The System Approach to Service Line Management

A guide to organizing service line structures to derive value from systemness

Look inside for:

- A field guide of common organizational structures
- Eight organizing principles for successful system service lines
- Three case studies of successful service line transformation
- Q&As with service line experts
Service line organization

WHAT YOU’LL LEARN

• Why service line management should be a top system priority
• What kinds of effective system service line management models exist today
• How three top-performing systems radically transformed their service line structures

BEST FOR
Executive teams and strategy leaders

READING TIME*
45 min.

* Estimate.
The System Approach to Service Line Management

A guide to organizing service line structures to derive value from systemness
Health Care Advisory Board

Project Director
Yulan Egan
eyany@advisory.com

Research Lead
Jamie Landsman
landsmaj@advisory.com

Contributing Consultants
Emily Brown
Brian Contos
Lindsay Conway
Laura Datz
Sarah Musco
Manasi Kapoor
Brian Maher
Shruti Tiwari
Anna Yakovenko

Design Consultant
Kate Young

Practice Manager
Ben Umansky

LEGAL CAVEAT
Advisory Board is a division of The Advisory Board Company. Advisory Board has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and Advisory Board cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, Advisory Board is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member’s situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither Advisory Board nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by Advisory Board or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by Advisory Board, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

The Advisory Board Company and the “A” logo are registered trademarks of The Advisory Board Company in the United States and other countries. Members are not permitted to use these trademarks, or any other trademark, product name, service name, trade name, and logo of Advisory Board without prior written consent of Advisory Board. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of Advisory Board and its products and services, or (b) an endorsement of the company or its products or services by Advisory Board. Advisory Board is not affiliated with any such company.

IMPORTANT: Please read the following. Advisory Board has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the “Report”) are confidential and proprietary to Advisory Board. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. Advisory Board owns all right, title, and interest in and to this Report. Except as stated herein, no right, license, permission, or interest of any kind in this Report is intended to be given, transferred to, or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.

2. Each member shall not sell, license, republish, or post online or otherwise this Report, in part or in whole. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.

3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.

4. Each member shall not remove from this Report any confidential markings, copyright notices, and/or other similar indicia herein.

5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.

6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to Advisory Board.
# Table of Contents

Introduction: Why Service Line Management Is a Top System Priority ............................................ 5
Field Guide: An Overview of Service Line Management Models ...................................................... 7
Eight Organizing Principles for System Service Lines ................................................................. 10
   1. Hardwired knowledge-sharing is a baseline requirement ......................................................... 11
   2. The corporate office has enough planning oversight to veto self-competitive growth initiatives .................................................. 12
   3. Each service line has a single, integrated financial statement .............................................. 13
   4. Service line performance is measured and shared at both the facility and system levels .......... 15
   5. Local leaders and staff have compensation tied to system-level goals .................................. 16
   6. The role of system leadership is clarified through an explicit authority matrix ..................... 17
   7. Responsibilities arising from dotted-line relationships are specific and unambiguous .......... 19
   8. Physicians are directly embedded in service line governance structures ............................ 20
Special Considerations for Five Key Service Lines ...................................................................... 22
Expert Perspective: Q&A with Two of Our Service Line Research Experts ............................... 24
Expert Perspective: Q&A with Michele Molden, SVP, Consulting and Management .............. 26
Case Studies: Profiles in Service Line Systemness ...................................................................... 28
   Premier Health: Structuring to Elevate Physician Engagement .............................................. 29
   Scripps: Structuring to Reduce Operational Inefficiency ......................................................... 34
   Intermountain Healthcare: Structuring to Reduce Clinical Variation ...................................... 40
Special Thanks

The Health Care Advisory Board is grateful to the dozens of individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

With Sincere Appreciation

Dan Weinman
*Banner Health*

Jennifer Bringardner
Teresa Heckel
Dax Kurbegov, MD
Baiya Krishnadasan, MD
Richard Deming, MD
*Catholic Health Initiatives*

Colleen Roberts
Kim Henrichsen
*Intermountain Healthcare*

Ron Stiver
Dennis Murphy
*IU Health*

Phyllis Gray
*MedStar Health*

Jess Judy
*LifePoint Hospitals, Inc.*

Craig Self
*Premier Health*

Vic Buzachero
Barbara Price
*Scripps Health*

Eric Lieberman, MD
*Tenet Healthcare*

John Stout
Susan Wyman
*Trinity Health*

Thomas McGann, MD
*WellSpan Health*
Dear Reader,

Health systems have, in theory, the potential to reap unique rewards available only on account of their size and scale. The ability to pool knowledge and expertise to create best-in-class care protocols and business processes, or to create a more efficient allocation of financial resources, can be a powerful advantage in the marketplace. At the same time, larger organizations run a greater risk of inefficiency as well; breakdowns in care continuity and patient experience, a lack of unified culture and engagement among physicians and frontline staff, and internal competitive dynamics are just some of the challenges that come hand in hand with scale. For systems intent on functioning as operating companies, not holding companies, an effective service line management structure is a necessary (though rarely sufficient) condition of success.

In practice, few systems satisfy that condition. Some lack any system structure at all; in these cases, service lines are managed as individual clinical departments at the hospital level. In other cases, a system-level structure exists, but recent (or not-so-recent) acquisitions have been added in a haphazard manner, with little adjustment made to the overall structure over time. And in still other organizations, system leaders have made initial moves toward greater centralization by hiring system-level VPs, but have stopped short of deleting meaningful authority given to those individuals.

This publication, the second from the Health Care Advisory Board’s new Health System Performance Initiative, begins with an overview of more effective and cohesive approaches. That said, there is no one-size-fits-all organizational model for service line management. Our research teams reviewed service line organization at over a hundred systems and found success with a variety of leadership models and reporting structures.

Nevertheless, it is clear that some kind of system-level oversight is necessary to achieve true “systemness,” and our research revealed eight organizing principles common among top-performing organizations. An analysis of those principles forms the core of this publication. Although no organization perfectly exemplifies all eight, many systems have made important strides on several. We have included detailed examinations of three such systems who have built service line structures in support of clearly defined objectives. You will also find in the following pages perspectives from many of Advisory Board’s clinical and operational experts, and I encourage you to contact them to learn more if you find this initial discussion rewarding.

Thank you as always for your membership in the Health Care Advisory Board and for all the work you do for your organizations and your communities.

Ben Umansky
Health Care Advisory Board
Inspiration for Your System’s Service Line Structure

Crafting a system service line structure requires a delicate balance—it’s important to learn from the successes of other organizations while still customizing a governance structure to fit your organization’s unique needs. This publication provides the guidance to help you chart that course.

To start, we’ve compiled a **field guide** laying out the key decision points in designing an effective service line structure and the common models and approaches organizations are deploying today.

- An Overview of Service Line Management Models
- Three Options for System-to-Facility Reporting Structures
- Six Key Service Line Performance Objectives

While the right structure and model for every system will vary, we have also observed a set of **eight organizing principles**, common among systems that have successfully leveraged their service line structures to overcome common performance challenges and achieve key service line performance objectives.

1. Hardwired knowledge-sharing is a baseline requirement
2. The corporate office has enough planning oversight to veto self-competitive growth initiatives
3. Each service line has a single, integrated financial statement
4. Service line performance is measured and shared at both the facility and system levels
5. Local leaders and staff have compensation tied to system-level goals
6. The role of system leadership is clarified through an explicit authority matrix
7. Responsibilities arising from dotted-line relationships are specific and unambiguous
8. Physicians are directly embedded in service line governance structures

We’ve included **service-line specific considerations**, as well as observations from several of our service line experts.

- Special Considerations for Five Key Service Lines
- Expert Perspective: Q&A with Two of Our Service Line Research Experts
- Expert Perspective: Q&A with Michele Molden, SVP, Consulting & Management

Finally, we take an **in-depth look at three organizations** that have dramatically and intentionally transformed their service line management structures to overcome a specific breakdown in systemness.

- Premier Health: Structuring to Elevate Physician Engagement
- Scripps: Structuring to Reduce Operational Inefficiency
- Intermountain Healthcare: Structuring to Reduce Clinical Variation
An Overview of Service Line Management Models

No One-Size-Fits-All Solution for Service Line Governance

Our research revealed that there is no one-size-fits-all solution when it comes to system service line management levels. Rather, organizations have a range of options at every level of the organizational chart.

First, top-performing systems have some level of oversight across service lines, with an individual or team that manages all clinical areas to ensure each service line’s initiatives support overarching organizational priorities.

Second, best-in-class organizations centralize management for each individual service line at the system level, with this individual or team held accountable for service line performance across facilities. Leadership at this level is typically comprised of a service line administrator or administrative-clinical dyad, often in conjunction with a steering committee, which engages a broader set of stakeholders in designing the service line’s strategic direction.

Finally, this leadership team oversees any sub-service line management components such as clinical working groups or patient advisory committees, which help execute on service line strategy and provide operational and clinical support.
In addition to establishing the appropriate model at each level of the organization, system leaders must also create clear reporting relationships between system service line leaders and local service line administrators. Organizations typically approach system service line reporting in one of three ways. They are presented below in order of increasing operational control at the system level.

**Influence-Based Reporting**

In influenced-based reporting, system service line leaders drive change without direct authority. They have no formal reporting relationship with service line directors at local sites. Influence-based reporting helps site leaders preserve governance autonomy and does not cause disruption to the existing reporting structure. Service line leaders are able to concentrate on strategic issues, rather than day-to-day operational issues. However, system service line leaders have limited control over areas of accountability and may encounter pushback or resistance from facility-based leadership.

**Matrix-Based Reporting**

Matrix-based reporting creates a formalized dotted-line reporting relationship between system service line leaders and site-based service line directors. This approach allows system service line leaders to be involved in site-level decisions and creates strong relationships between the system and its sites. Matrix-based reporting, however, also increases the potential for inefficient decision making on site-level service line issues. It can also lead to conflicting messages to staff from site-based leadership and service line leaders as system service line leaders have limited control over areas of accountability.

**Unit-Based Reporting**

Lastly, in unit-based reporting, the system service line has direct authority over discrete units and operates via dotted-line relationship with other areas of the service line. Units typically under direct authority include ambulatory, outpatient services, and physicians. In this approach, the system service line leader has direct control over discrete areas of accountability, which allows them to effectively manage those areas and drive system-wide strategy and initiatives. However, the system service line has limited control over other areas of service line accountability, which can potentially complicate the budgeting structure for the system.
Six Key Service Line Performance Objectives

System Challenges
Inform Service Line Objectives

The appropriate management approach and reporting structures for any given organization depends entirely on the intended goals of the service line. Therefore, in order to determine the right structure, system leaders must first identify and prioritize among the challenges in the organization’s current approach and the associated objectives for the new or modified system structure.

For example, a system struggling with cannibalization of volumes among facilities should aim to build a service line management structure that would reduce competition between care sites. On the other hand, a health system grappling with variable clinical outcomes and patient experience across sites would aim for a structure that minimizes unwarranted clinical and patient experience variation within each service line.

<table>
<thead>
<tr>
<th>Service Line Performance Challenges</th>
<th>Management Structure Performance Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siloed Growth Planning</td>
<td>1 Prevent System Service Line Silos</td>
</tr>
<tr>
<td>Irrational Service Distribution</td>
<td>2 Centralize System Footprint Planning</td>
</tr>
<tr>
<td>Cannibalization</td>
<td>3 Reduce Resource Competition Among Sites</td>
</tr>
<tr>
<td>Limited Physician Engagement</td>
<td>4 Improve Physician Engagement, Alignment</td>
</tr>
<tr>
<td>Variable Clinical Outcomes, Patient Experience</td>
<td>5 Minimize Clinical, Patient Experience Variation</td>
</tr>
<tr>
<td>High Clinical, Operational Costs</td>
<td>6 Rationalize Costs</td>
</tr>
</tbody>
</table>

Additional Resources: Service Line Strategy Advisor

Members of the Advisory Board’s Service Line Strategy Advisor program have access to a wide range of additional resources, including Models for Service Line Systemness. For more information about the program, please contact Shay Pratt at prattM@advisory.com
Despite Varied Organizational Models, a Set of Common Principles

While governance structures can and should vary, our interviews revealed eight distinct traits that successful systems tend to demonstrate, regardless of the organization’s service line management model.

