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Service Line Development in Academic Health Systems

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Service Line Development in Academic Health Systems

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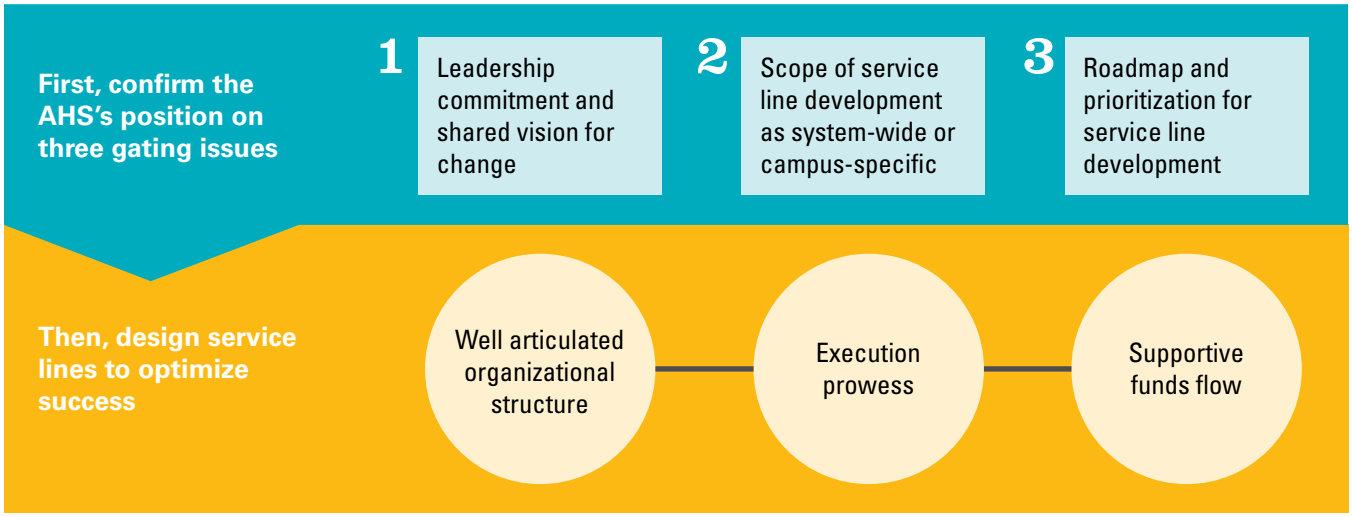
Executive Summary

An integrated service line organizes multidisciplinary services across the care continuum to serve a defined patient cohort. This patient-centric structure improves patient experience, clinical outcomes and operating performance; facilitates cross-department coordination and clinical research; and promotes the expansion and integration of clinical areas that provide high-margin services in increasingly competitive markets.

The use of service lines to improve the patient experience is common by community-based health systems. Due primarily to the organization of clinical faculty into departments, however, they are less frequent amongst academic health systems (AHSs). We propose AHSs start by addressing three gating issues and then design service lines to meet organizational structure, operational execution, and funds flow success factors.



The three gating issues that AHSs must address in considering the implementation of service lines are (1) ensuring leadership commitment at the highest levels and a shared vision for change; (2) determining whether the initial scope of the service lines will be systemwide or campus-specific; and (3) mapping the order in which to implement the service lines.

Achieving service line goals requires an organizational structure with well-articulated roles and responsibilities. This includes a governance structure with an executive council that brings together the key players to work with and support the designated service line leaders. These leaders must include a highly engaged administrative and clinical leadership team that is empowered to work collaboratively together. Operational committees round out the structure with defined roles that provide the focus for continuous self-evaluation and improvement.

Effective operational execution is also a requirement. Successful implementation is a multiyear effort requiring extensive communication and engagement throughout. Early operational steps include building consensus on success metrics, defining the patient cohort and identifying physician members. Dedicated resources, such as decision support, network development, business planning and marketing, are needed.

