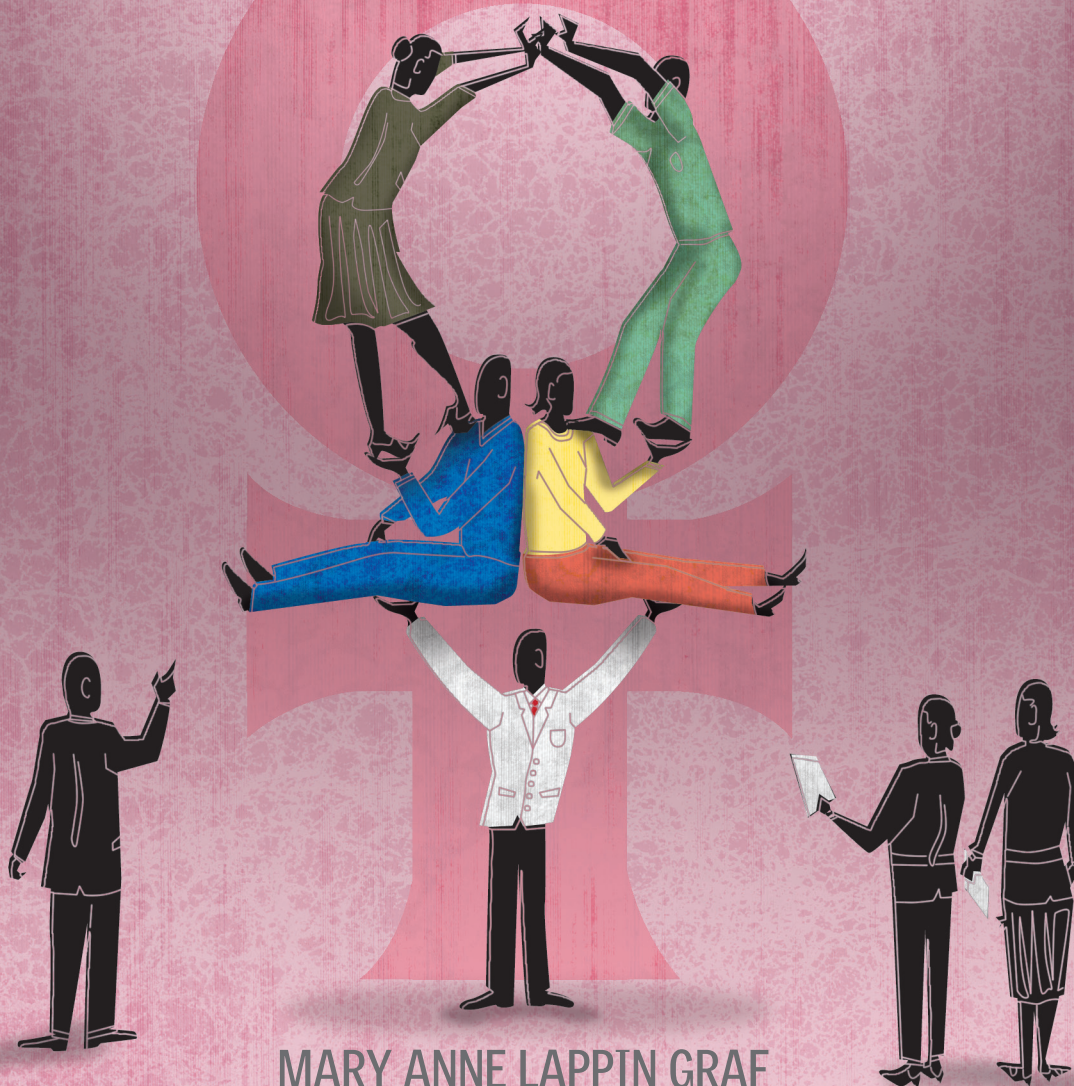


WOMEN'S HEALTH: STRATEGIES FOR SUPERIOR SERVICE LINE PERFORMANCE



MARY ANNE LAPPIN GRAF

WOMEN'S HEALTH: STRATEGIES FOR SUPERIOR SERVICE LINE PERFORMANCE

MARY ANNE LAPPIN GRAF, BSN, MS

+HealthLeaders^{Media}
A Division of *HCPro*

+HCPro

Women's Health: Strategies for Superior Service Line Performance is published by HealthLeaders Media.