1. **Hardwired knowledge-sharing is a baseline requirement**
   
   Regardless of the size of a system, the system office should play the role of convener, assembling key stakeholders on a recurring basis to share information and strategies.

2. **The corporate office has enough planning oversight to veto self-competitive growth initiatives**
   
   The extent to which the system office leads growth planning depends on its ability to lead the execution process, but some level of authority is necessary to ensure cohesion.

3. **Each service line has a single, integrated financial statement**
   
   A single P&L creates an incentive to maximize financial performance of the service line as a whole and provide greater transparency into cost-reduction efforts.

4. **Service line performance is measured and shared at both the facility and system levels**
   
   Sharing both overall and individual financial, quality, and patient satisfaction performance incentivizes collaboration and helps identify best practices.

5. **Local leaders and staff have compensation tied to system-level goals**
   
   System leaders must reconfigure incentive plans to encourage hospital administrators and frontline staff/physicians to support system goals.

6. **The role of system leadership is clarified through an explicit authority matrix**
   
   System and local leaders collaborate to create a formal document laying out the system’s role and scope of authority for key service line decisions.

7. **Responsibilities arising from dotted-line relationships are specific and unambiguous**
   
   A clear definition of areas of shared responsibility prevents conflict whenever possible, and there should be a clear process for escalating decisions in case of stalemate.

8. **Physicians are directly embedded in service line governance structures**
   
   Physicians help lead service line strategy from the very top—whether through a dyad leadership model or participation in an executive steering committee.
1: Hardwired knowledge-sharing is a baseline requirement

Transferring Best Practices Across Sites of Care

Even in organizations with clear leadership and governance structures in place, systems may struggle with sharing communication and information sharing across the organization. The sheer size and complexity of many systems can hamper efforts to increase collaboration. In many cases, there is little opportunity to connect with colleagues working on similar projects, resulting in duplication and inefficiency.

By creating regular forums to share ideas, troubleshoot barriers, and make network contacts, systems can hardwire knowledge sharing in a cost-effective manner.

Mercy Cancer Network, a group of 17 Trinity Health cancer programs in Michigan, addresses this issue by organizing conferences every six months. The conferences include key decision makers, such as hospital CEOs, physicians, and oncology leaders from area hospitals. The events provide an opportunity for the network’s affinity groups to meet and for individual sites to present best practices.

For example, in 2011 a social worker from St. Mary’s Health Care gave a presentation on the financial navigation program he designed to help cancer patients secure health coverage, drug replacement, copay assistance, and premium assistance. During the first two years of the program, he helped almost 400 patients find insurance and other types of financial assistance to pay for their cancer care, which yielded approximately $4 million in savings for the hospital. These results inspired representatives from four additional Mercy Cancer Network sites to replicate the program at their hospitals. The architect of Saint Mary’s financial navigator program worked as consultant to assist with implementation.

Semiannual Conference Enables Best-Practice Sharing

Over time, other Trinity cancer programs in neighboring states have expressed a desire to tap into the best practice sharing as well. Today, the network sends out a quarterly newsletter to all Trinity Health cancer programs to further drive collaboration.

Best-practice sharing and coordination across facility and regional lines is an effective first step toward greater system-wide collaboration. However, top-performing organizations recognize that there are opportunities to share information and ideas across services lines as well.

At Intermountain Healthcare, for example, the system brings all clinical program leaders together twice a year for a Clinical Leadership Team meeting. This forum enables service line leaders to network and discuss areas of shared success and challenge.

It’s worth noting that such knowledge sharing is at most a baseline requirement for functioning as a system service line. Playing the role of convener is important—but it’s not sufficient to address the biggest challenges facing systems today, such as variable clinical outcomes, duplicative service portfolios, and unnecessarily high operational costs.
2: The corporate office has enough planning oversight to veto self-competitive growth initiatives

Corporate Input into Planning Crucial for Many System Objectives

Strategic planning is one of the most challenging elements of cross-system collaboration. Out of all potential elements of service line management—strategic, operational, clinical, or financial—system-level involvement in strategic planning and business development initiatives is the most crucial in enabling organizations to overcome many common service line performance challenges. For example, system input into growth planning is a crucial for reducing internal competition for resources, ensuring rational service allocation, and rationalizing duplicative physical assets.

That is not to say that the system should conduct all planning activities or that local leaders should be removed from the planning process entirely. In fact, the expertise of local- and facility-based leaders is essential for ensuring that system goals clearly reflect market-based nuances. And the system’s level of involvement will depend heavily on the system’s ability to lead the execution process as well.

There are three main ways for systems to lead planning efforts from the system level, each requiring an increasing amount of centralization. Organizations may choose to employ one approach across the board or utilize a combination of these approaches. For example, smaller systems may be more likely to rely on system-level committees to complete all planning activities, while larger systems will still need to delegate some responsibilities to local leaders, with approval authority at the system level, where appropriate. In health systems where facility-based administrators are accustomed to leading planning efforts, elevating planning responsibilities to the system level requires a dramatic shift in process and culture.

Three Options for Elevating Planning to the System Level

<table>
<thead>
<tr>
<th>Bottom-Up</th>
<th>Cascading</th>
<th>Top-Down</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning proposals are developed by local leaders but sent to system-level leaders for evaluation and approval</td>
<td>Planning occurs at the system-level, but local leaders translate system goals into facility action plans</td>
<td>Performance targets and implementation plans are developed by a system-level committee, with input from local leaders</td>
</tr>
<tr>
<td>Pros: Less disruptive to existing structures</td>
<td>Pros: Enfranchises both local and system leaders</td>
<td>Pros: Ensures system objectives are executed on</td>
</tr>
<tr>
<td>Cons: Ambiguity over when to elevate decisions</td>
<td>Cons: May create inconsistencies in execution</td>
<td>Cons: May disenfranchise local leaders</td>
</tr>
</tbody>
</table>

Regardless of the approach taken, strong leadership at the system level is a must, as these individuals must have the ability to navigate highly political situations.

At Intermountain Healthcare, System Directors of the organization’s “Clinical Programs” (i.e., service lines) help guide local growth planning efforts without direct authority. For example, when the CEO from one of Intermountain’s hospitals, along with the hospital’s cardiovascular administrator, proposed a new cath lab for their facility, the request was sent to the System Director of the Cardiovascular Clinical Program. This director conducted a thorough analysis of local market volumes, cardiovascular services at nearby Intermountain hospitals, and the anticipated community perception of this expansion. Based on this analysis, she concluded that the community did not need access to an additional cath lab. Rather than simply recommending against the proposal in a top-down directive, however, she worked closely with the site-based administrator and CEO to identify a true community need for a heart failure clinic. As a result of this comprehensive analysis, the hospital was able to develop its CV service portfolio in a way that better aligned with community needs.
3: Each service line has a single, integrated financial statement

Redirecting Focus to System-Level Performance

Ensuring system insight into local planning has the advantage of coordinating strategy and minimizing internal competition. However, these planning efforts can fall flat if finances are not aligned or transparent. Shifting to a unified profit and loss statement for each service line not only creates a shared performance target, but also provides greater visibility into drivers of cost and revenue, which can help inform budgeting and planning efforts, and allow service line leaders to demonstrate the value of the service line to the system.

Consolidating Across Acute Care Sites a First Step

Integrating financial statements across multiple departments and acute care sites is a first step toward taking advantage of these opportunities. At MedStar Health, for example, the organization has consolidated each of its four cancer programs’ financial statements into a single report that is automatically generated each month. System leaders no longer look at facility-level oncology financial performance data unless the oncology service line as a whole is underperforming—instead, cancer programs succeed or fail together. Having a single financial statement also enables patients to be tracked across the system and links patient revenues and expenses from different sites. The report has helped to reduce competition between sites for resources, especially subspecialists and patients.

Moving Toward a Fully-Integrated, Cross-Continuum P&L

Moving to an integrated P&L statement can be an incredibly daunting and time-consuming task. At MedStar, building the consolidated report took years of planning, data validation, and refinement of report metrics. MedStar continuously modified its reports to improve accuracy and relevance. The most challenging steps included determining the coding used to identify cancer patients within the health system’s IT systems and validating the data inputs from each of the sites. Today, the report accounts for 99% of all oncology care provided at MedStar, and is coded and maintained by one FTE financial analyst.

Perhaps one of the biggest potential advantages of an integrated financial statement is greater visibility into patient costs incurred across the full care continuum. As organizations increasingly take on risk-based payments, this type of transparency will be crucial in identifying cost-reduction opportunities for the purposes of total cost management. Integrating financial statements not only across acute care sites, but across the entire continuum of care, should therefore be a long-term ambition for any organization looking to be a population health manager.

When Mount Carmel Health reorganized its CV service line to bridge silos across departments, physicians, and sites in system, it moved from separate financial statements at each site of care to an integrated P&L statement across the entire service line, including each hospital site and all relevant outpatient sites. Although the process was tedious and time-consuming, CV leaders point to a host of benefits as a result of the effort.

Integrated Statement Provides Multiple Perspectives on Service Line Performance

<table>
<thead>
<tr>
<th>Entire Service Line</th>
<th>Disease Program</th>
<th>Ambulatory Sites</th>
<th>Individual Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Holistic view of system CV performance</td>
<td>• Each CV specialized disease program assigned DRG group</td>
<td>• P&amp;L includes revenue, costs of all CV physician practices, hospital-owned sites</td>
<td>• Drill-down to patient level to track services received across the continuum</td>
</tr>
<tr>
<td>• Includes net CV revenue, previously reported only for hospital or specific populations as needed</td>
<td>• Able to track all downstream revenue, demonstrate ROI of program investments</td>
<td>• Can monitor, compare performance at the practice level</td>
<td>• Useful for identifying outlier cases for analysis</td>
</tr>
</tbody>
</table>
Case Study Spotlight
Mount Carmel's Use of an Integrated P&L to Increase Oversight

Before reorganization, each department within each hospital maintained its own financial reporting, limiting visibility of complete CV service line performance. In response to the reorganization, Mount Carmel created an integrated P&L statement across all care sites, allowing for a more targeted analysis of the newly centralized service line’s performance.

Mount Carmel's Process for Creating a Unified CV Service Line P&L Statement

1. Define service line based off DRGs and map to outpatient APCs
2. Revise DRG mapping to ensure capture of the whole CV patient population
3. Gain feedback, approval from executive, service line leadership on DRG mapping
4. Break down into sub-service line groups aligned with functional areas or disease states
5. Incorporate revenue and cost from CV physician offices
6. Compile all patient encounters that map to the CV service line

Deep Dive on Mapping Costs, Revenue on the P&L

Calculating Service Line Revenue

- Revenue is mapped by patient encounter, unless it’s capitated payment.
- Program is able to get a more accurate sense of service line revenue as each patient is assigned only one DRG, which maps them to a service line.
- 95% or more of revenue is credited to specific patients and from there to service lines. The remaining <5% of revenue is treated as a reconciling item; this includes capitation, HCAP¹, and GME² lump-sum payments.
- Gross revenue is still reported by department as well as service line, while net revenue is reported only by service line.

Calculating Service Line Costs

- Costs can be mapped in multiple ways: by patient encounter, individual service provided, service line-level purchase, hospital-level purchase.
- To create the CV service line P&L, Mount Carmel uses cost accounting to assign costs to individual patients, and map patients back to the service line.
- ≥90% of cost is expended for specific patients (i.e., variable cost) or is allocated to them (i.e., fixed cost); however, <10% of cost is not mapped to individual patients or service lines and is treated as a reconciling item. This includes hospital-based physician departments that cover the whole institution, including hospitalists, intensivists, pathologists, and radiologists.

