

Key Takeaways

- **Payment systems and the competitive environment are rapidly evolving to favor providers of service line focused organizations.**
- **Hospitals need to challenge their thinking about traditional organizational models, physician alignment, and other key structures that affect the ability to create value.**
- **Organizational culture and lack of effective clinical leadership are among the most challenging barriers to adapting to this environment.**

Creating Successful Service Lines

The market dynamics for healthcare services are changing rapidly, driven by new approaches to payment, more educated consumers, mandatory outcomes reporting, and purchasers' search for greater value. In the past, hospitals focused on creating a positive image or "brand identity" in their service area. Today, the solid reputation of a hospital in the community no longer ensures success. Rather, each of a hospital's clinical programs will succeed or fail based on its individual ability to respond to the needs of three separate constituencies.

We see clear evidence that patients, payors, and physicians shop not just for the "best" hospital, but for specific programs that can demonstrate their value by combining clinical quality, economic efficiency, and patient satisfaction. Medicare demonstration projects showcasing "bundled payments" are a harbinger of future reimbursement schemes that will attempt to align incentives across various parts of the healthcare system, and the service line organizational structure seems ideally suited to this new environment.

In response to these pressures, ECG has seen increasing activity by hospitals to develop service line structures that improve performance, encourage physician

involvement, and ultimately gain competitive advantage. Hospital service line activity varies widely, from those just initiating a first service line to those that have made service lines a fundamental organizing principle that guides all strategic and operational decisions. We have seen remarkable successes in some instances, but at most hospitals, service line activity is still a work in progress, and in many facilities, service line development is foundering. We consistently hear the following questions from CEOs across the country: How do we pick appropriate service line(s)? How do we get up and running? How do I make my service line(s) perform better? We have tried this before, so why will it work this time?

Our responses inevitably focus on seven key elements for service line success, and each will be summarized on the pages that follow. Some basic orientation is provided below.

What Is a Service Line?

Service lines are typically recognizable to patients and caregivers as rational collections of services that a patient may require during treatment for an episode or condition. A service line is organized around patient diagnosis to provide coordination of care and accessibility of information over time, regardless of where the care is provided or who provides it.

What Features Characterize a Service Line?

For years, hospitals have advanced a range of programs under the heading “service line,” and it is no surprise that the concept is now a bit unclear for most observers. A Center of Excellence, product line marketing, logo, or an occasional team meeting does not constitute a mature service line unless the following features are also present:

- Is recognized by physicians, management, and patients as a collection of services needed for specified conditions.
- Provides a single point of patient access throughout the treatment process.
- Offers coordinated provider teams for patient-based services and care.
- Incorporates standardized processes, protocols, and outcome measurements.
- Reports financial, operational, and quality-of-care data at the service line level.
- Demands full alignment of physicians, staff, and management across all sites of care.
- Offers participation in strategic, operational, and financial decision making for key providers.
- Has a unified management control structure that governs critical operations and the strategy regarding service line delivery assets.

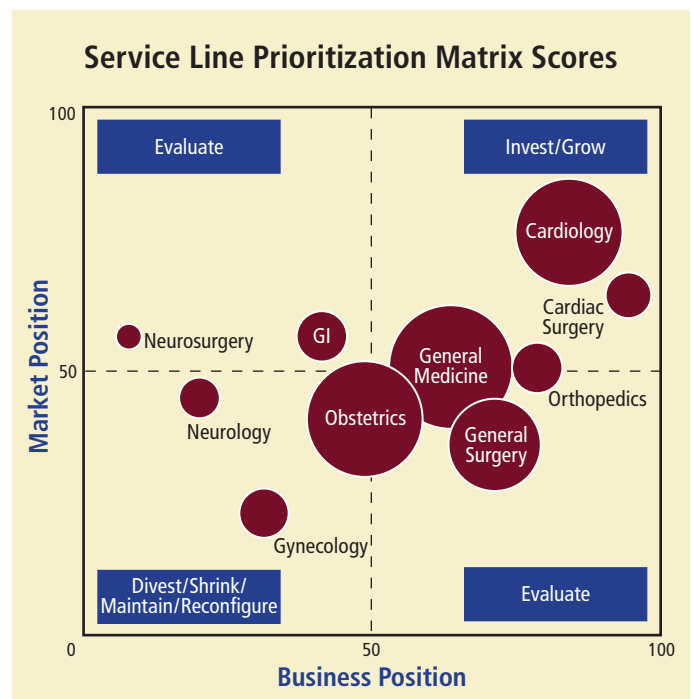
What Services Should Be Structured as a Service Line?