Copyright © 2010 HealthLeaders Media.

All rights reserved. Printed in the United States of America. 5 4 3 2 1

ISBN: 978-1-60146-776-8

No part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center (978/750-8400). Please notify us immediately if you have received an unauthorized copy.

HCPro, Inc., provides information resources for the healthcare industry. HCPro, Inc., is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

MAGNET™, MAGNET RECOGNITION PROGRAM®, and ANCC MAGNET RECOGNITION® are trademarks of the American Nurses Credentialing Center (ANCC). The products and services of HCPro, Inc., and The Greeley Company are neither sponsored nor endorsed by the ANCC. The acronym MRP is not a trademark of HCPro or its parent corporation.

Mary Anne Lappin Graf, BSN, MS, Author
Carrie Vaughan, Editor
Rick Johnson, Executive Editor
Matt Cann, Group Publisher
Doug Ponte, Cover Designer

Mike Mirabello, Senior Graphic Artist
Adam Carroll, Proofreader
Matt Sharpe, Production Supervisor
Susan Darbyshire, Art Director
Jean St. Pierre, Senior Director of Operations

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions. Arrangements can be made for quantity discounts. For more information, contact:

HCPro, Inc.
75 Sylvan Street, Suite A-101
Danvers, MA 01923
Telephone: 800/650-6787 or 781/639-1872
Fax: 800/639-8511
E-mail: customerservice@hcpro.com

HCPro, Inc., is the parent company of HealthLeaders Media.

**Visit HCPro online at: www.healthleadersmedia.com, www.healthleadersmedia.com/marketing,
www.hcpro.com, and www.hcmarketplace.com.**

Contents

About the Author..... vii

Acknowledgments ix

Dedication..... xi

Introductionxiii

 Why Do Service Lines Exist? xvi

 Are Service Lines Here to Stay?xxi

 Are There Objective Measures of Service Line Success?.....xxiii

 The Fit of Service Line With Today’s Challenges xxv

 Summaryxxix

Chapter 1: The Air We Breathe..... 1

 The National Context 1

 The Organizational Context 10

 Summary 15

Chapter 2: Why a Women’s Service Line?	17
The Return of the Babies	18
Unprecedented Growth.....	18
Utilization.....	21
The Family Healthcare Gatekeeper.....	22
Potential for Philanthropy	25
Summary	27
Chapter 3: What About Men’s Health?	31
Historical Perspective	31
Growing Interest.....	33
Chapter 4: Key Trends Driving Women’s Health Programming	39
Obstetrics and Neonatal Care	41
Non-Obstetrical Women’s Services	61
Summary	73
Chapter 5: Laying the Foundation.....	79
Visioning and Planning for Success.....	79
Women’s Service Line Organizational Structures	90
Who Leads the Service Line?	94
Positioning the Service Line	106
The Business Plan	112
Summary	118

Chapter 6: Finance and Marketing.....121

 Defining Service Line Value121

 Beyond Department Analysis.....130

 What Women Want: Attracting the Female Consumer.....141

 Summary153

Chapter 7: Kicking Off Your Service Line155

 Critical Components of Successful Women’s Services155

 Launching Your Service Line167

 Physicians and the E Words (Engage and/or Employ).....177

 Summary184

Chapter 8: Staying On Top.....187

 Maintaining a Healthy Balance189

About the Author

Mary Anne Lappin Graf, BSN, MS

Mary Anne Lappin Graf, BSN, MS, knew she would be a nurse by age four and was an entrepreneur by age five. She graduated as a nurse, and then, as a certified nurse-midwife, was privileged to assist hundreds of mothers during birth—all experiences that shaped her life and her career in healthcare.

