was wearing a brand-new turquoise uniform to mark that they were part of the oncology care team.

The uniform color, though it may seem like a small and possibly insignificant detail, became the cultural shifting point. Now we *looked* unified, and looking the part is sometimes half of the battle. That color and those three embroidered words across the uniform—Kettering Cancer Care—were a source of pride for our unified workforce.

Lessons Learned

Today, we are known as one entity: Kettering Cancer Care. When patients come for their treatment, they do not just interact with one nurse who cares for them; they interact with multiple caregivers who all want to be part of their extended family. When the quality of working relationships grows, the quality of care for the patient can also improve.

One of the most unexpected measures of success has been noticing how employees introduce themselves or communicate over the phone. Before, staff would indicate, "I work for Dr. So-and-So," or "I am the scheduler for practice X." Now we hear "I work for Kettering Cancer Care"—and it is always said with pride and a sense of achievement.

For others looking to conduct a similar overhaul of the the oncology service line, to break down existing silos, and to streamline best practices, I offer a few lessons learned:

1. We shared a unifying motivation. When we were tempted to engage in old conflicts and to operate independently, everyone could be brought back to the unifying goal: we are here to do what is best for cancer patients. Kettering Health Network does not simply want to be good at cancer care, we want to be the best in our community.
2. Kettering Health Network is a faith-based organization. While working on building this new culture, there was an underlying ground rule that we would treat each other with respect. Being a faith-based organization means nothing if we do not hold each other accountable for how we interact.
3. The executive leaders of the network believed in this project. At any point, if the executive leadership team had thrown up any barriers, we never would have accomplished such growth. Leadership initially offered to give $30 million to the building of the cancer center—they ended up contributing $66 million. Our leadership believed that we could be better and they gave us everything we needed to accomplish it.

Finally, none of this growth would have been possible without a unified commitment to work harmoniously, a vision for the future of oncology care, and the courage to become who we want to be. The landscape of cancer care is changing and the rate of cancer is increasing, and we need to be humble enough to change and grow so that we can offer the very best cancer care to patients. OI

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