"An integrated P&L lets us demonstrate a holistic view of the success of our new CV service line model. Now we can more accurately attribute the revenue of all services we bring to the organization—as well as our ability to remove total costs to the system across the continuum."

VP of CV Service Line, Mount Carmel Health System

¹ Hospital Care Assurance Program: a program administered by the Ohio Department of Medicaid, which provides funding to hospitals that have a disproportionately high share of uncompensated care cost.
² Graduate Medical Education.

©2016 Advisory Board • All Rights Reserved • 32228
4: Service line performance is measured and shared at both the facility and system levels

Communicating Performance Across the Organization

An integrated financial statement is one way to create a shared performance target, but best-in-class organizations promote performance transparency across all aspects of performance and levels of the system. Doing so not only creates alignment around shared goals and metrics, but also incentivizes individual facilities to improve and collaborate with one another. Sharing financial, quality, and experience data at the facility level can help system leadership identify opportunities for improvement and set appropriate performance targets. It can also reveal top performers in the system, prompting discussions about best practices and visits to high-performing sites. Site leaders are able to compare themselves to their system counterparts and use the data to communicate the importance of certain initiatives to their staff.

Catholic Health Initiative’s (CHI) National Oncology Service Line dashboard includes clinical, operational, financial, and patient satisfaction metrics that enable individual facilities to track how they compare to other cancer programs within the system. The dashboard is updated quarterly so that facilities can also see how initiatives are impacting their progress and standing within the system.

The dashboard development team initially included 20 people, but now includes over 120 employees from across the system. This team includes registrars, business intelligence staff, chemotherapy and radiation safety specialists, oncology-specialty physician leaders, and administrators.

The resulting data is shared across multiple levels of the organization. The individual CHI cancer programs are able to review their performance relative to the national cohort, identify improvement opportunities, and develop their performance improvement initiatives based on individual needs. CHI’s national chemotherapy and radiation therapy safety committees review de-identified facility-level data to look for trends and opportunities for system-wide projects to improve patient safety. Finally, the national oncology dashboard committee and physician advisory group use the data to make decisions about performance targets and dashboard modification, and to identify further opportunities for system-wide collaboration.

System-Level Dashboard Valuable to All Levels of the Organization

National Service Line Dashboard Performance Quarterly Review Plan

Site-Level Review
- Cancer programs review own performance
- Set targets and identify PI opportunities

Chemotherapy and Radiation Therapy Safety Subcommittees
- Committees review de-identified IRIS1 reports each quarter prior to populating dashboard
- Role of committees is not to root-cause individual incidents, but to identify trends and national PI opportunities
- Committees make recommendations to Oncology Leadership Team for PI projects and metric changes

Oncology Leadership Team
- Team reviews aggregate performance of all metrics quarterly
- Makes recommendations to Physician Advisory Group (PAG) for national targets, PI projects, and any changes or additions to dashboard

System-Wide Service Line Physician Advisory Group
- PAG reviews aggregate performance on all metrics quarterly
- PAG gives final approval for national targets, PI projects, and any changes or additions to dashboard

1) Incident Response Improvement System
5: Local leaders and staff have compensation tied to system-level goals

**Rewarding System-Wide Performance**

Shared performance data can go a long way toward incentivizing improvement and collaboration. However, top-performing organizations also rework compensation and incentive plans to ensure an appropriate balance between system and local goals.

If incentives are too far rooted in the success of individual facilities or service lines, competition may be unwittingly encouraged, and system priorities may go neglected. On the other hand, if incentives tend too far toward the system level, individual behaviors can be undermined. Our research suggests that system-level service line leaders should be incentivized on the basis of both system performance metrics (i.e. system-wide quality and/or financial performance) as well as service line-specific performance goals. This incentive structure ensures that service line leaders do not act at cross-purposes with one another, while also maintaining an incentive to maximize the performance of their individual service lines. Similarly, hospital-based service line administrators should be incentivized based on both facility-specific performance metrics, as well as the overall performance of the service line and/or system, with roughly 40% to 60% of their incentive plans tied to system-level goals.

**System-Focused Executive Incentives**

As Intermountain Healthcare refined its system-level clinical governance structures, the organization has evolved its compensation structure. Clinical Program Directors have incentive plans split evenly between system performance and performance against individual goals (i.e., goals specific to their Clinical Program). Hospital administrators are incentivized in part based on facility performance, with 50% of their incentive plans tied to hospital performance, but they also have 25% of their incentive plans tied to regional performance and system performance, respectively. These compensation structures further incentivize collaboration between system and local leaders, even in cases of indirect reporting relationships.

**Extending System Incentives to the Front Line**

In some cases, Intermountain has even restructured compensation at the individual physician level to mitigate individual behavior that is counter to the success of the broader system.

For example, one of the primary goals of cancer care leaders at Intermountain was to reduce competition between Intermountain radiation oncologists. They wanted the radiation oncologists to refer patients to the most appropriate site of care without concern for the implications to their income.

To that end, they developed a compensation model in which all radiation oncologists pool their wRVUs. Individual compensation is determined by dividing the aggregate wRVUs by the number of providers. Because compensation is not directly tied to individual productivity, physicians send patients to the most convenient facilities and are willing to support specialist deployment in traditionally low-access areas.
6: The role of system leadership is clarified through an explicit authority matrix

Defining the Role of the System

As organizations make strides toward creating or refining system service line structures, elevating appropriate responsibilities to the system level, promoting greater transparency, and restructuring compensation, it is crucial to develop a principled approach toward clarifying roles and responsibilities to prevent confusion or duplication.

At Intermountain Healthcare, for example, a formal charter lays out the scope of responsibilities for the organization’s system service lines, called Clinical Programs. This charter details specific areas of work and the role of the system leadership, and prescribes the frequency with which system leadership is expected to be involved. The charter also defines what is out of scope for system-level program leadership.

Intermountain’s Clinical Program Charter

<table>
<thead>
<tr>
<th>Area</th>
<th>Role</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitors work processes for clinical and financial variance reporting.</td>
<td>Monitor</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Leads clinical initiatives including products, equipment, and staffing.</td>
<td>Approve/Recommend</td>
<td>As needed</td>
</tr>
<tr>
<td>Collaborates with region and system colleagues in capital and operations budgeting and supply chain processes. Drives system standards. May execute and manage system projects.</td>
<td>Recommend Execute (system approved projects) Monitor</td>
<td>Yearly and as needed</td>
</tr>
</tbody>
</table>

Responsibility Charting Helps Clarify Individual Scope of Authority

Froedtert & The Medical College of Wisconsin took a similar approach by using a business tool known as a RASCI chart to clearly delineate between various stakeholder responsibilities at the individual level. Froedtert’s first RASCI chart was created for its cardiovascular service line. Cardiovascular service line leaders, physician group leaders, hospital executives, and system clinical leadership met weekly to define and establish consensus on the key tasks and decisions necessary to manage cardiovascular services throughout the system. From there, the group negotiated stakeholder roles and responsibilities, assigning roles (Responsible, Accountable, Supports, Consulted, or Informed) for each of the 23 distinct tasks. The original process took six months to complete, and the group now reconvenes on an annual basis to account for any new roles and adjust the chart based on both previous year’s experience and any new system priorities.
Case Study Spotlight
Froedtert’s Process for Completing Its Cardiovascular RASCI Chart

Froedtert & The Medical College of Wisconsin uses a RASCI chart to clearly delineate between various stakeholder responsibilities at the individual level. The RASCI process required system leadership to assign roles of Responsible, Accountable, Supports, Consulted, and Informed for each element of the management of its service lines, requiring both system and local leaders to come to consensus around scope of authority for specific decisions. Froedtert’s first RASCI chart was created for its cardiovascular service line. The group negotiated stakeholder roles and responsibilities for each of the 23 distinct tasks. An excerpt of the Cardiovascular RASCI Chart can be found below.

RASCI Chart Delineates Responsibilities in Complex Service Line Structure

Excerpt of Froedtert’s Cardiovascular RASCI Chart

<table>
<thead>
<tr>
<th>Tasks</th>
<th>CV Service Line Dyad</th>
<th>Hospital President</th>
<th>Physician Department Chairman</th>
<th>Physician Group CEOs</th>
<th>SVP of Service Line Development</th>
<th>System CMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create service line operating budget</td>
<td>R</td>
<td>A</td>
<td>S</td>
<td>C</td>
<td>A</td>
<td>S</td>
</tr>
<tr>
<td>Monitor and report service line profit and loss performance</td>
<td>R</td>
<td>I</td>
<td>S</td>
<td>I</td>
<td>I</td>
<td>S</td>
</tr>
<tr>
<td>Generate system annual capital budget requests</td>
<td>R</td>
<td>A/R</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>S</td>
</tr>
<tr>
<td>Create entity level capital budget</td>
<td>A</td>
<td>A/R</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>S</td>
</tr>
<tr>
<td>Set and monitor service line customer service goals</td>
<td>R</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
</tr>
<tr>
<td>Set and monitor service line quality goals</td>
<td>R</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
</tr>
<tr>
<td>Improve and maintain entity level service</td>
<td>R</td>
<td>R</td>
<td>S</td>
<td>R</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Improve and maintain entity level quality</td>
<td>R</td>
<td>R</td>
<td>S</td>
<td>R</td>
<td>S</td>
<td>R</td>
</tr>
<tr>
<td>Set, monitor, improve physician engagement</td>
<td>S</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Set, monitor, improve staff engagement</td>
<td>S</td>
<td>R</td>
<td>S</td>
<td>R</td>
<td>R</td>
<td>S</td>
</tr>
</tbody>
</table>
7: Responsibilities arising from dotted-line relationships are specific and unambiguous

Direct Reporting
Effective, but Not Right for All

Clear responsibility charting is simplest to execute against in systems with direct reporting between system service line leaders and facility-based administrators. In these cases, final decision-making authority can typically be delegated to a single individual.

However, for many systems, particularly those operating over a large geographic footprint and in multiple markets, direct line reporting may not be feasible. Matrix-based reporting structures are often a better fit as a means for enabling oversight and input from both facility-level and system-level leaders. However, matrixed-based reporting structures are not without their challenges, as they can often create confusion, lead to internal competition, and result in unnecessary duplication.

Strengthening the “Dotted Line”

At Intermountain Healthcare, the system’s Clinical Programs are managed through a matrix-based reporting structure. Hospital service line administrators report directly to their hospital’s COO, but also maintain a matrixed, “dotted-line” reporting relationship with the System Director of their clinical program. However, ambiguity around the definition of dotted line reporting initially made decision-making authority unclear and ambiguous. To increase collaboration and accountability in these matrixed relationships, Intermountain created a system-wide definition for dotted-line reporting, giving system executives shared approval authority for many key decisions. Today, system executives have a prescribed role in talent management, annual goal setting and review of goal achievement, prioritization of financial and human resources, and compensation and incentive decisions. System executives called out involvement in the hiring of facility-based administrators as especially crucial for ensuring strong alignment in matrixed relationships and reducing internal competition.