Consideration for a service line should focus first on those areas where the hospital has established experience. It is obvious that progress will be more rapid and greater value created by organizing existing expertise than in starting from scratch. Second, the service must have a significant ambulatory component, because it is the coordination of services and clinical information across varying sites that

adds value for stakeholders. Third, the service must have the potential for profitability. If increasing market share only leads to greater financial losses, investing time and money is difficult to justify. Finally, service lines typically have an element of multidisciplinary care that benefits from the coordination and superior information flow that service lines provide.

We most often see activity and interest in service line development in cardiovascular, oncology, women and children, neuroscience, and orthopedics. These services meet the criteria introduced above and are often a priority for payors in terms of demonstrating quality and efficiency in delivery of care.

Since resources are finite, hospital leadership will need to make decisions regarding which service lines to invest in. Since these decisions can be contentious, utilizing an objective approach such as service line portfolio management (SLPM) can help ensure that investment decisions are being made for the right reasons. SLPM creates an interactive dialog among key stakeholders in which each service line is scored across key criteria such as clinical leadership, market position, community need, and profitability. Performed properly, it can draw distinctions among service lines to prioritize which should receive additional investment. An example of a completed scoring diagram is shown below.

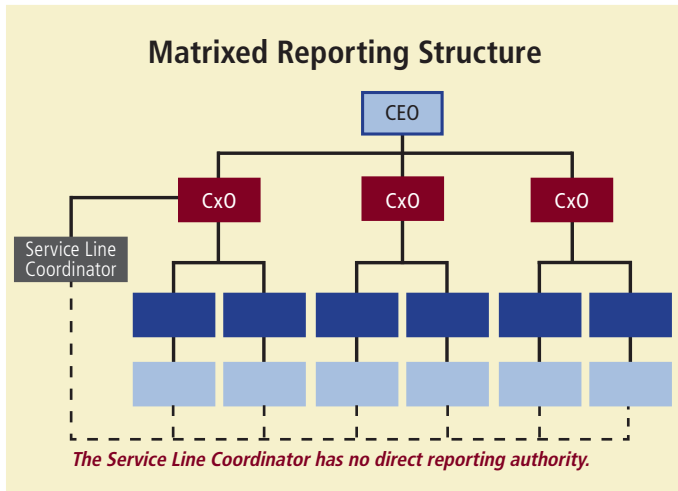


Key Elements for Service Line Success

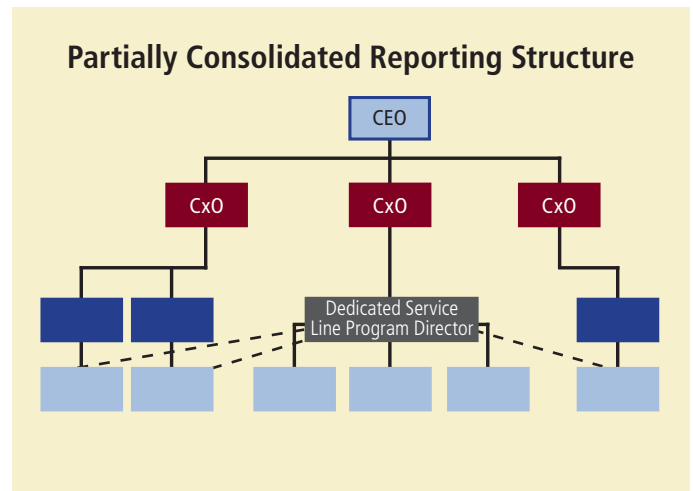
As a new service line or an enhancement of an existing service line is considered, we believe that seven key elements must be addressed.

