Progressive Organizational Structures
Shaping Service Lines to Span Health Care’s New Demands
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For acknowledgment of the industry leaders who contributed their expertise to this report, please see page 27.

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Executive Summary

**Progressive Organizational Structures**

Shaping Service Lines to Span Health Care’s New Demands

Major shifts in the locus of care delivery as well as payment and physician alignment have opened a deep crevasse under health care’s traditional organizational models. A discharge-driven, overly hierarchical modus operandi will not suffice much longer. What will take its place is largely a work in progress. But the structure that emerges must be founded in sound components and adhere to tried and true design rules to withstand the weight of the industry’s challenging new economics.

A management matrix likely will be the necessary superstructure for organizations to effectively compete in this age of multiregional health systems and full-continuum strategy. Service lines will remain key, but only if they evolve to support a clinical product focused heavily on ambulatory care, unify a portfolio of services and partnerships across far-flung geographies, and optimally manage the health of entire populations.

This evolution will not happen by chance. It can only result from methodical planning with two chief aims: engineering strong frameworks and imbuing a set of competencies into leadership throughout the organization. *Progressive Organizational Structures: Shaping Service Lines to Span Health Care’s New Demands* details elements in both areas, laying out three frameworks and six competencies already being pursued by leading organizations. It also applies a set of rules, adapted from well-accepted business principles, to underscore how the pieces ultimately fit together to create well-designed health care systems. Examples from leading organizations provide further insight into progressive restructuring efforts.

With this guidance, executives should be able to put aside their long-standing organizational charts. They’ll then be ready to consider afresh if their systems are set up to achieve their strategic goals and if they have the leadership talent to steer them there.

### Service Line Trends

- Once focused externally and used largely as a marketing tool, today’s service lines now have gained favor for their clinical and operational advantages.
- Those implementing service lines no longer do so strictly for volume or revenue growth.
- Quality-driven goals include: patient-centered care, better care coordination and successful population health management.

### Essential Frameworks

- Extend across the continuum.
- Regionalize planning and control.
- Position to manage broad populations.

### Strategies for Restructuring Service Lines

### Key Competencies

- Optimize the service line leadership model.
- Tailor approach to physician alignment strategy
- Rethink incentive compensation.
- Hardwire analytics to better inform strategy and operations.
- Build in flexibility.
- Tame the matrix to avoid overhead cost spiral.
New Health Care Marketplace Requires Innovative Organizational Design

Before a health system considers how to deploy or update its service line model, it is important that it evaluates its organization’s overall design or superstructure.

Moving From Hospital Inc to Health Company Inc

For the past two decades or more, health systems have operated largely as hospital companies. Although a variety of matrix and divisional models have evolved over time, most organizational structures have served to support and perpetuate the hospital focus of the enterprise. That basic design must be transformed, however, for systems to flourish under new payment models and provide appropriate focus to patient needs in an ambulatory health care marketplace.

Set of Rules Can Help Guide the Transformation

Depending on how a system operates today, it may need a minor update, a substantial overhaul or a combination of the two. Any design must be responsive to local market conditions, hospital-physician relationships, patient needs and institutional culture. Following a handful of rules can help executives build the right structure while avoiding potential pitfalls that often confront matrix organizations.

Rules for the Well-Designed Health System*

Moving forward, effective organizational structures must:

1. Focus the organization around patient needs.
2. Adequately emphasize ambulatory and physician services.
3. Provide or exploit the organization’s prime competitive advantage(s).
4. Enable the corporate office to truly support the entire health system.
5. Mobilize the strengths and weaknesses of the management team.
6. Be feasible given the current market or organizational situation.
7. Reflect or preserve parts of the health system that have or require unique cultures.
8. Enhance linkages and minimize unit-to-unit conflict across the health system.
9. Guard against excessive layers or reporting levels.
10. Instill accountability for health system clinical, financial and strategic goals.
11. Sufficiently evolve or flex over time in response to new challenges and opportunities.

Service Line Model Must Evolve

Under this organizational superstructure, service lines must be transformed to effectively span and support the clinical product and meet patient needs. The same design rules apply and can be enforced through a series of essential frameworks and organizational competencies.