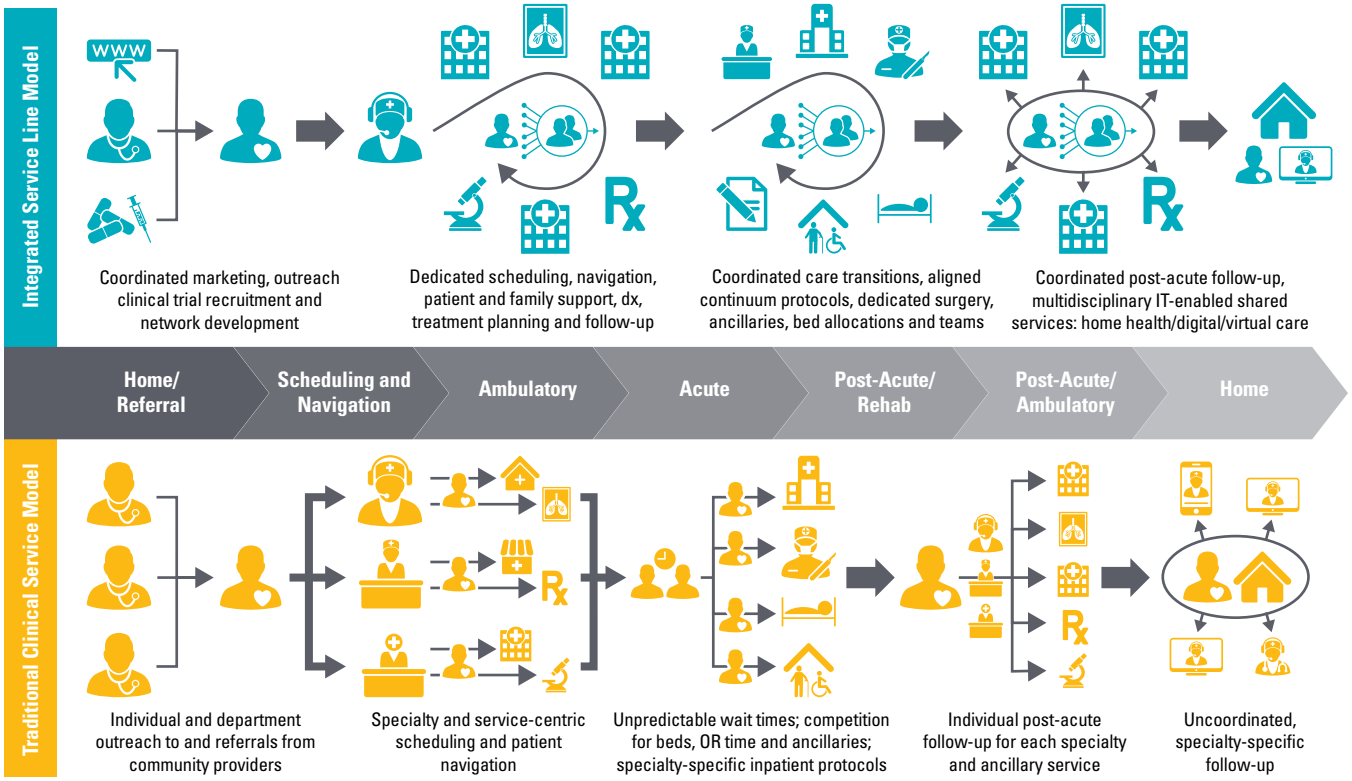
Building funds flow mechanisms that support the organization's objectives is the third requirement for successfully realizing the service line promise. Engaging department chairs, clinical faculty, and administrative leaders in collaborating on new funds flow mechanisms is critical to success. Building an operational or virtual profit and loss (P&L) statement that is integrated across entities and participating services enables a shared understanding of the service line's financial performance, which is foundational for identifying the required investments for growth and establishing the incentive structures for sharing in that growth.

What Is an Integrated Service Line, and Why Is It Important?

An integrated service line is the coordinated effort of organizing **multidisciplinary services**—by health condition, organ system, age or gender—across the **care continuum to serve a defined patient cohort**. Some examples are service lines devoted to cancer, neuroscience, children or women. In other words, an integrated service line is a well-organized model that promotes care coordination among all the specialties required to treat patients in the specified cohort. This structure provides a more **patient-centric approach** while improving clinical outcomes and efficiencies, facilitating clinical research, and promoting the expansion and integration of high-margin clinical services in an increasingly competitive market. Service lines also facilitate cross-departmental coordination by vesting service line leaders with **accountability and responsibility for optimizing clinical services** and nonclinical operations.

The figure below illustrates a patient-centered journey within an integrated service line compared with the fragmented patient experience in a traditional, departmentally focused model, in which scheduling for primary and specialty consults and imaging, laboratory, and acute and post-acute care services is departmentally-based and appointments typically are based on days and times that are convenient for the provider or facility. In contrast, the clinical team in an integrated service line map out a patient's journey and develop a plan to coordinate and schedule services across the entire continuum, in a sequence that is most clinically appropriate and convenient for the patient and their family.

Mapping the Patient Journey



AHSs have long grappled with the challenge of delivering patient-centric and coordinated care across multiple subspecialists. Service lines can be a highly effective tool in tackling these challenges while keeping the focus on high-quality care and outcomes. This level of coordination requires bringing together the full spectrum of caregivers' capabilities and expertise to organize services seamlessly for the benefit of patients. The value of designing and implementing service lines was documented in the 2004 Institute of Medicine (IOM) report, "Academic Health Centers Leading Change in the 21st Century," as well as in subsequent papers.[1]

> "AHCs should work across disciplines and, where appropriate, across settings of care in their communities to develop organizational structures and team approaches designed to improve health. Such approaches should be incorporated into clinical education to teach health-oriented processes of care." — Recommendation #3, Academic Health Centers Leading Change in the 21st Century

[1] "Academic Health Centers Leading Change in the 21st Century," Institute of Medicine, 2004; Baghai, Levine and Sutaria, "Service-line strategies for US hospitals," *The McKinsey Quarterly*, July 2008; "Service Lines Put the Patient First," *Managed Care Partners*, a Johns Hopkins Medicine publication for managed care organizations, Summer 2017.

Despite this call to action by the IOM almost 20 years ago, AHSs have been slow to realize the potential for multi-disciplinary clinical organization. Progressive advances in capability by community-based health systems, however, have raised the stakes. The AHSs' traditional high-margin services have become increasingly price and service competitive as community health systems deliver more advanced tertiary and quaternary services and focus intensely on patient experience. For AHSs to compete successfully, delivering integrated services has become essential. Integrated clinical program development in turn bolsters and complements the education, research and community service missions of the AHS. In short, integrated service lines are a key strategic tool AHSs can use to fulfill their missions. What follows are gating issues and best practices for achieving integration through organizational design, operational execution, and funds flow mechanisms.