1. Organizational Models

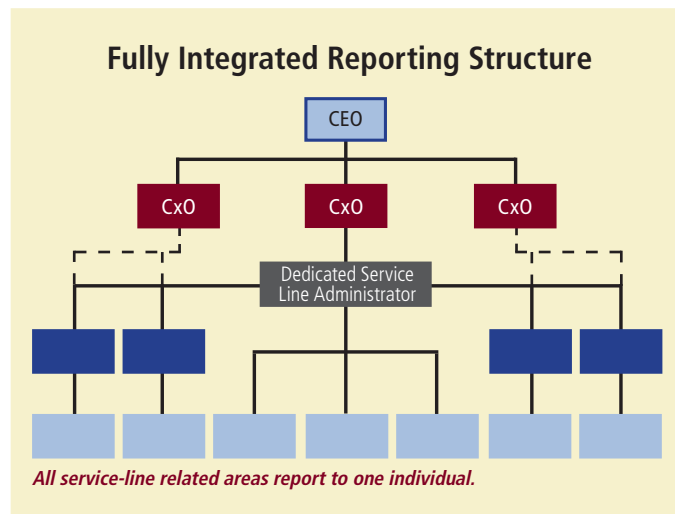
Service lines are emerging as the organizational backbone of many hospitals, with well-defined business units replacing the traditional organizational structure. There is a continuum of organizational ideas on how to best run a service line, as described below.



Key and shared service line areas have an indirect reporting relationship to service line coordinator.



Key service line areas are under the direct control of service line program director. Shared services have an indirect reporting relationship.



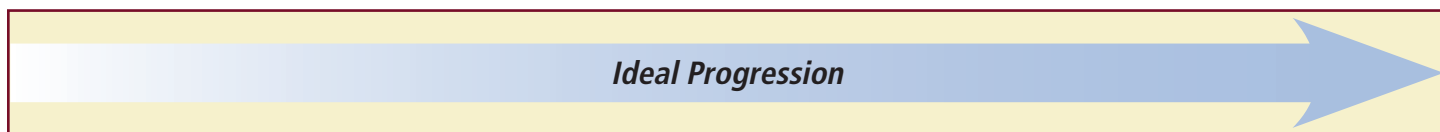
All areas within the service line report directly to service line administrator, who is fully dedicated to service line management.

2. Governance Structures

Central to effective service line development is the close coordination of services across sites of care, medical specialties, ancillary services, and support departments. Obviously, policies, procedures, and protocols need to be developed that are distinct from those of the traditional hospital and are based on collaboration between providers and managers. The governance structure determines, to a large extent, who makes key operating decisions and how those decisions are made.

We firmly believe that the complexities of service line management and the difficulties of breaking down barriers between multiple care disciplines demand a high level of physician involvement. A service line governance structure that engages physicians will not only result in massive improvements in decision making and resource allocation, but will also secure physician commitment to service line success.

The table below provides a summary of the governance options for service lines.

<i>Ideal Progression</i> 				
	Limited Governance	Ad Hoc Committee	Standing Committee	Leadership Board
Overview	No established mechanism for governance. Individuals informally consulted.	Formed to discuss specific issues, (e.g., new products, workforce planning) as they arise.	Established governance body responsible for wide range of oversight functions.	Board maintains complete accountability for service line performance reporting directly to hospital CEO.
Strategic Planning	No role.	Informed.	Advisory.	Advice, direction, and approval.
Management Selection	No role.	Input into hiring.	Input into hiring, performance review.	Accountability for hiring and firing.
Budgeting	No role.	Occasional advisory.	Advisory.	Advice and approval.
Physician Composition	Individual physicians may be consulted.	Limited physician involvement.	Significant physician composition.	Majority physician composition.

3. Management Composition

The question of day-to-day management and accountability for performance of the service line is often given too little thought. Consistent with most hospital management structures, a service line administrator can be given responsibility for operations. While such management by an administrator is familiar and easy to implement, the interdisciplinary nature of service lines suggests that a physician medical director should be part of the team (a dyad). Research conducted jointly by ECG and Thomson Reuters suggests that formalized physician management is highly correlated with top-performing cardiac programs.¹ While shared management responsibility can be difficult to implement, it is central to creating both quality and efficiency in a service line. Alternative approaches to management are shown below.