Firming Up the Dotted Line

The dotted line means the system [and hospital-level] executives will have a shared approval authority for:

- Talent management—selection, succession planning, performance evaluations, termination
- Annual goal setting and review of goal achievement
- Prioritization of financial (budget review) and human resources (staffing levels)
- Base pay and incentive decisions
- Functional organization design and standardized tools, processes, and metrics
- Functional strategy, alignment, and integration

Of course, even clearly designating areas of shared approval and authority does not necessarily guarantee consensus, so top-performing systems also have a means for elevating decision making in cases of stalemate. At WellSpan Health, for example, facility presidents have a matrixed reporting relationship with the VP of each of the system’s eight service lines. This matrixed dyad is expected to come to consensus on any strategic or financial decision impacting service line operations at the facility level. Although the expectation is that this dyad will come to agreement the vast majority of the time, any decisions that cannot be resolved are elevated to the system’s EVP, Clinical Practice and EVP/COO.
8: Physicians are directly embedded in service line governance structures

Including Physician’s Voice in Strategy Design

Top-performing systems always featured a prescribed, formalized role in the management of the service line and formulation of service line strategy. This was particularly apparent among those organizations focused on improving physician engagement or standardizing clinical processes, but it was also strongly emphasized as a key success factor by organizations focused on more strategic, operational, or financial system objectives (e.g., the rationalization of system services and assets).

Although many systems have long informally consulted physician champions and leaders in setting service line strategy, best-in-class organizations are formalizing physician involvement through dedicated service line leadership positions. Systems have two primary options for embedding physicians in service line governance structures at the system level: 1) implementing a dyad leadership structure with a clinical leadership position, and 2) including physicians in service line executive/governance committees. A growing number of systems, particularly those focused on improving physician engagement and reducing clinical variation, adopt both of these models.

Two Common Models for Physician Service Line Leadership

1. **Physician-Administrator Dyad**
2. **Physician-Led Steering Committee**

Premier Health has six service lines led by a system-level leadership dyad, made up of a physician leader and an administrative leader. Each service line dyad is also supported by a physician-led steering committee called a Physician Institute, which meets on a monthly basis to discuss service line strategy. Areas of focus vary by service line. For example, emergency medicine and trauma has focused on operations, growth, and geographical footprint expansion, while the cancer service line has focused on branding and clinical pathways.

Each Physician Institute is comprised of 12 to 14 physicians. To ensure system-wide buy-in and participation at the outset, the Institutes initially operated under a “House of Representatives” model, with significant care taken to ensure an accurate representation of the system’s mix of physicians across subspecialties, facilities, and alignment models (i.e., employed, academic, and independent).

Over time, the composition of the Physician Institutes has evolved to reflect the strategic focus of each group, with physicians rotating on and off as needed based on current organizational priorities. Evaluation of the composition of each Institute is the responsibility of the Chair and Vice-Chair of that particular Institute, as well as the service line vice president. Together they review the makeup of the committee on a regular basis.

As Premier Health’s Physician Institutes have evolved, they have also become much more multidisciplinary in nature. Physicians from other clinical areas are invited to participate when appropriate; for example, many of the committees have invited primary care physicians to participate, given Premier’s growing focus on population health and care coordination.

In addition to encouraging physician alignment through direct participation, Premier Health’s Physician Institutes also help drive broader engagement across the rest of the service line. For example, they may convene time-limited subcommittees focused on specific clinical and strategic issues.
In 2011, seeing all of the changes occurring across the health care industry, our CEO and board established a goal for our organization to become a “physician-led, professionally managed” system. One of the most important changes we made was to create six system service lines. We believe service lines are the chassis for change moving forward.

As we looked at many of the top objectives we had for the organization—reducing cost, rightsizing capacity, moving toward population health—we knew that Premier Health would be most successful if we could empower physicians to lead the charge. So as we chartered our service lines, we were careful to design a model that would give physicians the opportunity to drive strategy at the system level. In the past, system leaders would hand down a strategic plan to facility leaders to implement. Today, physicians from across the organization are directly involved in that planning process. In elevating our service lines to the system level, we’ve actually achieved a better balance in ensuring that planning is both a top-down and bottom-up process. Our plans are stronger because physicians lend their unique perspective, and physician engagement in execution is higher because they help set the strategy up-front.

How did Premier Health evolve to the structure it has in place today?

Each service line is run by a dyad, made up of a physician and an administrative executive, and a steering committee called a Physician Institute, which includes 12 to 14 physicians. Our Institutes are staffed by independent, employed, and academic physicians to ensure that we have strong engagement across the system. Physicians are also rotated on and off the Institutes depending on the strategic focus of the Institute at any given time.

Physician engagement isn’t just limited to the service lines. We’ve added physician chairs to each of our four hospitals boards, and physicians make up nearly 30% of our current system board. We also added a physician-led committee to the system board. This “Physician Partnership Committee” deals with issues related to provider engagement and education, as you might expect, but it is also responsible for overseeing the partnership we have with physicians in all aspects of the corporation, including strategy, management, and clinical activities.

We’ve learned a lot along the way and know there will be more challenges going forward. We continue to learn how to collaborate and build trust, and we will continue to evolve. For example, we currently have medical directors for different programs at each hospital—we’re looking to elevate these individuals to system-level medical directors.

How do you find the right physician leaders to fill these positions?

One of the biggest things we’ve learned is that we need to continually invest in our physicians and support them in their new roles. We have always had very talented clinicians, but it’s easy to forget that most weren’t trained to be business leaders. So we’ve invested heavily in professional development. We offer certification in health care administration and provide several scholarships each year for physicians to pursue MBAs. We also bring in outside consultants to provide regular leadership training. This is something that continues to evolve, but we’ve made amazing strides across the last few years. If you design the right structure and can tolerate the noise that comes with change, we believe you can drive significant transformation to create a substantial market differentiated health system.
Special Considerations for Five Key Service Lines

**Cardiovascular**

1. Physician leadership is crucial because of high levels of physician influence over key decisions with significant financial implications (e.g., physician preference items).
2. Successful CV programs are swiftly moving toward a regional “centers of excellence” approach; system CV leaders must be equipped and empowered to make decisions about what is included/excluded from the network (e.g., open heart surgery, TAVR).
3. Progressive systems are increasingly organizing cardiovascular services around disease-centered models (e.g., heart failure, arrhythmia, valve disease) and/or around strategic priorities (e.g., ambulatory care, care redesign, etc.).

**Orthopedics & Spine**

1. Given current levels of demand, there is less opportunity and need to consolidate and regionalize orthopedic services like joint replacement.
2. However, with the sheer number of providers involved in orthopedics and spine care, it is essential to build standardized, triage-based care pathways to direct patients to the appropriate site and provider.
3. Dedicated orthopedic nurse navigators should be employed to facilitate provider communication across sites, guide patient care transitions, and improve patient experience across the care episode.

**Neurosciences**

1. Providers should evaluate system strategies to address the neuroscience physician shortage, including leveraging advanced practitioners and implementing telehealth platforms, to improve access and capacity.
2. Advanced services can be centralized at a single site to rationalize system resources and promote program regionalization through referral relationships or formal hub-and-spoke networks.
3. Comprehensive subspecialty programs provide full-continuum care, attract referrals, and are associated with higher patient satisfaction than scattershot service offerings.

**Oncology**

1. Top opportunities to centralize operations include tumor registries, phone triage systems for symptom management, and clinical research/IRB.
2. Given the importance of care coordination in oncology, system-wide quality initiatives should focus first on care transitions to enable seamless patient movement across sites.
3. Leverage the scale of the network to increase patient access to subspecialist care (e.g., GYN oncologists, oncology genetics counselors) and high-end technologies.

**Imaging**

1. Much of the opportunity for standardization and centralization lies in IT.
2. Organizations should invest in a centralized way to share images and imaging reports across sites of care, an integrated reading platform to facilitate subspecialty reads, and imaging protocol standardization.
3. Care coordination and care standardization efforts will be particularly challenging in imaging due to the fact that most radiology groups remain independent.
Talk to Our Service Line Research Experts

Additional Resources to Support You

Service Line Strategy and Planning

Shay Pratt
Executive Director

Brian Contos
Executive Director

Alicia Daugherty
Managing Director

Matt Garabrant
Practice Manager

Anna Yakovenko
Senior Consultant

Sarah Musco
Consultant

For more information, please contact Shay Pratt at prattM@advisory.com.

Cardiovascular

Brian Maher
Practice Manager

For more information, please contact Brian at maherB@advisory.com

Oncology

Lindsay Conway
Managing Director

For more information, please contact Lindsay at conwayL@adivory.com

Imaging

Manasi Kapoor
Consultant

For more information, please contact Manasi at kapoorM@advisory.com

Orthopedics & Spine

Shruti Tiwari
Senior Consultant

For more information, please contact Shruti at tiwariS@advisory.com

Neurosciences

Emily Brown
Consultant

For more information, please contact Emily at brownEm@advisory.com
We sat down with two of the Advisory Board’s top clinical service line experts to get their take on how systems are approaching service line management and centralization. Read on to learn how Brian Contos, Executive Director of the Advisory Board’s clinical research programs, and Lindsay Conway, Managing Director of the Oncology Roundtable, advise their members on service line transformation.

We’ve seen increasing interest in systems that want to elevate their service line management structures to the system level. Why are we seeing this trend toward centralization?

Brian: I first started to see interest in more centralized service line management models a few years ago, and that interest has really persisted with time. There are a few different reasons to move toward a more centralized model. First and foremost, it’s a necessary precursor to standardizing clinical processes. The pressure to standardize has probably been felt most acutely in cardiology, where there’s a lot of public attention on unwarranted care variation, but it’s something that can help drive cost and quality gains across pretty much any clinical area.

Lindsay: Clinical standardization for oncology requires a different approach than many other clinical areas because there is very little external consensus on cancer treatment. It becomes much more about identifying opportunities for internal process improvement and building consensus across the organization. Some of our members have had incredible success with focusing standardization efforts on specific operational practices within oncology.

Brian: Another driving force toward centralization is the need to rationalize system assets. Most organizations have redundancies—from a capital standpoint, in service delivery, in the way their sites of care are organized—you name it. The value of having a system service line structure is that you can look across the market and make rational decisions about where to invest and where to scale back. That’s hard to do when you have a federalist model and largely independent facility leaders who have full authority to make those sorts of decisions.

Lindsay: I’d add that when it comes to service rationalization, the system infrastructure is important not just in delegating authority and informing planning, but also for ensuring seamless patient navigation. Care coordination is always incredibly important for cancer patients, but you raise the stakes when rationalizing services because patients have to be redirected to new sites of care. Having the system infrastructure to support those efforts is crucial.

Brian: There are two more forces I’d add to the list. One is the increasing emphasis on the ambulatory space. In cardiovascular, in particular, there has been a push to build a governance model that includes the entire care continuum. That’s hard to do when you don’t take a system approach, because ambulatory assets often aren’t directly tied to one hospital.

The last thing that comes to mind for me is the need to integrate for the purpose of total cost management. For example, if your goal is to reduce cost across the care continuum, you need to have an integrated P&L. That’s still a lofty ambition for most systems, but I think one that will become increasingly important as the industry continues to move toward alternative payment and value-based care models.
Brian: I’ve seen a lot of organizations design what looks like a smart governance model on paper, only to find that it doesn’t drive the type of change they were hoping for. What often happens is that the governance model is perfectly well organized, but it’s not necessarily aligned with the specific goals of the system. A really simple, but effective exercise I’ll do with members to assess this is what we call an alignment interview. We sit down with system executives to outline top organizational priorities, and then map out what each service line would need to accomplish to support those goals. From there, you can determine whether the governance model in place actually empowers the right people to deliver on those goals.

Lindsay: Having buy-in and alignment at the very top is crucial. The drive toward integration needs to be spearheaded at the system level, and you need buy-in from the hospital CEOs. Oncology can be an incredibly profitable program for individual hospitals, so it’s important that a hospital’s interests are aligned with the larger goals of the organization. They need to be able to put aside certain individual facility goals to get behind the system.

Brian: Personalities matter a lot in navigating these types of decisions. As soon as you add a layer of system governance, you add a layer of complexity. In most cases, local administrators will still report to facility leaders, with a dotted line to the system. And there is nothing more difficult than managing a dotted line. The person in that system role must know how to manage in a matrix and how to lead through influence. You need someone who is a diplomat above all else: they have to serve as an ambassador for the entire system and have the backbone and stomach to navigate extremely political situations.