Gating Issues for Service Line Implementation

Before implementation of specific service lines can begin, AHSs must address three gating issues:

1. Confirming leadership commitment at the highest levels and a shared vision for change
2. Defining the scope of service line development efforts as systemwide or campus-specific
3. Deciding which integrated service lines to develop and in what order

The first gating issue requires confirming the commitment of leaders at the board, C-suite and dean levels to deliver care through integrated service lines. Implementing this model will require the refinement of existing structures and incentive systems. As with any major organizational change, there will be champions and detractors. Thus, early on and continuously throughout implementation, medical center, health system, practice plan and medical school leaders must clearly articulate how their integrated service line vision supports the shared organizational goals. For many AHSs, these goals include market growth and expanding services to meet patients' needs. For others, the primary strategic goals may be extending their brand and ensuring consistently high-quality services across their systems.

Organizational commitment includes a shared vision that:

- Captures the benefits of delivering truly integrated care
- Promotes a high-productivity and high-growth model
- Maintains the responsibilities and accountabilities of the academic departments
- Attracts physicians and staff to a more coordinated care model
- Engenders engagement and support for a collaborative, trusting culture

The second gating issue requires determining whether the AHSs' service lines will be systemwide or campus specific. While the long-term goal for most AHSs will be to create systemwide service lines, many AHSs have started with their flagship medical center campus and then expanded to the broader health system over time, to manage the pace of change and integration of clinical faculty and community-based physicians. The benefits of systemwide service lines include a focus on the patient journey across all care settings and systemwide clinical leadership to ensure a consistently high-quality patient experience. Further, systemwide service lines facilitate consistency in physician practices and care protocols across a network—disseminating evidence-based clinical protocols to a larger array of patients—and consequently improve health outcomes more broadly.

The third gating issue requires deciding the order in which service lines will be implemented. The criteria for making this decision can include factors such as experience of the faculty and administration, the AHS's level of expertise and distinction relative to others in the market, and organizational readiness to collaborate across disciplines. Those areas in which the AHS is uniquely positioned to lead based on its strengths should take precedence. This is especially true with respect to foundational and complex services, such as cancer treatment, transplant, cardiovascular services, neuroscience and musculoskeletal care, where innovation, clinical research and translational research distinguish the AHS from other hospitals and health systems.

Having prioritized which service lines will be implemented first, leaders should focus on three areas to ensure successful implementation:

1. Organizational design, leadership, and governance
2. Operational execution
3. Funds flow

This report outlines considerations and recommendations in each of these areas.

Example AHS: Gating Issues (Detailed n Appendix)

University of Chicago Medicine
Response to Gating Issues

- Secured a deep commitment amongst senior leaders that service line development is a core component of its vision and strategy
- Committed to pursuing system service lines across its academic medical center and community hospital sites
- Identified cancer, heart and vascular, neuroscience, solid organ transplant, musculoskeletal and digestive diseases as service line priorities while recognizing that they are evolving at differing paces based on market opportunity and system needs

Service Line Implementation Key Questions

The questions AHS leaders should consider in implementing service lines include:

- How should service lines be structured? What is the most effective relationship between service lines and clinical departments that will strengthen the entire system?
- What is the scope of authority, accountability, and responsibility for the service lines? Should a service line be implemented across the health system or be site-specific?
- What is a realistic implementation timeline for setting up a service line? What functions are of the highest priority to develop at the service line level or with dedicated resources?
- Which metrics and incentives should be employed for optimal service line results? How should the hospital/health system and departments/faculty practice/school of medicine share in the profits resulting from any improvements?
- How can funds flow tools support strategic investment in service line development?

Organizational Design, Leadership and Governance

A well-considered and inclusive design avoids or minimizes tension with medical school departments regarding accountability and authority. Clinical chairs may perceive service line development as a reduction in their authority over key aspects of the clinical practice. However, strong service lines and strong departments are not mutually exclusive—indeed, they have proved to be mutually reinforcing, as the case studies in this report illustrate.

We have found that successfully implemented AHS service lines feature the following:

1. **A governance structure with an executive council that will work with and support the service line leaders.** This executive council must be the arbiter of the program strategy, to mitigate individuals going around service line leadership to seek alternative answers from hospital or department leaders. The service line governance structure should include:
   - An active and engaged executive council with senior leadership, including the health system/hospital senior leaders and academic leaders as well as representatives of involved departments and system functional areas
   - Regular and formal executive council meetings that keep all parties abreast of developments, provide a venue for leadership input and issue resolution, and support constructive communication
   - A cadence—at least quarterly—of reviewing transparent, understood, and trusted data on the metrics of service line performance
   - Consistent and frequent communication from senior leaders affirming the direction for the often-challenging work of reorienting care around service lines

2. **A highly engaged administrative and clinical leadership dyad.** To evolve service lines in an integrated model, AHSs need to recruit and appoint tenacious clinical and administrative leaders, recognizing that the skills required for service line development are different than those needed for a traditional physician practice or hospital operational leadership.