Administrative Director	Physician Leader	Dyad Leadership
Philosophy: A highly trained, experienced manager who understands the organizational, operational, and financial implications of running a successful service line is best equipped to lead these complex enterprises.	Philosophy: Physician leaders may be best prepared to ensure quality and safety, achieve patient outcome goals, pursue service line development opportunities, and foster relationships with key physicians.	Philosophy: The benefits of having both the clinical expertise of a physician and the business experience of an administrator may outweigh the added complexity that accompanies a dyad leadership structure.

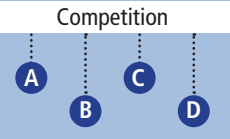
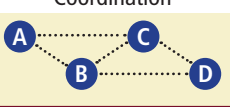
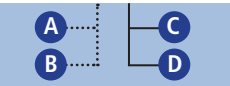
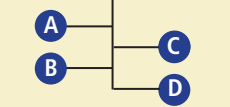
4. Physician Alignment

The critical objectives of most service lines – patient care protocols, outcome measures, enhanced patient experiences, and meaningful efficiency improvements – simply are not likely to emerge from traditional relationships between hospitals and independent physicians. The basic alternatives to unaffiliated practices are to offer medical directorships (essentially buying clinical input); develop contractual relationships (lease arrangements, joint ventures, gain sharing, etc.); or to employ physicians. There are benefits and drawbacks to each of the options, and our experience suggests that a combination of approaches may be most useful and practical, depending on the unique characteristics of each situation.

In addition to the relationship between physicians and the hospital, consideration must be given to the relationships among physicians who will be part of the service line. The inter-disciplinary nature of most service lines places a premium on cooperation

¹M. Sue Anderson, “Cardiovascular Service Line Management Survey - Key Results,” *Executive Briefing*, December 2008, www.ecgmc.com.

between physicians, and ensuring the desired level of collaboration, especially among physicians who may be competing for patients or resources, is a major management challenge. The table below depicts some of the structural variety in these relationships and the implications of each.

State of Alignment	Description	Strategic Priorities
	Each subspecialist is independently affiliated with the hospital. Clinical integration is lacking, and groups compete for patients and available resources.	<ul style="list-style-type: none"> Forming a strong, physician-led governance body. Building trust and coordination between groups through modest joint initiatives (e.g., service line dashboards, joint outreach clinics, coordinated physician referrals).
	Subspecialists remain independent but take a coordinated approach to referral relationships and physician recruitment.	<ul style="list-style-type: none"> Clearly aligning economic incentives. Developing more complex joint service line initiatives, such as program development and service line marketing.
	Some specialists remain independent, while others are formally employed by the hospital.	<ul style="list-style-type: none"> Building trust between employed and independent physicians. Aligning the financial incentives of all physicians regardless of employment status.
	All subspecialists are employed, resulting in a unified and coordinated physician workforce. Program planning, resource allocation, and physician recruitment are aligned.	<ul style="list-style-type: none"> Developing a compensation plan that aligns physician and service line incentives and accounts for the unique needs of each individual subspecialty. Ensuring physician engagement in service line planning, and governance.

5. Financial Management

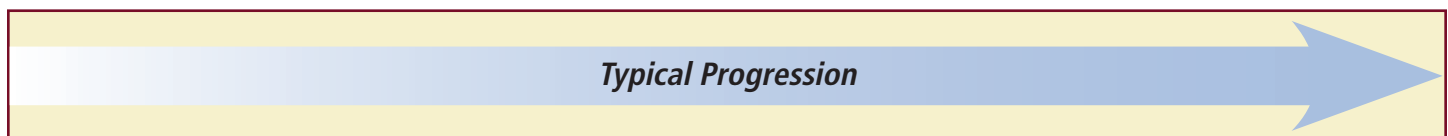
The familiar hospital financial management systems – characterized by granular “cost centers” and more general revenue reports – are not well suited to the multidisciplinary management needs of most service lines. To accurately measure financial performance, each service line should be accounted for as if it were a separate business unit, with all revenue and all costs for each patient allocated back to the service line. For example, if a cardiac service line patient is seen in the clinic, then has a cardiac catheterization and a 3-day hospital stay, the revenue from all three services should be credited to the service line. Likewise, the cost associated with each service should be charged to the service line through a system of transfer pricing within the hospital. While difficult to achieve, basing accounting on service lines can provide significantly improved data for the management of the organization, ultimately enabling better decisions on resource allocation.