Service Line Structure Has Staying Power

Service line models, although not new to health care, have gained considerable traction in the past decade. In a recent Sg2 survey, approximately three-quarters of respondents now report using clinical service lines, with the majority including hospital-based outpatient (OP) services within this structure. For some, multiple service lines are fully mature; others are moving slowly from a departmental structure to explore the model for a single clinical area. The industry’s new ambulatory care locus makes service lines even more essential for putting the right clinical product into the marketplace and managing the business more efficiently and consistently.

Sg2 Provider Survey: Criteria Used to Designate a Clinical Area as a Service Line

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volumes</td>
<td>84%</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>76%</td>
</tr>
<tr>
<td>Market Share</td>
<td>68%</td>
</tr>
<tr>
<td>Revenue</td>
<td>64%</td>
</tr>
<tr>
<td>Have the Physician Resources</td>
<td>64%</td>
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<tr>
<td>Supports Our Mission</td>
<td>60%</td>
</tr>
<tr>
<td>Meets a Community Need</td>
<td>56%</td>
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<tr>
<td>Quality Standards Met or Exceeded</td>
<td>40%</td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
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</table>

Note: Survey respondents could choose more than one category.

New Frameworks and Competencies Will Be Key

With their focus on core diseases and conditions, service lines are an effective mechanism to oversee the operations, information and logistics required to deliver high-value, comprehensive services. Done right, they offer economies of scale and skill essential in the increasingly vertically, horizontally and virtually integrated world in which many provider systems now find themselves.

Going forward, effective service lines will extend their scope in three broad ways. They’ll also need to excel in six areas that position them to play by the rules set for well-designed systems.

Key Competencies

- Optimize the service line leadership model.
- Tailor approach to physician alignment strategy.
- Rethink incentive compensation.
- Hardwire analytics to better inform strategy and operations.
- Build in flexibility.
- Tame the matrix to avoid overhead cost spiral.
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<th>Regionalize Planning and Control (Pg 8)</th>
<th>Position to Manage Broad Populations (Pg 10)</th>
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<tr>
<td>1</td>
<td>Focus the organization around patient needs.</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>2</td>
<td>Adequately emphasize ambulatory and physician services.</td>
<td>✓</td>
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<td>3</td>
<td>Provide or exploit the organization’s prime competitive advantage(s).</td>
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<td>4</td>
<td>Enable the corporate office to truly support the entire health system.</td>
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<td>5</td>
<td>Mobilize the strengths and weaknesses of the management team.</td>
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<td>6</td>
<td>Be feasible given the current market or organizational situation.</td>
<td>✓</td>
<td>✓</td>
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<td>7</td>
<td>Reflect or preserve parts of the health system that have or require unique cultures.</td>
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<td>✓</td>
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<tr>
<td>8</td>
<td>Enhance linkages and minimize unit-to-unit conflict across the health system.</td>
<td>✓</td>
<td>✓</td>
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<td>9</td>
<td>Guard against excessive layers or reporting levels.</td>
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<td>10</td>
<td>Instill accountability for health system clinical, financial and strategic goals.</td>
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<td>✓</td>
</tr>
<tr>
<td>11</td>
<td>Sufficiently evolve or flex over time in response to new challenges and opportunities.</td>
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<td>✓</td>
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</table>
### Key Competencies

<table>
<thead>
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<th>Optimize the Service Line Leadership Model (Pg 12)</th>
<th>Tailor Approach to Physician Alignment Strategy (Pg 14)</th>
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<th>Build in Flexibility (Pg 18)</th>
<th>Tame the Matrix to Avoid Overhead Cost Spiral (Pg 20)</th>
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**Essential Framework**

**Extend Across the Continuum**

Service lines increasingly must reflect the full care continuum, extending beyond the hospital’s walls to an array of ambulatory services that constitute the typical patient journey for a given condition. A framework is necessary to consolidate authority (or at least influence) across community-based, acute and post-acute sites. Initial steps toward such a framework sometimes:

- Narrow the range of sites (services) included to those most consistently linked to a particular clinical specialty (e.g., cardiovascular [CV] service line including only cardiac rehab in its post-acute sector)
- Establish niche service lines for offerings beyond the acute enterprise (e.g., post-acute services, retail clinics)
- Retain separate profit and loss statements by site with the goal of ultimately consolidating, or at least monitoring, a virtual bottom line