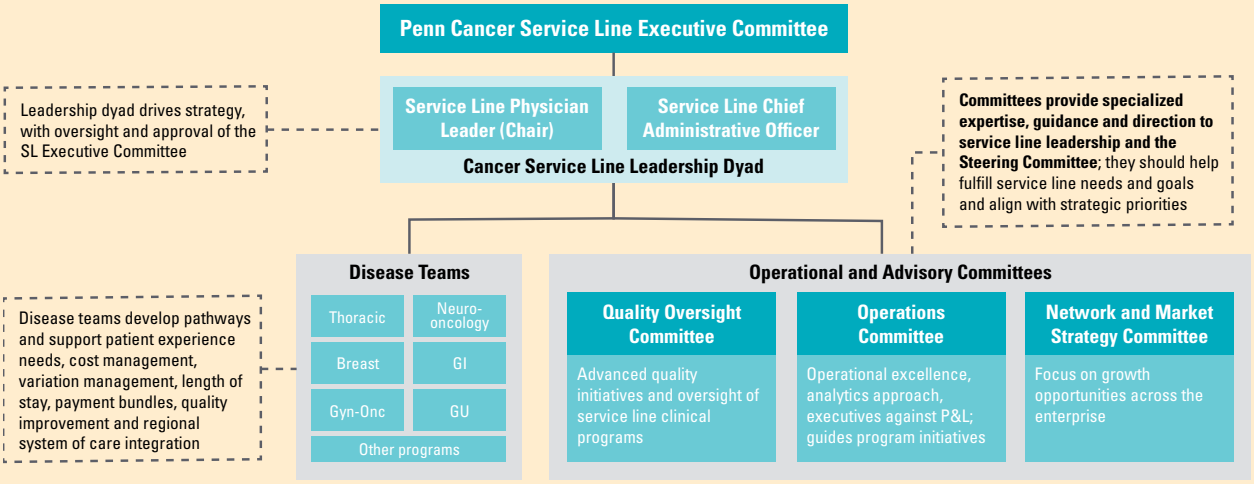
Required Attributes of a Service Line Physician Leader	Required Attributes of a Service Line Administrative Leader
• A strong track record as a high-performing clinician at a leading academic center • Leadership experience in clinical operations and patient experience transformation • Significant leadership, mediation and negotiation skills in matrixed programs (i.e., the ability to achieve goals without direct positional authority for all functions) • Positive energy and relational leadership to navigate matrixed decision-making structures and build high-performing multidisciplinary teams • The ability to rank competing priorities, translate them into clear and concise strategies, and execute those strategies	• Significant clinical operations management experience (suggest a minimum of five to seven years) • Leadership experience in clinical operations and patient experience transformation • Influence, mediation and negotiation skills in matrixed programs • Positive energy and relational leadership to navigate matrixed decision-making structures and build high-performing multidisciplinary teams • The ability to rank competing priorities, translate them into clear and concise strategies, and execute those strategies • Excellent financial management skills

3. **Clarity of roles between service lines and clinical departments.** To minimize internal competition, some AHS have chosen to have department chairs or division chiefs serve as service line physician leader. Under any structure, faculty continue to report to their department, with matrixed reporting to the service line for its activities, and department leaders are included in the service line governance as described above. Service line leaders need to build highly collaborative working relationships with the department chairs across all service line functions, but especially with respect to physician recruitment and management.

Example AHS: Organization Structure (Detailed in Appendix)

Penn Medicine service line structure is shown in the figure below.[2]

Illustrative Service Line Organizational Structure



Penn Medicine approach to organizational design:

- Before implementing service lines, System leadership made clear that academic departments were not being replaced by service lines. Faculty recruitment, Clinical Department budget accountability, broad oversight of quality, etc., remain purview of the Chair/Department.
- For service lines other than the cancer service line, where there was an established physician head of the NCI-designated Cancer Center, a clinical chair or chief was named as initial physician leader to minimize potential conflict between the academic department and the service line.

4. **Accountability for key service line functions that makes clear who is ultimately responsible and makes the final decisions.** Encouraging an open and inclusive dialogue while working through these issues will foster transparency and build trust. An illustrative example of accountability, authority and responsibility for a solid organ transplantation service line is shown below, adapted from the University of Maryland Medical Center and School of Medicine Program in Transplantation.
   - Including nursing in the service line leadership team is essential in order to achieve the integrated care delivery goals of the service line.
   - Finance and decision support teams need to provide dedicated support to the service line to ensure timely, consistent and transparent reporting to all stakeholders.

[2] Interview with Beth Johnston, Executive Director, Clinical Practices, University of Pennsylvania Health System.

Sample Service Line Authority, Accountability, and Responsibility Grid
Adapted from Program in Transplantation, University of Maryland Medical Center and School of Medicine