Lindsay: I think a lot of systems are starting from such a level of dysfunction that some degree of transformation is necessary. That said, you need to have the right leaders in place to take on a ‘big bang’ approach, and not every system is ready for that. And I’d note that even the transformative approach takes time; these things don’t happen overnight. One member organization I worked with spent months selecting the right system administrator for their oncology service line. Once they identified the right individual, he spent his entire first year on the job focused on relationship building: listening, making connections, and bringing people together. They’ve made incredible progress since then, and it required significant time investment at the outset.

Brian: I agree that there’s often an underappreciation for how much time and effort this all takes. If you design in a vacuum and haven’t gone through the steps to get buy-in and account for the necessary cultural change, things very quickly fall flat. You’re talking about massive changes in how people think about their roles and responsibilities. There are times when transformation is necessary, but this a dynamic process—transformation needs to be continuous. What is right answer today is not necessarily going to be true five years from now. Use today’s priorities to set the one- to three-year plan, and then continue evolving from there.

Systems seem to fall into two different categories. Some are making small changes and tweaking their structure incrementally. Others seem to take a more transformative approach and redesign all at once. What do you recommend when you work with members?

Lindsay: I think a lot of systems are starting from such a level of dysfunction that some degree of transformation is necessary. That said, you need to have the right leaders in place to take on a ‘big bang’ approach, and not every system is ready for that. And I’d note that even the transformative approach takes time; these things don’t happen overnight. One member organization I worked with spent months selecting the right system administrator for their oncology service line. Once they identified the right individual, he spent his entire first year on the job focused on relationship building: listening, making connections, and bringing people together. They’ve made incredible progress since then, and it required significant time investment at the outset.

Brian: I agree that there’s often an underappreciation for how much time and effort this all takes. If you design in a vacuum and haven’t gone through the steps to get buy-in and account for the necessary cultural change, things very quickly fall flat. You’re talking about massive changes in how people think about their roles and responsibilities. There are times when transformation is necessary, but this a dynamic process—transformation needs to be continuous. What is right answer today is not necessarily going to be true five years from now. Use today’s priorities to set the one- to three-year plan, and then continue evolving from there.
Michele Molden has experienced firsthand the challenges and opportunities inherent in building a system service line. Prior to joining The Advisory Board Company, Michele served as executive vice president and chief transformation officer for Piedmont Healthcare in Atlanta, Georgia, where she was responsible for strategic design and corporate business development initiatives for the five-hospital system. She focused on both optimizing the existing footprint of the system and supporting new acquisitions to foster continued growth of the health care system. She also served as founding president and CEO for the Piedmont Heart Institute, where she managed the development of a financially and strategically integrated partnership among the health system and more than 100 cardiovascular physicians to form one of the largest integrated and aligned cardiovascular groups in the country.

We sat down with Michele to learn more about her experience with the Piedmont Heart Institute, and how she’s brought her experience to bear through the Advisory Board Consulting and Management.

Michele Molden has experienced firsthand the challenges and opportunities inherent in building a system service line. Prior to joining The Advisory Board Company, Michele served as executive vice president and chief transformation officer for Piedmont Healthcare in Atlanta, Georgia, where she was responsible for strategic design and corporate business development initiatives for the five-hospital system. She focused on both optimizing the existing footprint of the system and supporting new acquisitions to foster continued growth of the health care system. She also served as founding president and CEO for the Piedmont Heart Institute, where she managed the development of a financially and strategically integrated partnership among the health system and more than 100 cardiovascular physicians to form one of the largest integrated and aligned cardiovascular groups in the country.

We sat down with Michele to learn more about her experience with the Piedmont Heart Institute, and how she’s brought her experience to bear through the Advisory Board Consulting and Management.

Michele Molden has experienced firsthand the challenges and opportunities inherent in building a system service line. Prior to joining The Advisory Board Company, Michele served as executive vice president and chief transformation officer for Piedmont Healthcare in Atlanta, Georgia, where she was responsible for strategic design and corporate business development initiatives for the five-hospital system. She focused on both optimizing the existing footprint of the system and supporting new acquisitions to foster continued growth of the health care system. She also served as founding president and CEO for the Piedmont Heart Institute, where she managed the development of a financially and strategically integrated partnership among the health system and more than 100 cardiovascular physicians to form one of the largest integrated and aligned cardiovascular groups in the country.

We sat down with Michele to learn more about her experience with the Piedmont Heart Institute, and how she’s brought her experience to bear through the Advisory Board Consulting and Management.

Michele: I really look at the Piedmont Heart Institute as an example of what systems across the country are striving to achieve through service line centralization and integration, underpinned by a commitment to physician governance and management. That doesn’t mean that getting there was easy. What led to the formation of the Institute was the leadership of three competing groups within the market deciding to come together and seek the best hospital partner. The Advisory Board was brought into the mix to help create a separate company within Piedmont to house and operate the Institute. The vision ultimately became about more than just expanding cardiovascular services; it evolved into building a new cardiovascular center of excellence.

Although physician support had been a challenge in the past, that vision of a physician-led, professionally managed center of excellence made the conversations more fruitful. Piedmont was ultimately able to acquire and integrate the three cardiovascular practices into a single heart institute that spans all five hospitals across the system. We worked together to build the infrastructure for the cardiovascular center of excellence, including the establishment of appropriate governance and management structures and the creation of a central billing function.

It took a lot of time and hard work, but the results really speak for themselves. Within a span of just two years, the Piedmont Heart Institute evolved into a fully integrated cardiovascular enterprise that bridged ambulatory and acute-care services. For the first time in Piedmont’s history, the system is aligned with more than 100 cardiovascular physicians and surgeons.
How have you applied your experience with the Piedmont Heart Institute to your work with other systems?

*Michele:* First of all, I want to acknowledge that there were some unique factors at play at Piedmont. For example, despite historically high levels of competition in the marketplace, the three practices that we ultimately partnered with recognized that there was an opportunity to build a brand around quality and patient experience through consolidation. Those groups eventually reached a point where they decided collectively that integration—both with each other and with a strong health system partner—was really going to be the path toward success moving forward. For that reason, we were able to build a model around a fully employed cardiovascular physician enterprise.

That said, while every system faces its own unique set of challenges and opportunities, I’ve learned that there are absolutely a set of common principles that can be applied to any organization.

For example, investment in physician leadership is always going to be crucial. At Piedmont, we learned the hard way the dangers of putting physicians in leadership roles who are not trained to do that work. In response, we launched a leadership institute to educate physicians and build up their leadership competencies. Today, a leadership boot camp program gets physicians ready to assume any type of leadership position. This was something that I learned through disruption—but we can help other systems work proactively to address that challenge by establishing those types of support services up-front. And the importance of leadership goes both ways: it’s crucial for administrative leaders to be tuned in to what’s going on clinically, and this often requires some additional education as well. At the end of the day, you really need to create a safe space for administrators and physicians to work together.

I want to note as well that the transformation doesn’t always need to be as drastic as what we did at Piedmont. In a lot of systems, it’s much more productive to smart small and make small tweaks over time. This is particularly true if you’re working in a mixed medical staff model—it’s harder to drive immediate, disruptive transformation when financial alignment isn’t as strong.

What kind of results have you seen from organizations that have centralized and integrated service line management?

*Michele:* At Piedmont, adopting a centralized, center of excellence approach certainly gave the system a more formidable presence in the marketplace. But just as importantly, it helped us make meaningful improvements in quality and patient experience. Today, if a patient needs a valve replacement, they can see a surgeon and cardiologist together. The two physicians will come up with a care plan together, taking into account the patient’s underlying condition. All of the cardiologists have also synchronized their schedules, which frees up personnel and enables us to have staff on the floor at all times. This speeds up the discharge process, which helped us to bring LOS down.

And I’ve seen similar results at organizations we’ve worked with through the Advisory Board Consulting and Management division to help optimize their service line management structures and operations. We helped one organization reduce cost per case within their cardiovascular service line, resulting in a total cost savings to the system of $50 million. At another organization, Consulting and Management executives led the successful negotiation of PSA/MSA agreements between the hematology/oncology service line and a key physician group to allow for the transformation of private practice to a provider-based facility, resulting in a net $2.5 million annual contribution margin.

Each project is different because the advantages of taking a centralized, integrated approach to service line management are really multifaceted. The “magic” is the authority and accountability that the system is willing to cede to the physicians.
Case Studies

Profiles in Service Line Systemness

Service Line Design Follows from System Objectives

As we stated previously, top-performing systems are those that design their service line structures in an effort to achieve a distinct set of objectives based on the specific challenges at hand. While structures can and should continue to evolve over time to address evolving organizational needs, it is crucial for organizations to prioritize at the outset in order to determine the optimal structure for the near term. Prioritization is also essential to avoiding the problem of going “too far, too fast” in transforming organizational structures and potentially disrupting day-to-day operations.

After conducting several dozen interviews with health system executives and service line leaders, we have identified three examples of systems that have designed their service line management structures purposefully and with intention. Rather than relying on legacy organizational structures inherited through consolidation, these organizations sought to transform their structures—but to do so with a distinct goal in mind, rather than a general sense for the need to centralize and “systemize” their service lines.

Meet Our Profiled Institutions

<table>
<thead>
<tr>
<th>Premier Health</th>
<th>Scripps</th>
<th>Intermountain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>• Four-hospital health system based in Dayton, Ohio, managed through a Joint Operating Agreement between four health systems  • Includes over 100 locations throughout Southwest Ohio</td>
<td>• Four-hospital system in San Diego, California  • Provides over 100 medical and surgical specialties</td>
</tr>
<tr>
<td><strong>Primary Objective</strong></td>
<td>To empower physicians to develop and execute on its strategic plan across both the provider-based and value-based continuum</td>
<td>To streamline operations and reduce unnecessary duplication</td>
</tr>
<tr>
<td><strong>Solution</strong></td>
<td>Realigned resources and chartered six system service lines led by 12 to 14 member Physician Institutes to develop and deliver on system strategies</td>
<td>Consolidated services across the system by creating four separately managed operational divisions overseen by a single executive; clinical operations division includes eight clinical care lines</td>
</tr>
<tr>
<td><strong>Full Profile</strong></td>
<td>Pages 29–33</td>
<td>Pages 34–39</td>
</tr>
</tbody>
</table>
Premier Health
Four Hospital Health System in Dayton, OH

• **About:** Based in Dayton, Ohio, Premier Health operates four hospitals. In addition, the health system offers a large primary and specialty care network, home health services, and a health plan. Premier Health is the second largest employer in the region and the largest health care system in Southwest Ohio.

• **Challenge:** Despite having centralized many core services, as of 2011 the system operated as an economically aligned group of hospitals and community care services with four distinct medical staffs that worked in a fairly hospital-centric manner. The organization struggled with driving physician engagement, physician leadership, and collaboration across clinical areas.

• **Solution:** Premier Health reorganized leadership structures throughout the organization, added a physician partnership committee to the board, increased physician leadership at the hospital level, and designated system VPs to hold system-level responsibilities. A core element of this restructuring was the chartering of six physician-led service lines. The service lines are intentionally designed to empower physicians to lead many of the system’s top objectives. Each service line is led by a physician-administrative leadership dyad and a physician-led steering committee called a Physician Institute.

• **Impact and Recognition:** The system has already made some initial strides on core goals that would have been out of reach prior to restructuring; for example, the organization is moving forward with plans to align its medical staffs, which recently voted in favor of consolidated bylaws across the four hospitals. Other key physician-led tactics include the deployment of provider compacts within service lines, planning for bundled episodes, partnerships with nontraditional partners (e.g., CVS Health), geographic access expansion plans, and growth strategies.