Graf currently has full-time responsibility for business development and marketing for women's and children's services for the seven-hospital Bon Secours Virginia Health System, the largest faith-based integrated delivery system in Virginia. Prior to joining Bon Secours as vice president for women's and children's services in 2001, Graf founded Health Care Innovations (*teambci.com*) and HCI Market Research Group. In the 16 years HCI was Graf's full-time business, she led the firm to specialty prominence internationally in women's and children's services planning and development.

As a consultant, Graf has personally led more than 800 projects in 48 states and six countries for hospital and health system clients ranging from the nation's top academic medical centers to for-profit, nonprofit, faith-based, governmental, and nongovernmental organization hospitals in the United States and abroad.

She combines a clinical background and a personal commitment to women's health with expertise in education, organizational change, facility development, and marketing.

She and Paul John Graf were married in 1974, then almost forgot to have children. They were finally joined in their 40s by Michael and Ryan, assorted fureluting pets, and for some time even by a gender-indeterminate tarantula. Graf's personal interests include almost any type of music, the Internet (eBay® diva, social media, website construction as a hobby), swimming, water aerobics, reading, and anything Notre Dame, Irish, or Japanese. With more than 7 million lifetime airline miles, travel is also in the equation.

Acknowledgments

Many thanks to all who answered my numerous requests for information with enthusiasm, and particularly for the insights and forbearance of Martin Charns, DBA, whose organizational work I have followed for years, and Rebecca Arbuckle, MBA, MHSA, whose women's health team at Sg2 yielded invaluable data. They and others quoted in the book were unbelievably responsive to my inquiries. Not directly heard in the book, but underwriting every word with what they have taught me over the years are my incredible Health Care Innovations clients and friends worldwide. It is my privilege to have worked with each of you.

My thanks also to the Sisters of the Congregation of Bon Secours, remarkable women with a history and mission to which I immediately related, and who welcomed me home to Catholic healthcare. It is an honor to be both inspired and challenged every day by this organization and by our affiliated providers and partners in Richmond and Virginia—and particularly by those whom I am tremendously privileged to not only respect but love dearly. You know who you are!

Then there is the wonderful gang at Sam and Alison Jarrar's Daily Grind, the coffee version of the television show *Cheers* located in Short Pump, VA, where I wrote all but a few words of this book. You nurtured my body, heart, and soul, and I thank you!

Acknowledgments

The team at HealthLeaders Media has been fabulous from the start. My heartfelt thanks to each of you for putting me in an ideal position to share what I can in women's health. Finally, it takes great music to write a book (or live a life). Many thanks to the musicians whose music is behind every page of this book:

- Alternative: The Black Keys, One Republic, Mogwai
- Celtic Fusion: Phil Coulter, Enya
- Classical: Sarah Brightman, Plácido Domingo, Yo-Yo-Ma,
- Country: Kris Kristofferson, Johnny Cash, and the rest of The Highwaymen
- Japanese: Jean-Pierre Rampal
- Jazz: Kenny G, Peter Popping
- Latino: Toni Brachi, Esteban
- New Age: Denise Young, Lorie Line, and many, many others
- Reggae: Bob Marley
- Rock: Paul Simon, Fleetwood Mac
- R&B: Roberta Flack, John Legend
- One of a kind: Nellie McKay, Dr. John, John Trudell

Dedication

This work is dedicated to Richard Ireland, arguably the father of contemporary women’s service lines, who died far too early in April 2010. Richard is very much missed by all of us who were inspired by Richard and his wife, Peggie Ann, through their Snowmass Institute.

And, of course, to my parents: Harold Vincent Lappin, 1911 to 1993, the Notre Dame-educated life-long journalist and managing editor whose benevolent presence nevertheless inspired my sisters and me to never use either the verb “to lie” or “to lay” casually when he was around. He’d be pleased to know I keep trying to limit my commas. And to my truly remarkable mother, Margaret Ann McGraw Lappin, who—at age 96—continues to coordinate, update, regale, prod, and recommend thank-you notes. With my beloved sisters, Eileen and Julie, the four of us truly have remained Four Women Laughing—definitely including The Infamous Orphanage Incident!