### Advantages

- Creates a cohesive clinical product
- Enhances care continuity
- Minimizes system leakage
- Fosters operational efficiencies
- Improves clinical quality
- Responds to payment innovation
- Increases patient satisfaction

### Challenges

- Adds complexity to day-to-day management
- Difficult to implement across a wide portfolio of owned and nonowned sites
- Can create nonconstructive internal struggles for staff, capital or other resources
- Requires management approach that may be in short supply

### Success Factors

- Mature System of CARE with substantial ownership and strong physician loyalty
- More sophisticated accounting and measurement capabilities
- Careful consideration of reporting relationships within the organization
- Leadership capable of leveraging influence as well as having the authority to integrate owned/affiliated sites
Sample Organizational Chart

Executive Leadership

Clinical Care

Acute Care Operations

Ambulatory Care Operations

Post-Acute Care Operations

Medical Staff Organization

Service Line Leadership

(Highlighted units are under direct authority of service line leader)

Med/surg beds

Critical care

Emergency dept

Observation unit

Transitional care

Primary care

Case management

Transport services

Rehab services

Laboratory services

Cases management

Transport services

Rehab services

Laboratory services

Case Study: **Unity Health System, Rochester, NY**

**Background**

- Initiated service line structure in early 2012 with neurosciences and behavioral health
  - Considered a natural starting point for the service line concept since significant program development across the care continuum had already occurred
  - Developed an orthopedics service line in July and a cardiovascular one in October 2012; planning for women’s health
- Gave a system-level senior vice president (SVP) oversight for all service lines with responsibility for strategic and business plan development and implementation

**Approach**

- Initiated service line development process with a comprehensive assessment of current clinical offerings, care paths and engagement level of clinical providers. Then devised a strategic plan, including service gap and market analyses, and business and recruitment plans for a one- to three-year period with defined targets and accountability
- Within each service line, sought to integrate an established collection of clinical services that span wellness, prevention, acute care and recovery
- Created dotted-line (indirect), collaborative relationships between VP-level service line dyads and system-level SVPs who are responsible for broad areas of the continuum (eg, community and acute services, physician group)
- Established a utilization threshold to determine which units/services would fall under the authority of a specific service line vs a general operations function. Services for which a single clinical area drives 75% or more of volumes take strategic and operational direction from the service line.
  - For example, the neurosciences service line has direct responsibility for neurodiagnostics, the Brain Injury Clinic, Stroke Center, IP/OP rehab, physician specialists (ie, PM&R, neurologists, neurosurgeons, neurohospitalists), and physician office–based pain and therapy programs.
- Building data systems capable of extracting financial information across care sites to support a consolidated service line budget

**IP = inpatient; PM&R = physical medicine and rehabilitation.**
Key Competency

Hardwire Analytics to Better Inform Strategy, Operations

Service line dashboards must become more standardized, agile and comprehensive to provide an accurate picture of the current state and trajectory of the clinical product. The pivotal question data must answer is not “Are we meeting budget?” but “Are we meeting patient needs?” In addition, an analytic framework that enables a rolling strategic plan will be crucial given the shrinking planning timeline. It also helps answer the related question: “How does our product compare to that of our competitors?”

Aim for Well-Rounded, Real-time Data

To effectively compete on value, leadership teams need to see progress toward strategic goals as well as operations and clinical performance issues as they are happening so they can make quick course corrections. Risk contracting will require a longitudinal view of patient care—both to ensure clinical appropriateness and to ascertain the degree of volume capture and downstream leakage. Robust patient registries will be essential to help mine elusive OP data. Such data will begin to be used as leading indicators of future volumes.

Most organizations use a set of domains (eg, growth, finance, clinical performance, people) to track ongoing service line performance. As payment models evolve, it will become increasingly important for executives to identify the right metrics, routinely revise their dashboards, and link them to both strategic and operating plans.

The following dashboard is meant to be illustrative (not comprehensive) and reflect how some organizations are refocusing efforts to create value for diverse stakeholders.