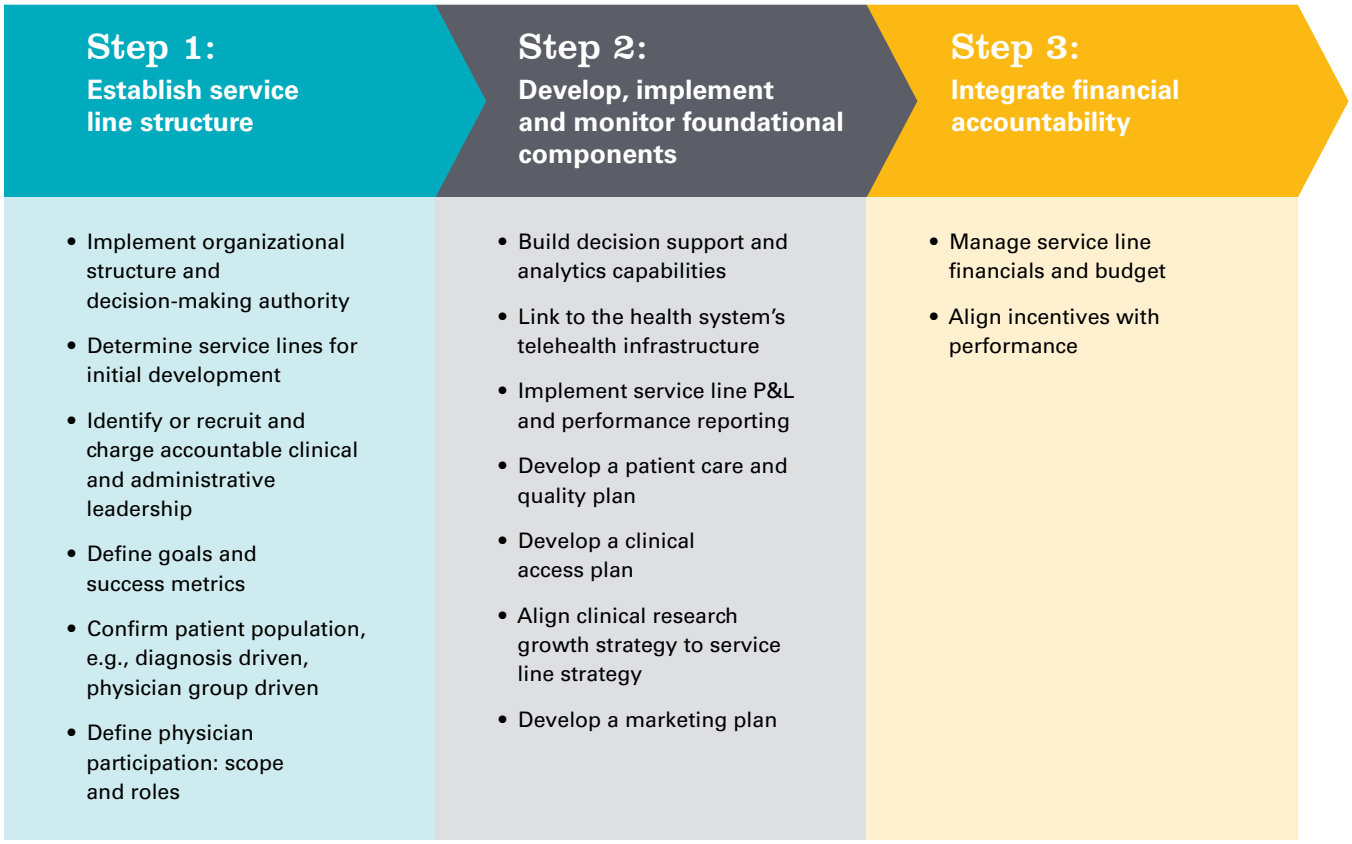
Category	Function	Executive Committee	Service Line Director (Clinical)	Service Line VP (Administrative)	Department Chairs	Medical Center Leadership	School Leadership
Strategy and Financial	**Strategic Planning and Goal Setting**	Review and Endorse	Develop	Develop	Review and Endorse	Advise	Advise
	Budgeting and Financial Management	Review and Endorse	Advise	Develop	Review and Endorse	Approve	Approve
	Funds Flow	Review	Develop	Manage	Review/ Advise/ Approve Reallocation	Design and Approve	Review
	Fundraising	Review	Recommend/ Manage	Not Engaged	Approve	Through Executive Committee	Through Executive Committee
Clinical Operations	**Clinical Teams**	Review	Accountable	Manage	Advise	Review	Review
	Site-Specific Operations	Review	Manage	Manage	Advise	Manage	Not Engaged
	Quality and Regulatory Oversight	Review	Accountable	Manage	Review/ Approve	Review	Not Engaged
	Service Line Care Model	Approve	Co-Design	Co-Design	Review/ Advise	Review	Review
Physician Membership and Academic Operations	**Physician Recruitment**	Review	Recommend	Recommend	Approve	Advise	Approve
	Personnel Hiring	Review	Advise	Recommend	Advise	Approve	Advise
	Service Line Physician Incentives	Review	Recommend	Review	Design/ Approve	Approve	Review
	Research	Review	Advise	Not Engaged	Manage	Review	Review
	Education	Review	Advise	Not Engaged	Manage	Not Engaged	Review

Operational Execution

Maturation of a fully integrated service line is a multiyear process, and leaders should establish realistic timelines and milestones. During this journey, continued open communication and stakeholder engagement are critical.

The following figure illustrates the path through which an integrated service line can be successfully phased in.

Illustrative Integrated Service Line Development Phases



Service line goals and success metrics should be defined to facilitate operational focus and align the service line team on priorities. The metrics should focus on the AHS's strategic priorities and may include quality, outcomes, access, patient experience and clinician experience, in addition to financial performance and market position. As the service line team embarks on its implementation journey, leaders should revisit these metrics at regular intervals, at least quarterly.

Setting meaningful goals and organizing service line activities begins with confirming the included patient cohort. Pulling data on historical patients served by the clinical services that will be incorporated into the service line provides a starting point for defining the scope. For example, for a heart and vascular service line, patient definitions might be created by combining diagnosis-related group (DRG) and current procedural terminology (CPT) code data for the cardiology, vascular and cardiac surgery services. A team of clinical leaders should review these datasets to confirm appropriate inclusion and exclusion criteria.

Service line leaders should also identify populations the health system is not currently serving. At this juncture, it is critical to ask questions regarding access, health equity challenges and unmet community needs. Once a target cohort of current and potential patients has been identified, the collected data should be carefully reviewed and confirmed with the relevant clinical teams to build consensus on the target population. After this initial consultative process, a mechanism must be established for ongoing assessment and reporting of patient needs, as well as service line growth and market potential.

Early in the implementation, the leaders should identify the physicians and staff who will be part of the service line, clearly articulating physician membership or participation criteria, responsibilities and benefits to ensure accountability. Physician membership criteria typically require that physicians devote a significant portion of their time (usually a minimum of 25% or 50%) to the service line specialty area and that they have an affinity for and interest in developing and growing service line clinical programs to meet patients' needs.

In step 2 of operational execution, service line leaders need to establish dedicated resources to support execution, such as decision support, network development, business planning, marketing and digital health. The individuals dedicated to the service line for these support services may continue to report to their functional departments, but they should also be accountable to their respective service lines.