### Organizational Background
Growth through Consolidation

- **Key Facts**
  - Hospitals: 4
  - Region(s): 1
  - Physician Network: 475 employed, 3,000 affiliated through Premier Health Group
  - Service lines: 6

- Premier Health was formed 20 years ago through a joint operating agreement between two Ohio-based hospitals. The organization has continued to grow over time; today, the system encompasses four hospitals and over 100 sites of service across nine counties in Southwestern Ohio. Premier Health is managed through a joint operating agreement between MedAmerica Health Systems Corporation, Catholic Health Initiatives, Upper Valley Medical Center and Atrium Health System.

- Premier Health employs over 14,000 individuals, making it the second-largest employer in the Dayton region and the ninth-largest employer in the state of Ohio. Almost 3,000 physicians are affiliated with the system through Premier Health Group, a physician hospital organization, including 475 primary care and specialist physicians affiliated through Premier HealthNet/Premier Health Specialists, the organization’s physician employment enterprise.

- The system operates the Dayton region’s only Level IIIB Neonatal Intensive Care Unit and Level I trauma center, Miami Valley Hospital, and offers more than 70 specialties and post-acute care services. In 2014, the system acquired a state insurance license and began offering its own health plan for employees and their family members. In 2015, Premier Health Plan moved beyond the health system’s own employee base; the plan now covers over 9,500 Medicare Advantage members and 7,000 employer, individuals, and family plans.

- Premier Health is the largest health system in Southwest Ohio.
Moving Away from the Hospital-Centric Mind Set
Becoming Physician-Led and Professionally Managed

When a new CEO, Jim Pancoast, was appointed in 2011, the system had already elevated many organizational functions—legal, finance, human resources, quality, planning, and strategy—to the system level. However, despite being a legally and financially integrated system, the medical staff and organization as a whole maintained a fairly siloed, hospital-centric mind set, with facility leaders determining how to execute against system strategy and financial objectives, and individual hospitals leading the implementation process locally.

In setting a long-term strategy for the organization moving forward, Pancoast and the board established a vision for Premier Health to become a physician-led, professionally managed organization. At the crux of this overarching goal was the need to become a more cohesive system, with physicians embracing and leading the charge on an array of system-wide transformation efforts including medical staff integration, patient quality and experience initiatives, the physician employment enterprise, capacity rightsizing, cost reduction, growth, and population health management.

To this end, Premier Health has undertaken a multi-year initiative to restructure and increase physician representation in leadership positions across the entire organization.

Structuring a System
Re-Organizing for Change

Restructuring has happened at many levels throughout the system. A new Physician Partnership Committee, chaired by a physician, was added to the system board to drive the system’s partnership with physicians in system strategy, management, and clinical activities. During Premier Health’s most recent strategic planning process, the Physician Partnership Committee was given responsibility for reviewing the plan and recommending it to the system board for final approval. The committee also focuses on provider issues, including physician satisfaction, physician leadership training, physician alignment strategies, and physician team culture. Participants are appointed by the board chair and include the Chief of Staff at each system hospital, community members of the board, and other physicians as recommended by the CEO and Chief of Staff at each hospital.

New Board Committee Extends Physician Oversight at the Very Top

At the facility level, each hospital board now has a physician chair. Community members who had previously participated on individual hospital boards have been elevated to the system-level boards, positioning facility boards as primarily physician-driven entities. Hospital and system executives also now serve on hospital boards.

Although many components of the organization’s restructuring have focused on physician leadership, changes have been made on the administrative side as well. For example, the VP of Operations at each of the system’s four hospitals has been given matrixed responsibilities at the system level. These responsibilities include environmental services, laundry services, campus security, nutritional services, imaging, plant operations and maintenance, respiratory, lab, pharmacy, clinical engineering, and sterile processing.

Perhaps most crucial to Premier Health’s restructuring has been the establishment of six system-level service lines: emergency and trauma services, cancer care, cardiovascular care, orthopedics/sports medicine, neurosciences, and women’s health. It is these service lines that are intended to serve as a key chassis for change and integration as the system responds to changing market demands.
Establishing Physician-Led Service Lines

Dyad Leadership Structure Provides System-Level Oversight

- Each of Premier Health’s six service lines is led by a system-level leadership dyad: a physician leader and an administrative leader. These dyads report directly to the system Chief Strategy Officer, who has cross-service line oversight. Each dyad then has matrixed relationships with facility-based operational executives. In a few select cases, the service line administrative executive has direct reporting authority over specific units within the service line that are more easily parsed out from hospital operations; for example, athletic trainers report directly to the orthopedics/sports medicine executive and flight services reports directly to the emergency medicine and trauma executive.

By design, service line dyads are not responsible for facility operations or implementation of strategic initiatives; operational responsibility and deployment sits at the facility level. However, the matrixed reporting structure allows the dyad to support and monitor facilities in the implementation process. Facility-based operational executives report directly to their respective hospital CNO or COO.

The system has invested in development and training programs to educate executives and physician leaders on how to manage effectively through matrixed reporting structures.

All service line leadership dyads meet with the system’s senior executive team six times per year to discuss accomplishments, provide updates on tactics to meet strategic plan objectives, and review opportunities for improvement for the system and service lines.

Beyond the Dyad

Physician Steering Committee Enables Broader Engagement

- In accordance with Premier Health’s commitment to physician leadership, each service line dyad is supported by a physician-led steering committee called a Physician Institute, which generally meets on a monthly basis to discuss service line strategy. Areas of focus vary by service line. For example, emergency medicine and trauma has focused on operations, growth and geographic footprint expansion, while the cancer service line has focused on branding and clinical pathways. Each Institute is comprised of 12 to 14 physicians with one of the hospital’s CEO or COO appointed as well as a member. To ensure system-wide buy-in and participation at the outset, the Institutes initially operated under a “House of Representatives” model, with significant care taken to ensure an accurate representation of the system’s mix of physicians within the service line across subspecialties, facilities, and alignment models (i.e., employed, academic, and independent).

Over time, the composition of the Physician Institutes has evolved to reflect the strategic focus of each Institute, with physicians rotating on and off as needed based on current priorities. Evaluation of the composition of each Institute is the responsibility of its Chair, as well as the service line Vice President; they review the makeup of the Institute on a regular basis. As the Institutes have evolved, they have become much more multidisciplinary in nature. Physicians from other clinical areas are invited to participate when appropriate; for example, many of the Institutes have invited primary care physicians to participate given Premier’s growing focus on population health and care coordination. Each Institute is also supported by an administrative quality director, a market analytics researcher, and a marketing director from the system.

In addition to encouraging physician alignment through direct participation, the Physician Institutes also help drive broader engagement across the rest of the service line. For example, Institutes may convene time-limited subcommittees focused on specific clinical and strategic issues.
Empowering Physicians to Drive System-Wide Initiatives

Decision-Making Responsibilities Defined Across the System

- The structure of the Institutes enables physicians to drive system-wide initiatives. Typically, proposals emerging from the Physician Institutes for approval at the system level fall into one of two categories: operational and strategic. In both cases, there is a clear process in place for elevating proposals to the system level as appropriate.

  Operational proposals (i.e., initiatives impacting supply chain, HR, clinical operations, quality and safety, or patient experience) are brought to the system’s operational leadership group, which includes system COO, the CEOs from each of the system’s four hospitals, as well as the system CMO, CNO, and CHRO. Once approved by System Operations, new operational processes are cascaded down to hospital operational executives for implementation or, when appropriate, recommended to hospital boards and Medical Executive Committees (MECs) for final approval.

  Strategic proposals developed by the Physician Institutes follow a slightly different path. Any proposal that impacts multiple disciplines or facilities (e.g., branding initiatives, partnership strategies, EHR changes, etc.) go to system leadership for discussion and are then passed on to the Physician Partnership Committee, which provides direction and makes recommendations to the system board. Any growth initiative is also evaluated by the organization’s growth strategy group which includes the system CEO, COO, CFO, CSO, and SLVPs before being passed on to the broader leadership group.

Elevating Service Line Needs to Appropriate, System-Level Decision Makers

Given the significant role physicians play in proposing, evaluating, and approving system-wide strategies, Premier Health invests heavily in education and professional development for physicians. For example, the system offers certificates in health care administration for cohorts of physicians and provides several scholarships for physicians to pursue MBAs in partnership with Wright State University. It has also brought in an outside consultant through its Learning Institute to provide physicians with ongoing leadership development training for success within a complex matrix organization.
Adjusting Financial Incentives to Reflect Restructuring
Compensation Ensures System Is Working Toward Singular Strategy

To align financial incentives with its increasingly integrated organizational structure, Premier Health has adjusted incentive plans among administrative leaders to ensure a balance between system and individual goals. The system also uses a cascading goal-setting process to ensure that even individual goals reflect system priorities. All system strategic goals relating to experience, people, partners, growth, and finance cascade from the system CEO down to managers at the facility level, impacting over 800 employees overall.

At the system C-suite level, incentives are 80% based on system-level performance (provider-based and value-based services) and 20% based on individual performance, as aligned with the system’s strategic plan. System vice presidents (which include service line leaders) have a 70/30 incentive structure, with 70% of their incentive tied to system goals, and 30% tied to individual goals. Hospital-based executives and director-level administrators operate under a 50/50 incentive structure.

On the physician side, medical directors at the hospitals also have a portion of compensation at risk based on system goals. At-risk compensation averages 30% and focuses on clinical operations, quality and safety, and patient experience metrics. Service line physician chairs and vice chairs have defined job descriptions and are currently compensated at an hourly rate. In the near future, service line dyads will begin developing plans for putting a portion of physician compensation at risk based on system-level goals.

New Structure Already Driving Gains in Coordination, Integration
Extending Gains Across the Continuum the Next Step

Just three years into fulfilling an ambition to become a “physician-led, professionally managed” organization, Premier Health is already seeing the benefits of its restructuring. Physicians who have historically been hesitant to collaborate or even communicate across facilities or specialty lines now meet regularly and work together to set and deploy system strategy. Strategies that would have previously been unimaginable are not only underway, but are being driven by physicians. For example, at the end of 2015, the system’s individual medical staffs voted to align under a single set of bylaws—something that would have historically been out of reach for the organization without the level of physician engagement it has today. Other physician-led initiatives have included:

• Coordination of medical staff development and recruitment across the system (historically led on a practice-by-practice basis)
• Definition of “right” location for destination services to concentrate volumes in key locations (i.e., Centers of Excellence strategy)
• Unified marketing initiatives for each Physician Institute/service line

Moving forward, Premier Health aims to sustain and extend the level of integration it has been able to drive between its four hospitals into the ambulatory space, particularly as it looks to develop its population health management strategies. While the service lines have made significant strides in integrated planning and strategy across Premier Health’s acute care facilities, system leaders acknowledge that there is still opportunity to elevate the system’s status as a consumer-centric organization by focusing on access in the outpatient and primary care settings. As with all major strategic objectives related to Premier Health’s clinical service portfolio, the system’s service lines and Physician Institutes will support the charge on the system’s consumer and population health strategies.

Premier Health’s ultimate goal is for multidisciplinary service line teams to take responsibility for the full cycle of care for a single medical condition or a set of closely related conditions, encompassing outpatient, inpatient, virtual health (telehealth), post-acute care, rehabilitative care, and supporting services such as nutrition, social work, and behavioral health.
Scripps

Four Hospital Health System in San Diego, CA

• **About:** Scripps is a four-hospital system based in San Diego, California.

• **Challenge:** Due to declining reimbursement and increasing financial pressures as a result of health care reform, system leaders recognized the need to reduce cost. Without large-scale transformation to target underlying system cost structures and processes, the system faced the possibility of needing to lay off staff.

• **Solution:** In 2010, CEO Chris Van Gorder established the OneScripps initiative as a commitment to improving system-wide efficiency and reducing unnecessary cost. Rather than relying on one-time cuts and lay-offs, OneScripps targets underlying inefficiencies in Scripps’ organizational structure and processes (i.e., areas of unwarranted variation and duplication in operational processes and service allocation). One element of this initiative was a dramatic transformation of the system’s vertical organizational structure into a matrixed, horizontal structure. This transformation included the creation of several system service lines to drive improvements within Scripps’ clinical programs.