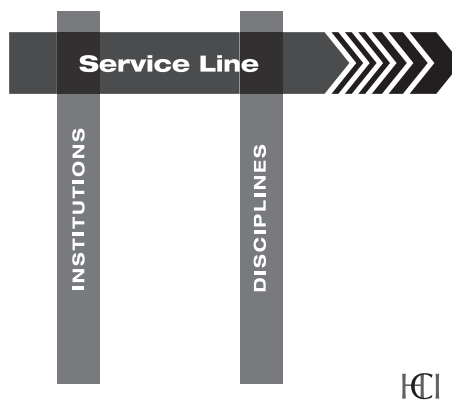
Then there is my ever-patient husband, Paul John Graf, who has never wanted anything but my happiness, and my great kids, Michael and Ryan, who somehow grew to manhood in the blink of an eye. All of them have spent the better part of their lives waiting for me to finish something I just had to do—most recently it was this book. I love each of you more than air, and someday I’ll stop working. Honest. Really.

Introduction

Service line is an organizational structure focused on the outputs, or outcomes, of care. The role of service line is to coordinate the patient’s journey through services related by his or her core identity or individual healthcare needs, with the goal of achieving optimal clinical and business outcomes.

Service lines cross and connect many vertical silos of healthcare—institutions and disciplines—in a way that improves access, care continuity, and outcomes, as shown in Figure A. They are meaningful to the patient during the treatment of a disease process, or because of core identity or life stage.

FIGURE A
SERVICE LINE CONNECTS FUNCTIONAL SILOS OF HEALTHCARE



Source: *Health Care Innovations*, www.teamhci.com.

Service lines don't usually replace healthcare core functions, such as hospitals, departments, or professional education and development. Instead, service lines coordinate those critical functions to create value for the patient.

Service lines are implemented to yield balance and control of resources and outcomes, attract and protect key markets, and improve care of patient populations. Organizational theorist, Martin Charns, DBA, is a professor of health policy and management and co-director of the Program on Healthcare Organizational Studies at Boston University School of Public Health. Charns has researched, implemented, evaluated, and extensively published on product/service line development in industry and healthcare for more than two decades, including his most recent work on healthcare organization design and coordination (see Figure B for examples of service lines). Charns defines a service line as being:

Multi-disciplinary and organized around one or a combination of patient populations, a disease or family of conditions, or a technology or treatment process.

In healthcare, services lines are also referred to as product lines, centers of excellence, clinical service lines, macro segments, core business, strategic business units, or care centers. The variety of names leads to confusion about what they really are, says Charns.

FIGURE B
SERVICE LINE ORGANIZATIONAL STRUCTURES

SERVICE LINE ORGANIZATIONAL MODELS

Disease process or condition	<ul style="list-style-type: none"> • Cardiovascular • Orthopedics • Cancer • Behavioral health
Populations cohorts, including core identity or life stage	<ul style="list-style-type: none"> • Women • Children • Men • Senior health
Technology or treatment process	<ul style="list-style-type: none"> • Surgery • Emergency • Transplant

To determine the organizational type or form of a company, Charns asks a series of questions, based on different forms of organizations detailed in Chapter 1. For example, one organizational form is characterized by supervisors with authority over members of a single discipline (like departments of nursing or medicine). In another organizational form, an employee may have a solid line reporting functional relationship to one supervisor and a dotted line reporting relationship to others in completely different areas of the organization. The latter form is where service line most often fits in.

Why Do Service Lines Exist?

If service lines are just a fad, they're a long-lasting one and getting stronger both in the United States and abroad. Health systems have been using service lines for nearly three decades in the United States, and service lines are even more developed in healthcare institutions in Europe and Australia, Charns says.

Service line organizational structures have a longer history outside healthcare. After World War II, the product line concept arose in the manufacturing industry, supported by the postwar economic boom and technology of the 1950s and 1960s. These product lines were developed to identify, isolate, and brand specific products. The goals were to improve strategic focus, growth, and profitability, building on the scientific base within such functional operations as engineering, finance, and marketing.