We recommend starting with decision support capabilities. It generally takes a significant investment of time and effort to educate clinicians and all stakeholders on budgeting and financial metrics and creating a shared understanding of both current-state and future goals. Robust data analytics capabilities supported by clear reports for quality, access, patient experience and financial (both hospital and faculty practice) performance is required. Widespread transparency will also build trust in the analytics. The potentially tedious work of accurately mapping every admission and procedure to a service, to ensure no double counting, and consistent reporting are essential to garner the confidence and trust of clinicians. This work is also foundational to supporting the service line team in network development, business planning and marketing. Accurate business planning to serve more patients is not possible without an accurate understanding of the starting point.

Service line development should also include health equity metrics as a foundational component of service line dashboards. As the country grapples with a pandemic that

Example AHS: Operational Execution (Detailed in Appendix)

Johns Hopkins Medicine Lessons Learned in Operational Execution

- Retain focus on the patient and how they navigate a complex system
- Establish the systems and infrastructure to support service lines to accelerate development including decision support and analytics and legal and financial structures

has disproportionately impacted communities of color, AHSs are examining opportunities to intentionally promote equity across their clinical, research, and education missions, implement antiracist policies, and bring science to bear in eliminating health disparities in access to and outcomes of care.[3] Beyond dashboards, clinical pathways should be evaluated for race-based biases and include screening to assess unmet social needs and identify mechanisms to link individuals to community resources as needed.

As outlined in the 2021 AAMC Report prepared in consultation with Manatt Health, "Sustaining Telehealth Success: Integration Imperatives and Best Practices for Advancing Telehealth in Academic Health Systems," telehealth is a critical imperative for high quality care delivery today. While many AHSs have stand-alone telehealth operations, they are increasingly integrating telehealth capabilities into their clinical service lines. High volume telehealth programs embed individuals from the telehealth group in clinical departments and service lines. For example, Ochsner Health's (Ochsner) telehealth group has ten associate program managers (APMs) who report through the telehealth organization but are embedded in Ochsner's service lines and centers of excellence to support program implementation and telehealth operations. Ochsner APMs are responsible for developing, implementing, marketing, and managing telehealth programs and services at the service-line level and also help individual sites define their own telehealth strategies.[4]

Funds Flow

AHSs are governed by complex and often opaque funds flow arrangements between the hospital/health systems and their schools of medicine/clinical departments. These funds flow arrangements should be viewed as investments that fuel joint strategic priorities, including integrated service line development.[5] While funds flow arrangements vary widely across organizations, funds often flow through academic departments to compensate faculty effort and provide support for all AHS missions. Seeking to establish integrated service lines as part of the institution's strategic goals and prioritizing their funding can create tension with department leaders who may view this new direction as a loss of financial control. To address these concerns and align all stakeholders across the enterprise, leaders should follow service line funds flow best practices, which include building an integrated profit and loss (P&L) view of the financial position of each service line and providing adequate investment in the service lines to realize their objectives.

[3] Newman, Naomi, et al. "On the Path to Health Justice: How Academic Medicine Can Accelerate an Equitable Health System." Manatt Health, July 2021, https://www.manatt.com/Manatt/media/Documents/Articles/AMC-Health-Equity-Paper,-Framework-and-Case-Studies-July-2021_c.pdf.

[4] Augenstein, J., Enders, T., et al. "Sustaining Telehealth Success: Integration Imperatives and Best Practices for Advancing Telehealth in Academic Health Systems." AAMC – Manatt Health, July 2021, https://store.aamc.org/sustaining-telehealth-success-integration-imperatives-and-best-practices-for-advancing-telehealth-in-academic-health-systems.html.

[5] Orlowski, J., Enders, T., et al. "Next-Generation Funds Flow Models - Enhancing Academic Health System Alignment." AAMC – Manatt Health, October 2018, https://store.aamc.org/next-generation-funds-flow-models-enhancing-academic-health-system-alignment-future-of-academic-medicine-series.html.

The first step in establishing the funds flow arrangement of an integrated service line is creating a P&L statement that provides an integrated view of the revenues and costs across the health system and the faculty practices that contribute to the service line. Depending on the corporate structure of the entities and their level of integration, service line P&Ls could be operational (i.e., used in day-to-day financial management and reporting) or virtual (i.e., used for reporting and planning purposes).

We recommend the following steps in creating this P&L statement:

1. Convene a working team of financial leaders from across the hospital, the participating clinical departments, the school of medicine and the faculty practice plan.
2. Define the patient cohorts the service line will serve (as outlined above).
3. Gather P&L statements from all entities that serve the service line patient cohort.
4. Review these financial statements with the team to standardize data definitions for cases, encounters, revenues, assessments, and direct and indirect expenses.
5. Codify assumptions on how to allocate physician activity that is dedicated to the service line as opposed to other clinical efforts.
6. Determine revenue or expense categories that should be eliminated in the integrated virtual P&L to avoid double counting (e.g., funds that flow from the hospital might be revenue to a practice or college and thus should not be included in the service line P&L).
7. Set growth goals and project the financial benefits expected to accrue as the result of upfront investments in the service line (see discussion below). Determine opportunities for cost reduction through improved efficiencies from coordination and integration.
8. In alignment with general funds flow principles, medical school and health system compensation policies, create service line and faculty incentive funds that will be available for distribution when service line goals are achieved. Design of these incentive models should always be carefully considered in the context of the Anti-Kickback Statute and the Stark Law.
9. Collaborate with service line leaders to regularly review financial results and, as needed, implement operational interventions.
10. Communicate financial results with the service line's executive council at regularly established intervals.