Model	Description	Considerations	Relative Effort and Effectiveness
Traditional Reporting	Traditional structure; each cost department is accountable for creating and maintaining its own budget (e.g., cath lab, OR, and cardiology clinic have separate budgets and financial statements.)	<ul style="list-style-type: none"> Requires no additional implementation. Necessitates a manual collection process. Provides ambiguous reports on overall service line performance because of different reporting systems. 	Low
Structured Service Line Reporting	Partially integrated financial structure; some financial reporting methods are consolidated to provide more comprehensive service line performance reports.	<ul style="list-style-type: none"> Requires the development of a standardized reporting process to ensure the development of comparable financial reports. Provides some indication of overall performance, but results are often still ambiguous. Is a somewhat labor-intensive process. 	Medium (Depending on Extent of Decision Support Services)
Integrated Service Line Reporting	Fully integrated financial structure; the cardiac service line has one budget for all cardiac-related facility and management services and reports integrated financial statements.	<ul style="list-style-type: none"> Offers the most accurate method for assessing service line performance. Requires a more comprehensive financial reporting system. May be a labor- and cost-intensive implementation process. 	High (Depending on Extent of Decision Support Services)

6. Facilities

From a patient’s perspective, nothing says “organized care” more clearly than being able to see all major components of the continuum of care immediately upon entering the lobby. Proximity of related services is inherently comforting to patients. From a practical standpoint, locating related services near each other provides opportunities for information sharing, reduced travel time for staff, and more immediate identification of work flow and bottleneck issues.

Dedicated facilities are the ultimate ambition of nearly all service line managers, and are among the most difficult to achieve due to constraints on capital, real estate, and the necessity of shared services that support other hospital departments. Nevertheless, a facility strategy needs to be part of any service line plan. This is inherently easier for services that are outpatient-oriented (e.g., oncology) and incrementally more difficult for services that blend inpatient and outpatient services. At a minimum, a hospital should group service line components as close together as is practical. Other details, such as a dedicated entry and common signage, will provide comfort to patients, impart a sense of coordination, and help establish a brand identity. The continuum of facility options is as follows:

<i>Typical Progression</i> 			
General Program	Focused Service Line	Specialty Service Line Center	Institute Model
<ul style="list-style-type: none"> ■ Some shared medical and surgical facilities, with limited dedicated procedure areas. ■ No subspecialty patient clinics. ■ Diagnostic ancillaries available but are a shared resource. 	<ul style="list-style-type: none"> ■ Highly focused on one or two subspecialties. ■ Dedicated entry/lobby area with external signage. ■ Important services located in proximity to each other, but some services are scattered. 	<ul style="list-style-type: none"> ■ Designated facility, typically freestanding or "hospital within a hospital." ■ Single check-in/reception area. ■ Multidisciplinary clinics and case review. 	<ul style="list-style-type: none"> ■ Generally a freestanding facility associated with a research organization or academic department. ■ Integrated facilities for distinct but related specialties. ■ Often a distinct brand from sponsoring hospital.

7. Information Management

If a service line is to be successful, it must be able to demonstrate that its outcomes are better, its costs of care are lower, and that its patient satisfaction is high – in short, that it is providing greater value than its competitors. The driving principle of service lines is that coordination of services improves quality and efficiency. Gathering and reporting data that measures performance is therefore critical and is a major shortcoming in many of the service line initiatives that we have reviewed. Database requirements for a fully developed service line include, but are not limited to:

- Patient encounters by site.
- Diagnosis.
- Treatments.
- Outcomes of care.
- Cost of care by diagnosis and treatment.
- Financial performance of the service line.
- Patient satisfaction.

