Clinical Service Lines: Mapping the Future of Community Health

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About this report

While accountable care, health reform and meaningful use of electronic health records dominate today’s healthcare discussion, the clinical service line has emerged as a critical framework for delivery of care under any emerging scenario. To shed more light on this strategic solution and its implications for the future, C-Suite Resources surveyed 40 leading community-based health systems to determine their current status and future strategies regarding clinical service lines. This report highlights the survey’s findings. It was co-authored by Daniel K. Zismer, PhD, Associate Professor and Director, Masters of Healthcare Administration and Executive Studies Programs in Healthcare Management and Leadership at the University of Minnesota School of Public Health, and Donald Wegmiller, MHA, FACHE, Chairman and co-founder of C-Suite Resources and Chairman Emeritus of Integrated Healthcare Strategies.
Whether it incorporates clinical integration or full integration with employed physicians, the U.S. healthcare market will continue to encourage the consolidation and integration of community hospitals and physicians. This move toward integration is reshaping traditional community hospital models of governance, leadership, operations, finance and strategy.

As integration models mature, health systems are “regionalizing” clinical programs, especially those of high strategic importance such as cardiovascular, cancer care, neurosciences, stroke and women’s and children’s services. Integrated clinical service lines are emerging as the preferred approach to clinical program design and management. Regional clinical service lines are organized arrays of clinical services that are focused on the diagnosis, treatment and management of a specific disease state—or related clinical conditions—for specific populations and delivered in an integrated and coordinated manner with services located across sites and specified geographies. The patient experience is that of coordinated care delivered at multiple sites with the entire care team and staff operating from a common mission, vision, strategy and clinical model.

When the clinical service line strategy works well, patients experience a well-managed and seamless process regardless of site.

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While logical from the patient’s perspective, the transition to clinical service line strategies can disrupt more traditionally configured and managed community hospitals and health systems, especially those where each service site—a hospital or clinic—is an independent financial unit operating within a multi-site health-system structure.

Design and Operation: Five Principles

Successful regionalized clinical service lines cite five key principles of design and operation, regardless of service line type:

1. Centralize strategy, operations, clinical protocols and patient care models and methods with a multidisciplinary team under the leadership of a “dyad”—a lead physician and service line executive working together as a team.

2. Apply evidence-based clinical standards and control privileging of professionals who operate within the service line within a specified service line leadership structure across sites.

3. Centralize operating and capital-budget development and management as well as selection of relevant products like pharmaceuticals and devices with service line leadership.

4. Perform financial accounting for the service line by site and embed it in “host-site” revenue and operating expense accounting.

5. Ensure that each site contributes support services e.g. materials management, dietary, lab, radiology, pharmacy, to the overall service line entity.
Clinical Service Lines: Community Health Systems Speak

C-Suite Resources surveyed executives at 40 large, U.S. community health systems to determine their organizations’ current activities and future plans regarding clinical service lines.

The survey asked three questions:

1. “Are you operating clinical service lines now and, if so, which are priorities today?”
2. “Is it likely that you will continue the strategy?”
3. “Do you expect to expand/extend the strategy to new clinical services in the future?”

TYPICAL SERVICE LINES UTILIZED

Almost all of the organizations currently operating service lines (98%) said those lines had assigned full-time executives to lead them, either a single accountable officer or a leadership dyad. Two out of three use the dyadic model, in which a lead physician was one of the two leaders. All physician leaders were either employed by the health system or contractually compensated for their time.

ADMINISTRATIVE/CLINICAL TEAM FOR SERVICE LINE MANAGEMENT

More often than not, clinical service line leaders reported to high-level executives within the health system. Four of five organizations (80%) said their service line leaders reported directly to vice presidents or higher.

Nearly nine in 10 (87%) said they were actively pursuing clinical service line strategies, with the most common lines being cardiovascular, cancer care, orthopedics, neurosciences and women’s and children’s services.
Service line financial accounting was the norm—at least operating revenues and direct operating expenses of the service line across sites. Most operated from a service line operating and capital budget that had been developed as part of the annual or multi-year strategic plan for the clinical service line.

Health systems supply support services by site according to a matrix model. In other words, the organization assigns clinical professionals, support staff and services by site to support each clinical service line. Related staff may directly report to clinical service line leadership and management staff while maintaining a dotted line relationship to site-specific management.