Midwestern Health System Dashboard

<table>
<thead>
<tr>
<th>Growth</th>
<th>Clinical Performance</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique patients</td>
<td>Sg2 Value Index™ percentile</td>
<td>Weighted average total cost</td>
</tr>
<tr>
<td>New patient visits</td>
<td>Case mix–adjusted length of stay</td>
<td>per case</td>
</tr>
<tr>
<td>Patient leakage</td>
<td>Readmission rate</td>
<td>Contribution margin per</td>
</tr>
<tr>
<td>Disease-specific volumes</td>
<td>Potentially avoidable admission rate</td>
<td>disease, case or episode</td>
</tr>
<tr>
<td>Site-specific volumes</td>
<td>Potentially avoidable ED visits</td>
<td>Commercial volume, revenue</td>
</tr>
<tr>
<td>Medical group RVU</td>
<td>Pathway compliance</td>
<td>or margin percentages</td>
</tr>
<tr>
<td>Volume reduction due to care redesign</td>
<td>Comanagement metric performance</td>
<td>Ambulatory volume, revenue</td>
</tr>
<tr>
<td>Same-day visit performance</td>
<td>VBP metrics</td>
<td>or margin percentages</td>
</tr>
<tr>
<td></td>
<td>Disease registry metrics</td>
<td>Physician cost per RVU</td>
</tr>
<tr>
<td></td>
<td>Clinical trial enrollment</td>
<td>Site-specific revenue,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>margin</td>
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<tr>
<td></td>
<td></td>
<td>Risk contract performance</td>
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</table>

<table>
<thead>
<tr>
<th>People</th>
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</thead>
<tbody>
<tr>
<td>Patient net promoter score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee net promoter score</td>
<td></td>
<td></td>
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<tr>
<td>Physician net promoter score</td>
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<tr>
<td>Employer outreach</td>
<td></td>
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<tr>
<td>Physician outreach</td>
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</tbody>
</table>
Simplify the Platform for Integrating and Analyzing Data

Precisely how organizations mine for such data presents an opportunity to revisit organizational structure. Historically, many systems have embedded business analysts in service lines (often as part of a leadership triad), ready to respond to data requests. This approach, used successfully by Mission Health and Hospitals, has its benefits: rapid response times and depth of knowledge of a specific area. However, some organizations may find this strategy furthers service line silos and hamstrings efforts to standardize data and incentives. Some already are pursuing more centralized alternatives.

Alternative 1: Centralized Business Analysts

- Incorporated within strategic planning
- Staffed with an expert for each major service line or through a pool of analysts assigned by project
- Enables common definitions and methodologies for data extraction
- Facilitates a common reporting framework needed for a portfolio perspective on the business

Caution: Pool models, although easier to justify financially, may limit the ability to extract real-time data. Housing this group within strategic planning may complicate access to cost and operations data.

Alternative 2: Consolidated Analytics Department

Despite being much trickier to pull off, enterprise-level data warehouses are likely to become routine across provider systems. Consolidating data generated through different systems—the EMR, cost accounting, Press Ganey reports—through a single source ensures a consistent data format and obviates the need to referee conflicting numbers. Centralized data groups will be positioned to identify problematic patterns and flag them for leadership teams to quickly address, not just respond to data requests.

- Controls virtually all data across the enterprise
- Creates platforms for easy access to daily reports
- Feeds data to strategic planning, hospital finance departments and service line management to inform strategic planning and daily operations
- Typically led by an executive on an equal plane as the CFO, COO and SVP of strategic planning
- Staffed by individuals with strong analytics and financial decision support skills

Caution: Homegrown solutions are necessary to integrate utilization, financial and operations data. A dedicated department adds administrative overhead—these costs may be challenged.
Key Competency

Build in Flexibility

Service lines sharpen leadership focus on system subcomponents critical to success...or at least those viewed that way today. Therefore, the managerial time, talent and capital allocated to deliver a clinical product must evolve as priorities change and new challenges arise.

Responsiveness is essential in three dimensions: by organization, by market and by service line. In interviews with Sg2, executives frequently cited similar trends.

Common Organizational Variables

“Our board has refocused the organization to increase value and provide care for a population.” Complete product overhauls likely demand commensurate structural change, while add-on products may be incorporated with only minimal tweaks. Piloting high-risk products—like those geared toward population health—through departments specifically designed for experimentation and innovation is one way to fine-tune before determining the optimal structure needed for the long-term.