Furthermore, each of the metrics needs both internal and external benchmarks to measure improvement and to demonstrate performance relative to competitors. Process- and outcomes-oriented databases are available for most of the service lines described above, and committed institutions devote the financial and staffing resources to utilize these databases and track institutional progress against these measures.

Implementation Issues

The design and planning of a service line is relatively straightforward if the elements listed above are carefully considered. However, implementation of a service line can be daunting. In our experience, we have found two major potential roadblocks to service line implementation:

■ Institutional Culture

Service lines demand the integration of traditionally siloed hospital functions. While we believe this is a positive development for the reasons previously outlined, it represents potentially significant change within the established hospital hierarchy. Management in nursing, finance, ancillary services, and employed physician clinics will be challenged to respond to service lines' needs in these environments. For instance, nursing within a service line may entail staffing for physician offices, diagnostic and procedure centers, patient education programs, and inpatient care. Service line leadership will seek nurses with specific expertise who are dedicated to that service line and accountable to service line management. Nursing administration may have legitimate concerns related to education and enforcement of nursing standards and may resist accommodating such changes.

Other hospital departments and members of the medical staff will face similar pressures, and intramural disputes can be expected. To minimize this friction, the basic tenets of change management should be followed for all stakeholders:

- Explain or remind key constituents what the **purpose** of a service line is. Explain why the hospital is making changes, as well as the implications of not doing so.
- Offer a **picture** of what the future can look like with a successful service line. This will begin to create a positive vision and sense of where the hospital is going among participants.
- Carefully explain the **plan** for service line implementation. It is important that all stakeholders are confident that hospital leadership knows how to reach the goals it has set.
- Allow **participation** in planning and decision making throughout the process. It is less threatening if managers and others believe that they will be heard and can shape service line development.

■ Physician Leadership

Effective service line development demands tight alignment of physician and hospital interests, and getting there is often the most challenging aspect of service line management. Regardless of the method used to align with physicians, hospitals with successful service lines acknowledge the requirement of physician champions and the importance of ceding true clinical and operational power to physician leaders. Physicians, for their part, often do not realize that the input they have long sought can be achieved through service line management.

Unfortunately, it is rare for a community hospital to have a physician with both the interest and the ability to lead a service line. More often, the hospital has to identify a doctor with potential and then work to create the interest and skills necessary to be an effective leader. Hiring from the outside should be carefully thought out, since there is a danger of antagonizing existing providers. The challenge for CEOs is to first acknowledge the importance of physician leadership and then invest in the structure needed for it to happen.

What Is the Future for Service Lines?

It is appropriate to ask if service lines are simply the most recent manifestation of a 30-year organizational fad or if they will have a longer-term impact on hospitals. Our vision is shaped by existing trends. In the near term, we see hospitals focusing on the one, two, or three service lines that can best attract patients, providers, and payor contracts. In this short-term scenario, service lines are essentially an “add-on” to the organization’s business. Over time, however, we see that service lines have the potential to be the organization’s central business, with approximately 12 separate service line initiatives dominating the services provided. We see that ambulatory care will grow much faster than inpatient care. Lengths of stay will continue to drop, with a 2-day inpatient stay becoming standard as diagnostic and therapeutic modalities become less invasive and more effective. In short, today’s generalist hospital with limited coordination between hospital and ambulatory services will be replaced by coordinated groupings of inpatient and outpatient facilities interconnected by a shared organizational culture, value-driven leadership, and IT infrastructure.

The underlying (perhaps unsettling) implication is that many hospitals and health systems are not likely to remain as full-service providers. Providing the full range of services to all patients is simply not going to work in an era of focused competition, limited resources, and empowered patients. With the increased availability of effectiveness data to both payors and patients, services must be highly rated for both cost and quality or they will fail in a competitive marketplace. Thus, it is likely that markets will be split up by service lines with a relatively small number of providers in each niche and “turf battles” in emerging or contested services. In a number of markets, we are starting to see the beginning of this evolution, with payor RFPs for services that are costly yet data-rich, such as cardiac services.

Fundamentally, we believe that service line development must be viewed as a major organizational commitment and that service lines should be carefully nurtured over time. It is likely that the future of an organization’s service lines will determine the future of the organization as a whole.

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