Of those clinical service lines successfully operating today, the vast majority (89%) expect to maintain the model in the future. Of those who have not yet adopted the model, nearly two-thirds (61%) expect to do so in the future.

Five challenges

Almost without exception, senior executives cite challenges with the model:

- **FIRST**, each site—typically a hospital—must move from acting as a self-contained financial and economic unit to one whose primary role is to house components of regionalized service lines. Site executives may end up operating a “negative margin” component of a clinical service line, which negatively affects the overall financial performance of “their” site;

- **SECOND**, clinical and support staff may serve two masters—the site leader and the service line leaders;

- **THIRD**, it can be difficult to perform accurate and reliable accounting of service line revenues and expense through standardized accounting methods within and across sites;

- **FOURTH**, site executives and service line leaders may report to different and more or less senior officers in the health system, raising the risk of confusing accountability;

- **FIFTH**, physicians who operate at sites must also operate within the service line structure. If the physician organizational model within the integrated system is immature, delivery of physician services and management of physicians themselves within the service line and site can pose a significant challenge.
Implications

Our survey identified the following implications for clinical service lines:

HOSPITALS AND HEALTH SYSTEMS

- Community health systems will extend the specialty-focused, clinical service line model to an expanding array of clinical services and programs.
- Clinical service lines will become more comprehensive in nature, regional in geographic scope and nest their clinical and operating models in site or facility-based structures and operating models.
- These clinical models will emphasize comprehensive, coordinated care across geography and time. They will make available prevention, acute care and chronic-disease services.
- Sites will be connected electronically and will operate from common, standardized service-demand and access models, methods, protocols and standards.
- Operating, capital and human resource plans and budgets will be controlled under unified, service line plans.
- The clinical service line will carry a health-system brand that is promoted across sites.
- Larger clinical service lines will manage contracted financial risk under payment frameworks like episodes of care, bundled payments and pay-for-performance.
- Health-system leaders must become comfortable with organizational and reporting ambiguity. Senior executives will need to think within and across sites and organizational models as they operate and evaluate clinical service line performance.
- Management must redesign performance mapping and scorecards to accommodate the key characteristics of service line design.

PHYSICIANS

- Physicians will become integrated as clinical leaders and co-managers and their compensation will reflect to at least some extent the service line’s overall performance.
- Physicians will need to cede some professional autonomy to the mission, vision and driving values and principles of service line design.

PATIENTS

- An integrated, coordinated team will care for patients. Sites will become merely places where patients receive care.
- Successful clinical service line organizations will create enhanced value propositions for patients, families, payers and customers. They hold promise for accountable care organizations especially if multiple health systems collaborate in an ACO.
- Ultimately, the clinical service line model promises to improve the quality of care and enhance patient satisfaction by delivering care in a unified, coordinated and predictable way across the continuum of time, multiple caregivers and locations.
SUPPLIERS

Product and service suppliers will have to go back to school and redesign their sales approach to health systems with clinical service lines.

Conclusion

The clinical service line has become the favored business and operational framework for hospitals and health systems to deliver care. It will continue to grow as a strategic solution even as new models for accountable care and value-based purchasing emerge. Successful service lines offer a governance structure that balances clinical expertise with management know-how within the larger context of the regional corporate enterprise. While many challenges accompany the move to the service line model, the model provides a vehicle for successful physician integration with the larger health system and moves the health system away from a traditional hospital-centric focus and into an integrated clinical, financial and cultural framework focused on patient care and population health.

About C-Suite Resources

C-Suite Resources provides market intelligence, education and strategy support to companies that serve the healthcare industry. The company’s services enable healthcare suppliers and vendors to improve their strategy, sales and marketing performance. C-Suite Resources’ “Faculty-Advisors” include over 200 nationally recognized C-level executives, including CEOs, COOs, CFOs, CMOs, CIOs and others, from well recognized healthcare organizations. They have been carefully selected based on depth and mix of C-suite experience, high performance in their field, thought leadership, ability and desire to share knowledge, and leadership in industry organizations. C-Suite Resources’ customized programs include focus groups, phone surveys, on-going executive advisory services and advanced education programs. C-Suite Resources was founded by Don Wegmiller, Stan Nelson and Ralph Wakerly. For more information visit www.c-suiteresources.com or call 952-544-0325.

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