• **Impact and Recognition:** Scripps achieved $47.7 million in cost savings due to expense reduction in 2011, and a $320 million reduction in operation variation costs between 2010 and 2014. Centralization and consolidation of service lines have produced quality gains in cardiovascular care, elevating Scripps' La Jolla campus to the 19th position on US News & World Report’s Top Cardiology and Heart Surgery programs nationwide.

Organizational Background

An Enduring Community-Based Provider

Scripps has been providing care in the southern California region since its first hospital opened in San Diego in 1890. Over time, the system has grown to encompass four hospitals and five separate campuses, and it provides over 100 medical and surgical specialties. Scripps also provides home health care and hospice services.

Scripps employs 1,000 primary care and specialty physicians through its medical foundation, and an additional 3,000 private practice physicians are affiliated with the system. Overall, Scripps employs over 15,000 employees.

Scripps has been widely recognized for its quality, efficiency, and working culture. U.S. News & World Report’s 2015-2016 Best Hospitals rankings named the combined programs of Scripps Memorial Hospital La Jolla and Scripps Green Hospital among the best in the nation for eight specialties, and Scripps Green Hospital is listed among the top 100 U.S. hospitals by Truven Health Analytics. Scripps has been named to Truven’s list of top 15 health systems in the country—which recognizes systems for quality, efficiency, and patient satisfaction—three times. The system has also been on the Fortune “100 Best Hospitals to Work For” list for the last eight years.

Scripps had $2.5 billion in annual revenue in 2014 and holds a 24.5% market share in San Diego.
A Need for System Unity Drives Reorganization

Scripps Commits to Breaking Down System Silos

In 2010, Scripps President and CEO Chris Van Gorder launched a system-wide campaign to address the significant financial challenges posed by declining reimbursement and health care reform. This initiative, called OneScripps, was designed to reduce cost by breaking down system silos and reducing unwarranted variation. Rather than resorting to across-the-board layoffs to achieve necessary levels of cost savings, Scripps committed to a broader transformation intended to help the system capture the benefits of its scale as a multi-facility health system.

The OneScripps initiative includes five primary goals:

1. Identify and reduce variation in quality and cost
2. Break even on Medicare by 2016
3. Establish greater alignment between inpatient, outpatient care
4. Create greater health care value for the community
5. Foster greater physician alignment

Structuring a System

Horizontal Management Structure Enables Visibility Across Facility Lines

As a first step toward achieving these goals, Scripps consolidated services across the system by creating four separately managed operational divisions, each responsible for overseeing a distinct set of services system-wide. Scripps elevated its four facility-based COOs to the system level to oversee these newly created horizontal divisions. The four divisions include:

1. Corporate Medical Division: nursing, quality, medical and physician comanagement
2. Clinical Operations Division: clinical support, clinical ancillaries, and clinical care lines
3. Support Services Division: surgery, supply chain management, and facilities design
4. Administrative Services Division: finance, human resources, and project management

This new, horizontal management structure allows staff from different departments and facilities to collaborate more effectively and gives system leaders visibility over processes at multiple facilities. For example, service line leaders across facilities are able to collaborate with peers across the system on issues ranging from budgeting to staff allocation. Department administrators meet to compare processes within the hospital, sharing best practices on everything from equipment utilization to patient flow. Furthermore, individual employees share best practices across the system without guidance from their managers, boosting smaller-scale frontline process improvement efforts across the system—15,000 employees exchange ideas across hospitals, departments, and roles. A culture of transparent communication from leadership further focuses employee efforts.
Structuring Newly Merged Clinical Care Lines

Opening Lines of Communication After Decades of Operating Independently

- Oversight of all of Scripps’ clinical services, including its eight service lines—called “Care Lines”—falls within the Clinical Operations Division. This division also includes all clinical support services and ancillaries, in addition to Scripps’ home health services.

OneScripps: Clinical Operations Division

Oversight of the entire Clinical Operations Division is the responsibility of corporate Senior Vice President Barbara Price. Each individual Care Line is led by a dyad: an administrative director paired with a physician leader. The administrative leaders within these dyads report directly to Barbara Price, while the medical directors report to the system’s CMO. Facility-based service line administrators and medical directors report directly to their respective site leaders.

Without formal reporting relationships between corporate Care Line leaders and facility-based administrators or directors, Scripps has continued to evolve its structure to encourage better cohesion between system- and facility-level leaders. For example, to engage facility-based physician leaders in system initiatives, each individual Care Line is supported by a steering committee populated with facility-based medical directors, which helps set system-wide priorities for the Care Line. In accordance with the goals of the OneScripps initiative, these steering groups focus on reducing non-value-added variation in clinical and operational processes (e.g., labor, supply, quality).

Each Care Line dyad and steering committee is also responsible for convening working groups and subcommittees, which work on reducing variation in specific areas and establishing new clinical and operation processes. For example, the Cardiovascular Care Line has specific subcommittees focusing on EP, echo, surgery, and vascular, comprised of the appropriate specialists in each case. Clinical Care Line subcommittees often collaborate with Clinical Support or Clinical Ancillary groups when designing clinical processes. For example, the Neurology Care Line wanted to create a standardized practice for CTs in stroke patients. It formed a stroke subcommittee, which in turn partnered with the Imaging Clinical Ancillary group. Together, the groups created standardized practices for CTs in stroke patients.

Scripps also encourages collaboration across clinical areas through monthly meetings of the Clinical Care Line Council, a governing body made up of all of the Clinical Care Line dyad leaders, along with leaders of the Clinical Support and Clinical Ancillary groups. This council convenes to discuss and share current initiatives and collaborate around strategies that span multiple clinical areas.
Although most of Scripps' service lines were established during its organizational restructuring in 2010, Scripps' most mature service line is its cardiovascular service line, the formation of which preceded the OneScripps initiative.

In the early 2000s, new seismic standards passed by the state of California forced Scripps to make a decision between either closing or rebuilding its La Jolla Hospital campus. Scripps took this disruption as an opportunity to examine service allocation across the system and look for opportunities to move or consolidate services if and where appropriate. A decision was ultimately made to consolidate La Jolla’s cardiology program with the cardiology program at Scripps Green Hospital, with the goal of improving quality and reducing cost through a single, high-volume program. The consolidation of these two programs (the two highest-volume cardiology programs within the system) also involved the creation of a system-level service line structure employing a physician/administrative comanagement leadership model.

To decide which campus would house the cardiovascular service line, Scripps included all site leaders and key cardiologists from all four hospitals in the decision-making process to help bolster system-wide support for the consolidation. A decision was ultimately made to move cardiovascular service out of Scripps Green Hospital and build a new campus dedicated to cardiovascular care at the old La Jolla campus. The Prebys Cardiovascular Institute opened in 2015; a corresponding MOB building will be open in 2016, along with an ED located on the first floor of the Institute.

**Major Milestones**

<table>
<thead>
<tr>
<th>2000s</th>
<th>2010</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>New state regulations force Scripps to rebuild hospital campus</td>
<td>Scripps unveils 25-year plan that includes new La Jolla Campus and Cardiovascular Institute</td>
<td>Opened Prebys Cardiovascular Institute</td>
</tr>
<tr>
<td>2006</td>
<td>Scripps announces the development of a Comprehensive Cardiovascular Institute</td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>Scripps breaks ground on new campus</td>
<td>2016</td>
</tr>
<tr>
<td>2016</td>
<td>MOB Building, ED to open</td>
<td></td>
</tr>
</tbody>
</table>

With the increased integration of cardiovascular services through the system-level comanagement structure and the consolidation of the two programs, La Jolla Hospitals and Clinics reached number 19 in US News & World Report's Cardiology and Heart Surgery ranking in 2014. Additionally, with the space and capacity available at Scripps Green Hospital, a new building dedicated to radiation oncology was built on the Green campus, and Green Hospital quickly emerged as the system’s leader in that service.

With the broader move toward horizontal comanagement models across five other service lines as part of OneScripps, similar efforts to consolidate and rationalize services are occurring in other clinical areas as well. The system as a whole has begun to establish Centers of Excellence at different locations: the Encinatas campus houses all rehab services, for example, and the Mercy campus houses all behavioral health services.

**Scripps' Key Elements of Success**

- Inclusion of all site leaders in transition plan development
- Proactive redress of physician problems
- Visible public unity among administrative leaders
- Aligned financial incentives across staff
Transforming Beyond Leadership

Reworking Incentives to Enforce Adherence to System Standards and Engage Frontline Staff

- OneScripps has elevated more aspects to the system level than just leadership, personnel, and organizational structures. It also eliminated individual financial metrics and rolled performance up to one system target. Previously, each hospital was responsible for reporting its margin, volumes, and cash on hand. Today, all hospitals' metrics are rolled into one pro forma with a system target.

Scripps also extended system incentives to frontline staff through an employee incentive, or "Success Shares," program. The program awards additional days' pay for employees meeting facility and/or system goals. Goals are set at both the facility and system levels based on the previous year’s performance on metrics such as facility-level patient satisfaction, facility-level volume-adjusted labor dollars, and system-level earnings before interest, depreciation, and amortization (EBIDA) targets. The award pool is predetermined annually with payout based on days’ pay, and the potential bonus and explanation of metrics is provided so that the staff knows the exact amount of possible reward.

From 2007 to 2013, Scripps made a cumulative of $60 million in success shares payments—$10 million in 2013 alone. In 2013, 71% of staff were satisfied with their pay—up from 54% in 2005, before the Success Shares Program began.

Scripps has found that transparency is also a large motivator for staff. A monthly scorecard update is distributed internally for all business units to show progress toward goals. As shown below, the award amount is presented in that day’s pay, and the shaded area highlights the percentage of the possible award staff at each site will receive.

Scripps Health’s Success Shares Award Statement

To better align financial incentives for the Clinical Care Lines specifically, Scripps is moving toward a budget and an integrated P&L for each service line that will span all relevant sites of care. While still a work in progress, leaders expect that these changes will help to elevate system-level priorities and reduce competition among sites.

Leaders at Scripps also emphasize the importance of establishing non-financial incentives as well. The system has been working closely with its Physician Leadership Cabinet (PLC), comprised of all of the Chiefs of Staff and Vice Chiefs of Staff, to encourage more consistent implementation of processes and standards across the system. Moving forward, the PLC will enforce adherence to system standards through their annual OPPE process.
Results from the Transformation to OneScripps
Centralized Governance Reduces Variation, Produces Savings

OneScripps has driven a wide range of process improvements and cost savings, both within specific services lines and across the organization more broadly. Below is just a sampling of the results Scripps has been able to achieve through this restructuring.

$47.7M
Cost savings due to expense reduction in 2011

$29.1M
Revenue capture increase in 2011

$320M
Reduction in operation variation costs between 2010 and 2014

$6M
Annual savings from streamlined laboratory services

$19M
Savings from improved emergency department patient triage

Perhaps most crucially, OneScripps has translated into patient-facing gains as well as internal improvements. Quality gains within distinct service lines have improved patient outcomes and resulted in a growing number of external accolades from organizations such as US News & World Report; notably, improvements in cardiovascular services, due in large part to increasing centralization and consolidation, have ensured its appearance in national rankings 11 years in a row, and Scripps is now San Diego county’s largest heart care provider.

Scripps has seen substantial gains in patient satisfaction as well, due to improved collaboration and efficiency as a result of its restructuring. The system went from being in the 38th percentile on patient satisfaction in 2005, to the 73rd percentile by 2013.

Patient Satisfaction Score
By Percentile

FY05 FY07 FY09 FY11 FY13

73
38
Intermountain Healthcare

**Twenty-Two Hospital Health System in Salt Lake City, UT**

- **About:** A 22-hospital, integrated delivery system headquartered in Salt Lake City, Utah, with facilities located throughout Utah and southeastern Idaho.