“Our CEO (or other key leader) is within two years of retiring.” Talent is a critical factor in determining how best to organize leadership. A change at the top can be disruptive. Yet it also creates opportunities to promote current leaders with key skills for the changing marketplace or bring in fresh perspective from the outside to force major culture shift. Systems seeking a more physician-driven structure may use the opportunity to merge the CEO and CMO roles. Beyond turnover trends, expect to have to refine or tweak the model after launch to address unforeseen conflicts, talent issues or cultural reality.

“Our health system recently merged with another health system—I am going to need a bigger map!” Mergers and acquisitions risk redundancies without thoughtful planning regarding leadership and a willingness to eliminate positions. To ensure top talent is retained, key executives may be redeployed into new roles. A deal that creates a geographically dispersed organization presents a ripe opportunity to devise the right regional framework. If the goal is a unified enterprise, the need for a structure that supports standardization and rationalization will be readily apparent.

Common Market Variables

“A payer in our market wants to pilot new payment models with our organization as their partner.” Accountable care models typically require enterprise-wide change and core interventions across service lines. Narrower payment innovation, like episodic bundles, typically applies only to specific clinical products and, thus, necessitates only minor structural change. In either scenario, effective frameworks minimize system leakage and foster efficiency.

“Employer benefit redesign and Medicaid expansion will rapidly transform our payer mix.” Clinical areas previously viewed as not warranting dedicated leadership may need to be elevated to ensure efficiency and guard against margin erosion as significant numbers of high-risk patients enter the system and the commercial payer base contracts.

“We’re suddenly competing against new types of organizations and real market heavyweights.” Market entry of a super-regional adds urgency to restructuring aimed at extending the span of an organization’s product, both geographically and further into the ambulatory arena. A strengthened management framework for new community-based service lines or overlaid coordination services may be needed to counter market share drains from wellness or retail companies’ incursions.
Service line structure must be customized to the current state of the clinical area across many variables. Details are provided below for four common service lines: CV, cancer, orthopedics and neurosciences.

<table>
<thead>
<tr>
<th>Common Service Line Variables</th>
<th>Current State by Clinical Area</th>
</tr>
</thead>
</table>
| **Local Market Competition**  | - Cobranding with national leaders or achieving NCI designation can create instant clinical franchises for a market’s cancer services.  
- Limits on comprehensive stroke center designation lock out many organizations from neurosciences expansion. |
| **Growth Potential**          | - Sg2’s 2013–2023 IoC forecast for key IP 10-year growth rates: orthopedics (+17%), neurosciences (+8%), cancer (+3%), spine (0%), then CV lagging far behind with a projected 23% decline  
- Sg2’s 2013–2023 IoC forecast for key OP 10-year growth rates: cancer (+31%), CV (+26%), neurosciences (+22%), orthopedics (+20%) and spine (+18%).  
- Ultimately, however, localized forecasts vary widely and are much more accurate for service line planning. |
| **OP Shift**                  | - In orthopedics, extensive physician ownership of ambulatory surgery centers and inclusion of key ancillaries in specialist private practices hamstring system efforts to extend across the continuum.  
- Formerly high-margin IP services in CV are rapidly moving OP. |
| **Physician Relations**       | - Balancing the four subspecialties that comprise most oncology programs has led some organizations to forgo traditional dyad leadership models.  
- Ongoing specialist independence makes orthopedics most susceptible to hospital/physician politics, but employment is taking hold in many markets. Regulatory relief may further alignment. |
| **Clinical Quality Standards**| - CV and cancer lead other areas with robust protocols founded in evidence-based medicine.  
- Standards are just emerging in the neurosciences.  
- Within orthopedics/spine, there is intense scrutiny of the evidence base for some high-margin procedures. |
| **Consistent Care Paths**     | - CV already emphasizes wellness/prevention services and the need for effective postdischarge handoffs.  
- The duration of typical care in cancer and neurosciences has led many systems to invest in cross-continuum services. |
| **Payment Evolution and Penalties** | - Procedure-driven areas of orthopedics and CV are prime targets for risk-sharing and accountable payment models.  
- Readmission penalties already are reshaping CV care. |
| **Partnership Potential**     | - AMC/community hospital affiliations are common in cancer, spurred in part by clinical trial recruitment.  
- Significant variation in the quality and supply of skilled nursing facilities and home care agencies impacts effective neurosciences service line development. |

NCI = National Cancer Institute; IoC = Impact of Change®; AMC = academic medical center.
Source: Impact of Change® v13.0; NIS; PharMetrics; CMS; Sg2 Analysis, 2013.
Case Study: **Sutter Health, Sacramento, CA**

**Background**
- Began in May 2011 to move toward a regional approach to service line strategy and operations for oncology and neurosciences in its six-hospital, nine-county Sacramento Sierra Region. Next up for Sutter Health is cardiovascular services.