These early product lines were characterized by the emergence of science married to business leadership, and a need to grow individual businesses without totally decentralizing the functional manufacturing structure. Early leaders included the aeronautic industry and General Electric. Over the years, these firms successfully hardwired long-term success across multiple sites and disparate functions using the product line model.

Healthcare started adapting the product line concept from the manufacturing industry in the early 1980s. In healthcare, the concept was referred to as a "service" line, partly to denote the service component, and also because of an aversion

within healthcare to the commercial language of “products” and “customers.” The “product line” nomenclature likely caused some of the initial resistance to the service line concepts, Charns notes.

Hospitals and health systems eventually started to develop service lines as a way to better manage cost and growth.

Industry also developed product lines to ensure quality. Healthcare—paid largely for the care process, not outcomes—was slower to exercise the capability of service lines to define and derive high-quality outcomes, but this is without a doubt the challenge in service lines today—especially with the move toward accountable care organizations (ACO).

By the mid- to late 1990s, the concept of an integrated delivery system (IDS) was pushing hospitals toward system development. By 2000, service lines started evolving into a system model, rather than hospital-centric service lines, which is when it became imperative to clearly define the service line leader.

At the same time, industries outside of healthcare also made advancements in product line management. The more advanced companies have an overarching model that “strategically, tactically, and operationally integrates key functions across service lines and geographies,” including cost and pricing, financing, service delivery, performance improvement, recruitment and retention, and information technology, according to Mike Nugent, coauthor of the article “Seamless Service Line Management.” In many health systems, these functions are referred to as “shared services.”

Nugent notes that the company leadership in these non-healthcare industries sets “clear expectations regarding functional competencies and decision-making rights/responsibilities for each of its functional areas (e.g., revenue cycle, facilities management), service lines (e.g., neuroscience, imaging), and site-based management teams (e.g., department directors, chief operating officers, and CEOs).” By studying these companies, the healthcare industry is starting to dissipate some of the current murk around the domain of service line versus functional entities.

Currently, healthcare reform and global trends are forcing strategic prioritization systemwide in healthcare. Some of these trends include the inevitable beginning of the end of open-ended funding of healthcare, transparency of data, the recession, decrease in the availability of capital and credit, a greater emphasis on compliance, reductions in government payments, the burgeoning amount of knowledge that clinicians must be able to act on quickly, decreased utilization as consumers bear more of the burden of healthcare costs, health insurance reform, pay-for-performance, expanded insurance coverage, and the move toward ACOs. The elements all emphasize people, programs, and processes, rather than costly facility development.

Even without the current financial crisis, there is an increasing national awareness that healthcare costs are not sustainable, and our outcomes are not what they should be, given the scientific and technical capabilities of our nation.

WHAT'S THE DIFFERENCE BETWEEN A FUNCTIONAL AND A MATRIX ORGANIZATION?

BusinessDictionary.com defines matrix and functional organizations as follows:

Matrix organization

A multifunctional team structure that facilitates horizontal flow of authority, in addition to its normal (vertical) flow, by abandoning the “one person, one boss” rule of conventional organizations. Used mainly in management of large projects or product development processes, it draws employees from different functional disciplines (accounting, engineering, marketing, etc.) for assignment to a team without removing them from their respective positions. These employees report on day-to-day performance to the project or product manager, whose authority flows sideways (horizontally) across departmental boundaries.

The employees continue to report on their overall performance to the head of their department, whose authority flows downward (vertically) within his or her department. In addition to a multiple command and control structure, a matrix organization necessitates new support mechanisms, organizational culture, and behavior patterns. Developed at the U.S. National Aeronautics & Space Administration in association with its suppliers, this structure gets its name from its resemblance to a table (matrix) where every element is included in a row as well as a column.

Functional organization

A classic organizational structure where the employees are grouped hierarchically, managed through clear lines of authority, and report ultimately to one top person.

Based on the word count, it's not too hard to see which one is more complex (see Figure C for a breakdown of the differences between matrix and functional organizations). But if you're a woman with cancer, being told you had the best surgeon in the

WHAT'S THE DIFFERENCE BETWEEN A FUNCTIONAL AND A MATRIX ORGANIZATION? (CONT.)

world isn't nearly as important as being told you're cured—that is the critical difference between the functional input/process orientation of a department of surgery and the service line output/outcome orientation.