- **Challenge:** An internal research study conducted in the 1980s revealed that vast inconsistencies in care delivery were driving variable outcomes for patients and causing the system to incur substantial and unnecessary costs. Initial efforts to improve quality were successful, but they tended to be limited to a single location or facility.

- **Solution:** Intermountain Healthcare established a robust clinical governance structure to oversee the development, deployment, and ongoing improvement of system-wide care standards. The system has since established 10 Clinical Programs organized around key processes of care. Each Clinical Program is led by a Guidance Council which identifies and prioritizes areas of unnecessary clinical variation and convenes Development Groups to define, develop, and deploy care standards.

- **Impact and Recognition:** Between 1995 and 2011, Intermountain introduced over 100 successful clinical improvement initiatives. Today, the system attributes 95% of care delivery to 104 clinical processes, which the system constantly works to improve. Standardization efforts have produced significant cost savings and outcome improvements for both the system and the community; for example, Intermountain’s induced labor protocol led to a $50 million reduction in health expenditures across all of Utah.

**Organizational Background**

A Truly Integrated Delivery System

- Intermountain Healthcare is a 22-hospital, not-for-profit health system headquartered in Salt Lake City, Utah, with facilities located throughout Utah and southeastern Idaho.

Although Intermountain Medical Group employs over 1,100 physicians, independent physicians deliver a significant percentage of care at the organization; over 4,000 independent physicians have privileges at Intermountain facilities.

Intermountain’s owned health plan, SelectHealth, has become an increasingly crucial part of the organization’s business. Health plan membership increased by 19% between 2013 and 2014 alone.

In 2015, Intermountain was named a top three organization in patient safety by the Patient Safety Movement Foundation for their work to reduce adverse drug events.
Variability in System-Wide Care Processes Creates Impetus for Change

Desire to Reduce Variation Necessitates Reorganization of Clinical Governance Structure

- In 1996, Intermountain began an initiative—championed by Chief Quality Officer Dr. Brent James—to improve quality through the standardization of clinical practice across the system. In 1998, as part of this ambition, the system established a clinical governance structure designed to organize Intermountain’s care standardization and process improvement efforts. The resultant structure has served as the foundation and organizing principle for all of Intermountain’s clinical care services since that time, even as the system has continued to grow.

Structuring a System

Positioning for Care Standardization

- Intermountain’s clinical governance structure includes both “vertical” clinical programs (i.e., service lines) organized around key processes of care, and “horizontal” clinical services, which encompass support functions that span multiple disease states and specialties. As of 2015, there are 10 Clinical Programs and 15 Clinical Services.

Intermountain’s Clinical Programs and Clinical Services

<table>
<thead>
<tr>
<th>Case Management</th>
<th>Continuum of Care</th>
<th>Food and Nutrition</th>
<th>Imaging Services</th>
<th>Laboratory Services</th>
<th>Nursing</th>
<th>Pain Management</th>
<th>Publications</th>
<th>Patient Flow</th>
<th>Patient Safety</th>
<th>Pharmacy Services</th>
<th>Rehabilitation Services</th>
<th>Respiratory Services</th>
<th>Infectious Disease</th>
<th>Genetics</th>
</tr>
</thead>
</table>

The system CNO and CMO jointly chair the Clinical Operations Leadership Team (COLT), an executive committee with oversight over all Clinical Programs and Clinical Services. Each Clinical Program is led by a physician-administrator dyad and a steering committee called a Guidance Council which helps to set system-wide strategy for the service line. Site-level program administrators oversee day-to-day operations and facility-level planning activities.
Enabling Cross-Service Line Collaboration
Formal Processes for Sharing Best Practices Across Clinical Areas

As the executive committee with oversight over all Clinical Programs and Clinical Services, COLT is charged with responsibility for clinical care across the entire system. COLT is chaired by the system CNO and CMO, and includes the system CNIO, CMIO, the CMO and CNO from each of Intermountain’s four regions, Home Care, Medical Group, and health plan, along with the system AVPs for quality and patient safety, patient engagement, and integrated care management. COLT has decision-making authority for actions proposed by Clinical Program leaders that will cross the entire organization, such as a change in a care model or a significant purchase.

Clinical Program and Clinical Service leaders do not attend the COLT meetings that occur every other month, except when presenting a proposal or initiative for approval; however, the system does bring all service leaders together twice a year for a Clinical Leadership Team meeting. This forum enables service line leaders to network and discuss areas of shared success or challenge.

Two Methods For Driving Collaboration Across Clinical Programs

Clinical Operations Leadership Team (COLT)
- **Purpose:** To establish and approve strategic priorities impacting clinical care across the system
- **Frequency:** Every other month
- **Members:** System CMO/CNO, system CNIO/CMIO, regional CMOs/CNOs, Home Care CMO/CNO, Medical Group CMO/CNO, AVP Quality and Patient Safety, AVP Clinical and Patient Engagement, AVP Care Management, AVP Nursing, AVP Medical Affairs, System Associate CMO

Clinical Leadership Team
- **Purpose:** To enable best-practice sharing across programs and services
- **Frequency:** Twice a year
- **Attendees:** All system-level Clinical Program and Clinical Service Leaders

Driving Service Line Strategy, Care Standardization Efforts from the System Level
Role of System is Clearly Defined

As noted earlier, each Clinical Program is led by a dyad, comprised of a part-time medical director and a full-time operations director (often a nurse). This dyad works closely with a steering committee called a Guidance Council, which includes regional clinical leaders, administrators, and dedicated IT, finance, and support staff. This group is ultimately responsible for identifying areas of unwarranted clinical variation, prioritizing among those opportunities, and convening working groups known as Development Teams to develop care standards.

To prevent any ambiguity around the role of the system-level dyads and Guidance Councils, Intermountain has developed a formal charter which lays out the role of system leadership in service line planning, finance, and operations.

Intermountain’s Clinical Program Charter

<table>
<thead>
<tr>
<th>Area</th>
<th>Role</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitors work processes for clinical and financial variance reporting.</td>
<td>Monitor</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Leads clinical initiatives including products, equipment, and staffing.</td>
<td>Approve/Recommend</td>
<td>As Needed</td>
</tr>
<tr>
<td>Collaborates with region and system colleagues in capital and operations budgeting and supply chain processes. Drives system standards. May execute and manage system projects.</td>
<td>Recommend Execute (system-approved projects) Monitor</td>
<td>Yearly &amp; As Needed</td>
</tr>
</tbody>
</table>
Balancing System Authority with Local Autonomy Through Matrixed Reporting

Intermountain Uses Dotted Line Reporting Between System and Facility Leaders

Clinical Program Operations directors have dotted line reporting with their counterparts at the facility level. Hospital-based administrators report directly to their hospital’s COO; however, Intermountain felt that it was crucial to foster a collaborative relationship with the System Clinical Program Director as well. However, ambiguity around the definition of “dotted line” reporting initially made authority for decision-making unclear and ambiguous.

To increase collaboration and accountability in these matrixed relationships, Intermountain has created a system-wide definition for dotted line reporting, giving system executives shared approval authority for many key decisions. System executives called out involvement in the hiring of facility-based administrators as especially crucial for driving alignment in matrixed relationships and reducing internal competition.

Clinical Program Leaders Working in Matrix

This definition provides a level of clarity that is often absent in matrixed reporting relationships. As an example of how Intermountain puts this into practice, when the CEO from one of Intermountain’s hospitals, along with the hospital’s cardiovascular administrator, proposed a new cath lab for their facility, the request was sent to the System Director of the Cardiovascular Clinical Program. This director conducted a thorough analysis of local market volumes, cardiovascular services at nearby Intermountain hospitals, and the anticipated community perception of this expansion. Based on this analysis, she concluded that the community did not need access to an additional cath lab. Rather than simply recommending against the proposal in a top-down directive, however, she worked closely with the site-based administrator and CEO to identify a true community need for a heart failure clinic. As a result of this comprehensive analysis, the hospital was able to develop its CV service portfolio in a way that better aligned with community needs.
Regional Leadership Lends Their View
Regional VPs Provide Extra Level of Indirect Oversight

- Because Intermountain serves four distinct and diverse markets, the system is divided into five regions with one tertiary “hub” hospital in each region. Each region is led by a Regional VP (RVP) based out of the area’s hub. The position is a system-level role, and each RVP works with the region’s CMO and CNO through a direct line reporting relationship to ensure that system strategies are tailored to address local market conditions. RVPs also help to collect local market intelligence that can help inform system-level strategy. While RVPs have no direct or matrixed reporting relationships with Clinical Program leaders, they do provide support when necessary; for example, working with smaller hospitals to help implement Clinical Program initiatives.

Compensation Structure Aligns with Governance Structure to Provide Balance
System-Level Metrics Act as Counterweight to Individual Ambition

- As Intermountain Healthcare has refined its clinical governance structures and worked to maintain an appropriate balance of oversight at both the system and local levels, the organization has evolved its compensation structure as well. These compensation structures further incentivize collaboration between system and local leaders, even in cases of indirect reporting relationships. Performance goals vary depending on current system priorities, but encompass areas such as clinical excellence and operational effectiveness. Within the clinical excellence domain, Intermountain sets annual goals that directly measure the organization’s adherence to evidence-based guidelines.

<table>
<thead>
<tr>
<th>Clinical Program Directors</th>
<th>Hospital-Based Administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Composition of Incentive Plan</strong></td>
<td><strong>Composition of Incentive Plan</strong></td>
</tr>
<tr>
<td>50% System performance</td>
<td>50% Hospital performance</td>
</tr>
<tr>
<td>50% Individual performance</td>
<td>25% Regional performance</td>
</tr>
<tr>
<td>25% System performance</td>
<td>25% System performance</td>
</tr>
</tbody>
</table>

Good for the System, Good for the Community
Clinical Programs Drive Better Care, Substantial Cost Savings

- While clinical governance and the establishment of Intermountain’s Clinical Programs is only one component of the system’s strategy to reduce clinical variation, it has been a crucial underpinning to the system’s success, and system leaders identify governance as an important precursor to any attempt to standardize care processes.

Over the past two decades, Intermountain has made substantial strides in reducing clinical variation and improving quality. Below is just a sampling of some of the quality improvements and cost savings the system has been able to achieve.

<table>
<thead>
<tr>
<th>Induced Labor</th>
<th>Colon Surgery</th>
<th>Hip Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50M annual reduction in health care expenditures in Utah</td>
<td>Achieved $1.2 Million annual savings LOS decreased from 8.44 to 6.75</td>
<td>Average internal cost fell from more than $12,000 to about $8,000 per case</td>
</tr>
</tbody>
</table>
Want more on system performance?

This report is a publication of the Health Care Advisory Board, a division of Advisory Board. As a member of the Health Care Advisory Board, you have access to a wide variety of material, including webconferences, research reports, implementation resources, our blog, and more. Check out some of our other work on health system performance.

**Research Report: The System Blueprint for Clinical Standardization**
See seven common principles that are foundational to best-in-class organizations’ success in setting consistent care standards across large and often dispersed footprints.

**Blog Post: The top four 'systemness' priorities for 2016 and beyond**
Learn the four initiatives members say are most important to the future success of their organizations.

**Expert Insight: 10 Things CEOs Need to Know in 2015**
Learn how to win in this world of competing incentives: by uncovering enduring returns from systemness and delivering consumer-oriented solutions.

Visit us at: advisory.com/hcab
Email us at: hcab@advisory.com
ADVISORY BOARD AT A GLANCE

RESEARCH AT THE CORE
A comprehensive platform to drive best practice performance at every level of your health care organization.

TECHNOLOGY AND CONSULTING TO HARDWIRE BEST PRACTICES
Deep solutions across three areas of critical importance:

- HEALTH SYSTEM GROWTH
- CARE VARIATION REDUCTION
- REVENUE CYCLE MANAGEMENT