**General Approach**
- Service line leaders focus on quality improvement, program and business development for clinical services across the continuum and the region. They also oversee operations of select OP units (eg, in oncology: cancer center, tumor registries and infusion centers).
  - IP operations remain local; physician clinics remain the domain of Sutter Medical foundation and independent specialty practices.
  - Physician recruitment/deployment, capital budgets, metric development and service distribution decisions are centralized.

### Leadership Model
- Regional dyads reporting to regional leaders oversee the service lines; the regional structure was built with a commitment to an FTE-neutral approach.
  - **Regional Executives:** Coordinate strategy and business development for ambulatory through acute services across sites. These leaders have varied degrees of operational responsibility at each affiliate; they report to the regional VP for strategy and business development.
  - **Regional Medical Directors:** Manage some clinical aspects of the service line, for example the specialty clinics within the foundation; directly oversee medical directors of individual clinical programs (eg, back pain or breast health programs).
- Leaders collaborate closely with individual hospitals, the medical foundation and other service line leaders to link pieces across the care continuum. For example, some services (eg, neurodiagnostics through the CV department) may be integrated through a matrix reporting relationship for specific IP departments or through a strategic partnership (eg, radiation oncology in partnership with a competitor).
- Steering committees meet quarterly and advise leadership on strategic programming, business development and capital investment decisions. Members—hospital and physician leaders from around the system—serve two-year terms.

### Service Line Metrics
- Common metrics (eg, contribution margin, new patient visits) enable regional planning and cross-service line comparisons. These complement service line-specific metrics for daily operations.

### Incentive Structure
- Regional dashboard targets and goals established for individual affiliates cascade to service line executives to ensure strategic alignment.

### Physician Alignment
- The model is grounded in the organization’s 600-member physician foundation but also includes private practice physicians. Directorships and nominal stipends are used in some service lines to compensate physicians for administrative roles. Comanagement agreements are being considered.
Action Plan for Restructuring Service Lines

☑ **Affirm or revise the organization’s vision and mission.**
  - Evaluate the payer landscape in your market and how your organization will respond to changes in payment incentives.
  - Ensure a patient-centered perspective to guide product development and management.
  - Change the game to control your destiny, but always play by the rules for well-designed health systems.

☑ **Confirm or redefine your health care product.**
  - Determine how your product will span the System of CARE and what sites will be owned.
  - Incorporate a regional perspective across sites.
  - Prepare for management of populations.

☑ **Identify administrative and physician leaders.**
  - Clearly state roles and responsibilities regarding strategy and operations:
    - Across the system and regional sites
    - For all services along the continuum of care
    - With physician governance structure
  - Delineate primary and secondary reporting relationships.
  - Align leadership and team incentives to reflect responsibility and goals of the organization.
  - Create a support system with key individuals, including physicians, across sites.
    - Service line councils
    - Quality committees
    - Regular service line leader meetings
    - Planning retreats
    - Business development and strategy liaison
  - Facilitate opportunities to expand leadership competencies.

☑ **Centralize key functions.**
  - Consider assigning a single senior leader to manage across service lines.
  - Weigh the benefits of a consolidated analytics department.
  - Leverage similarities in function as opportunities to manage cost.
    - Marketing
    - Human resources
    - Research initiatives
    - Registry reporting

☑ **Maintain flexibility.**
  - Plan for leadership attrition.
  - Include extra oversight for new service lines; wean administrative infrastructure from more mature ones.
  - Watch payers, employers and competitors in the market.
  - Anticipate mergers and acquisitions, preparing to integrate leadership models.
  - Allow each service line autonomy in structure that accommodates clinical guidelines and leverages available physician and administrative talent.
Anticipate the Impact of Change

Sg2’s analytics-based health care expertise helps hospitals and health systems integrate, prioritize and drive growth and performance across the continuum of care. Over 1,200 organizations around the world rely on Sg2’s analytics, intelligence, consulting and educational services.