Successful service line implementation typically includes two types of investments: enterprise base commitments and strategic funds flow investments, which should be aligned to overall funds flow rules and designed collaboratively with department chairs. Enterprise base commitments compensate physicians for their time in providing above-and-beyond services, such as taking on a medical directorship, clinical rounding, call coverage, etc. For example, if various medical directorships in a service line have different clinical and regulatory demands, the AHS and medical school may want to establish different levels of medical director compensation. The physicians serving in these roles (and their compensation) would be reviewed annually to ensure they continue to meet the service line's goals.

Strategic funds flow investments create a "shared risk, shared reward" culture of collaboration across the AHS. They are used to fund faculty recruits, performance incentives, and academic, research and clinical programs. Although strategic funds are time limited, they typically require applicants to submit a plan for how the funded program or initiative will be sustained over the long term via the service line's regular budget. For example, a transplant service line may have a business need to revamp its wait list management processes and may require an investment in medical transplant specialists. The service line would need to support its request for special funding with projections on how it will continue to fund these specialists' salaries beyond the initial investment period.

Example AHS: Funds Flow (Detailed in Appendix)

Yale New Haven Health Funds Flow Lessons Learned

- Incentivize outcomes, experience, program development, and productivity
- Agreement on and satisfaction with funds flow requires an investment in transparent systems to monitor and report performance

Conclusion

Through careful, deliberate organizational design and operational execution, integrated service lines can and should be an important component of an AHS's organizational development strategy. AHSs and dedicated service line leaders should recognize that this critical work is a multiyear process and that service lines will evolve at different paces depending on an organization's strategies, needs and leadership capabilities. Service line development is an evolution, not a revolution.

Appendix: Case Studies

University of Chicago Medicine

The University of Chicago Medicine identified signature program development and growth in cancer, heart and vascular, neuroscience, solid organ transplant, musculoskeletal, and digestive diseases as essential to fulfilling its strategic Vision 2025 plan: "Be an eminent academic health system by being at the forefront of discovery, advanced education, clinical innovation and the delivery of transformative health care."

Service lines play a key role in achieving UChicago Medicine's overall vision by elevating the quality of signature clinical programs that integrate the discovery and delivery of novel therapies into innovative clinical trials and training programs.

Service line objectives include:

- Facilitating growth in key strategic areas through seamless interactions among different specialties and disciplines and their respective academic departments.
- Focusing on the recruitment of high-quality faculty with broad impact across the clinical enterprise.
- Investing in key strategic areas of differentiation to increase market share.
- Integrating care delivery across the continuum, from initial contact in the ambulatory setting to inpatient evaluation and treatment to post-acute care and long-term follow-up and health maintenance.

Governance, Organization and Leadership

UChicago Medicine's executive leadership team, chaired by the Executive Vice President for Medical Affairs (vice president and dean), serves as the steering and oversight committee for the overall service line effort. While fulfilling this role, the leadership team is responsible for:

- Monitoring progress toward execution of the service line strategic plans; ensuring that volume, finance, quality and programmatic target metrics are met; and developing corrective plans when targets are missed.
- Ensuring strong communication among service lines, clinical departments and hospital departments/operations.
- Approving budgets, incentive payments and hiring plans and integrating them into the financial plans and budgets of the medical center, school of medicine and clinical departments.

Individual service line steering committees include the service line physician director and co-director (if applicable), an administrative director, and appropriate leaders in the hospital and faculty practice (school of medicine dean, health system president, health system chief operating officer and chief strategy officer), as well as clinical department chairs whose departments play a major role in a service line.

What UChicago Medicine Got Right

- A deep organizational commitment to service line development as a core component of its vision and strategic plan.
- Becoming progressively more metrics-oriented by developing dashboards for key performance metrics including patient experience and access, quality, financial performance, and value-based care, where applicable; trusted data has been particularly important in evaluating incentive structures.

Most Significant Challenges

- Accurately assessing operational and governance readiness throughout the process.
- Effectively managing stakeholder involvement with clear communication, given the many stakeholders across entities.

Key Lessons Learned

- Accept that service lines will mature and evolve at different paces, not necessarily all at once.
- Successful execution requires patience and flexibility.

Penn Medicine

Penn Medicine was an early adopter of integrated service lines, and its primary service lines include cancer, heart and vascular, neuroscience, musculoskeletal, and digestive diseases. The initial objectives for the service lines were to (1) improve market position and grow; (2) improve operational execution, particularly in relation to access and patient and physician experience; and (3) achieve program integration across service sites and the continuum of care.

The service lines are charged with the following:

- Leverage integrated care teams to focus on patient cohorts, improving clinical outcomes and overall patient experience.
- Work across entities/geographies, related specialties and physician employment models (i.e., faculty, employed physicians and independent medical staff).
- Reduce unnecessary variations in practice.
- Manage bundled services (a single payment to hospitals, doctors, post-acute providers, and other providers for a defined episode of care) for success under new payment models.
- Grow market share.
- Grow margins by serving more patients and managing costs.

Governance, Organization and Leadership

Each service line has an executive committee and three subcommittees to drive service line development: a quality subcommittee, an operations subcommittee, and a network and market strategy subcommittee.

The Penn Medicine service line leadership team includes a physician lead and an experienced administrator with disease-specific strategy and operations experience. Penn chose not to use co-chairs to maintain clear accountabilities.

Quality directors support the clinical leadership teams (disease-team physician and nurse leaders), which develop pathways and support patient experience needs, access, cost management, variation management, length of stay, payment bundles, quality improvement and regional system of care integration.

Operational Execution

Marketing, decision support, IT and other dedicated personnel provide key support services to the service lines while continuing to report to their respective departments.

Service line leaders decide together how to assign patients to service lines, based on DRG, ICD classification, and best fit for program alignment; for example, whether a patient with glioblastoma should be assigned to the cancer or neuroscience service line.

Funds Flow

Service lines are supported by baseline funds flow for infrastructure support and are incentivized based on contribution margin, quality, cost and efficiency.

The service line incentive structure is designed to align the various stakeholder departments with institutional goals (e.g., quality, operating efficiencies, cost management). At the start of each fiscal year, the SL Executive Committee approves a distribution methodology for any incentives earned in the upcoming year. The methodology defines the split between SL and the participating clinical Departments, with the lion's share being returned to the Departments. The Chairs determine the use of the Department incentive dollars. The SL leadership determines use of SL incentive dollars; generally, incentives are used to fund time-limited and/or proof-of-concept investments that further goals of the SL (e.g., nurse navigator to improve rate of discharges to home).

What Penn Got Right

- Held numerous discussions about the integrity of the academic departments and their continuing accountabilities and authority. Named an existing de facto leader or a chair/chief of an existing clinical department—a choice that enabled any potential conflicts between the service lines and the departments to be resolved internally.
- Built trust and transparency into the analytics. Performed the upfront tedious work of mapping every admission and procedure to a service line to ensure accurate and consistent reporting.
- Used service lines to drive critical work (e.g., performance under value-based contracts, solving critical quality issues, increasing market share, improving financial performance, improving externally reported ratings).
- Developed financial incentives that aligned departments, service lines and the health system.
- Had a mature funds flow model that easily accommodated service lines.

Most Significant Challenges

- Different physician cultures at different Penn hospitals made building consensus difficult and time-consuming.

Key Lessons Learned

- It takes approximately two years for a service line to get its sea legs—where disease teams begin to take ownership—and three to four years for sustained culture change.
- Don't "boil the ocean." Start small and achieve results with a couple of disease teams and/or quality goals (e.g., increased new patient visits, reduced readmissions).
- Understand that not everyone will be on board at the beginning and invest in change management resources.

Johns Hopkins Medicine

Integrated system service line development is a core component of Johns Hopkins Medicine's (JHM) clinical road map for growth and system evolution. Maryland's unique global budget revenue methodology—which prospectively sets hospital budgets and incentivizes hospitals to manage volume and meet budget targets—historically deterred growth and led JHM to shift its focus to expanding services in the National Capital Region, where it already had a presence. JHM is currently prioritizing the following service lines: heart and vascular, cancer, transplant, and transgender health.

The service lines were designed to provide a more integrated patient experience, clinical efficiencies, improved performance and growth. They also have provided an effective forum and mechanism for the development of bundled payment arrangements with payers.

Governance, Organization and Leadership

Service line leaders share accountability and responsibility for optimizing clinical services and managing capital and operational budgets. JHM established a formal governance and legal structure with defined charters to support the service lines. Decision rights are clearly articulated in each service line's charter. The organizational model takes into account the broad spectrum of stakeholders required to ensure a collaborative and all-inclusive planning effort and ensures that strategies and tactics derived from this process and their related budgets are tied to performance measures and outcomes.

What JHM Got Right

- Developed new legal and financial structures and models to support service lines and break down organizational silos
- Focused on the enabling functions and infrastructure to support success

Most Significant Challenges

- Taking the time to attribute patients to each service line and using that data to allocate revenues and expenses
- Reaching agreement on how to value the various contributions of specific individuals or departments to each service line when developing funds flow arrangements

Key Lessons Learned

- Focus on the patients and make it easier for them to access and navigate the system
- Establish the systems and infrastructure (e.g., legal and financial structures, decision support and analytics) to support the service lines and expedite their maturation

Yale New Haven Health

Governance, Organization and Leadership

The Yale New Haven Health service lines each have an executive committee composed of the medical and surgical directors of each program, the hospital and school of medicine finance leads, nursing leaders for the dedicated inpatient and outpatient units, and a quality/outcomes/patient experience manager. Each executive committee meets quarterly.

Each service line has a vice president executive director and a medical/surgical director who, along with the related nursing director, constitute the service line operations group that meets weekly or biweekly.

A senior-level vice president supports all service lines, working with the finance leads from the hospital and medical school or principal department, and is responsible for producing the combined service line virtual P&L, managing funds flow agreements and ensuring consistency in new service business plans.

Funds Flow

Funds flow includes a plan to incentivize superior outcomes, a quality patient experience, program development and work RVU (relative value unit) productivity. The funds flow dollars are paid through the school of medicine departments that employ the participating faculty.

What Yale New Haven Health Got Right

- Having a senior-level executive oversee all service lines to drive the funds flow and financial reporting.
- Engaging community and health system physicians outside of the Yale faculty to be a part of the development of service line goals and capabilities when this has been most appropriate to help grow and mature the model.
- Investing in systems to monitor outcomes and operating performance, as well as increased volume and contribution margins.

Most Significant Challenges

- Getting the department chairs to buy into the service line concept.
- Identifying effective physician leaders who can navigate complex matrix structures.
- Finding a pathway to service line membership or participation for hospital-based department chairs and members and referring physicians and establishing suitable academic appointment tracks for network physicians participating in the service lines.

Key Lessons Learned

- Keep the incentive plan targets as reasonable stretch goals.
- Ensure that the marketing department embraces and provides resources for the service lines.
- Maintain dedicated pods of access representatives who are familiar with the service line programs and providers in order to ensure access to services.

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