**FIGURE C
DIFFERENCES BETWEEN FUNCTIONAL AND MATRIX ORGANIZATIONS**

	Functional organization	Matrix organization
Organization	Vertical	Horizontal
Command and control	Singular	Multiple
Focus	Inputs, process	Outputs, outcomes
Complexity	Low	High
Example	Hospital or department	Service line

National results of service line organization show that the following three goals can be accomplished:

- Reduction in costs (and often length of stay [LOS])
- Optimal market positioning and quality
- Appropriate balancing of resources and capital

The service line organizational structure focuses on outputs or outcomes, and the functional organization focuses on inputs or processes. The need to control health-care costs now is far higher than ever before, and service line is arguably better suited to balance cost and quality than the functional organizational structure is.

Are Service Lines Here to Stay?

There have been two earlier waves of service line development in healthcare, each taking about a decade. We are now in the third wave. The good news is that each stage has taken the best of the prior wave and built on it.

The first wave was in the '80s and was primarily built around financial analysis of diagnosis-related groups. The second wave featured marketing and business development more prominently. The current wave is around quality.

Each wave has been accompanied by a different type of service line leader, from the “super managers” of the '80s to the executive directors in the '90s and early 2000s. The latter stage often went awry and became purely a marketing ploy. For

example, this was the phase when many labor and delivery staff found a new sign on the door one morning, announcing it was now a “birthing center.” Processes and outcomes often stayed the same; only the name changed.

Tension often shows up between the functional side of an IDS and service lines. Those tensions may arise at high levels in the organization when capital or significant resources are in play, and at lower levels in the organization when managers have difficulty with the concept of responsibility to more than one supervisor. I asked Dr. Charns whether the tension ultimately might undermine service line as an organizational structure.

His answer was that, if anything, service line in healthcare is strengthening in the United States and even stronger in other countries. “You can expect heightened tension any time there are people who know and focus on the process, and people are added who focus on outcomes,” says Charns. “At some juncture there is conflict. The conflict is always there, under the surface, it’s just not articulated and managed—so you may think there isn’t any, but it’s just not being managed. At some point you have to manage it to mature and grow the organization.”

Executives who sponsor service lines are well aware of this dynamic, and consider the pushback from each side to be part of the team learning process during change.

Ask any senior IDS executive with long-term service line experience, and you’ll hear sentiments similar to those of Peter J. Bernard, who has implemented service

lines in three health systems. Bernard is the CEO of Virginia’s fourth largest IDS—Bon Secours Virginia Health System—which has seven hospitals, a medical group and multiple entities, and campuses throughout central and southeastern Virginia. Bernard says unequivocally that “without a doubt, service line has been a huge part of our success. I want the [functional entity] CEOs waking up in the morning thinking about nothing but their organizations, and I want the service line VPs waking up in the morning thinking about nothing but their service lines across the system. Between the two approaches, we have both the depth and breadth we need to succeed.”

Are There Objective Measures of Service Line Success?

Where else do you buy just the process, not the outcome? Granted, not all healthcare outcomes are cures—but the patient and family still want the best possible outcome, and that’s something healthcare has had trouble identifying and consistently producing.

With a smile easily detected through the phone, Charns notes that after his first foray into hospitals two decades ago, he came out saying, “They couldn’t have organized it that way—it doesn’t make sense.” He says he satisfied that question intellectually with the realization that hospitals were originally organized around medical education, not the needs or wants of the patient. But the latter is where healthcare is rapidly headed now.

Examples of service line outcomes measures include:

- The Veteran’s Health Administration reorganized care for 10 diseases/conditions around an “output-oriented approach to quality improvement... resulting in dramatic improvements in quality of care,” according to Joseph Francis in his article, “QUERI II: The Next Generation.” VHA cites improved prevention, diagnosis, treatment, and patient compliance, as well as decreased readmission.
- Judith Westphal, a nationally respected nursing thought leader at the University of Wisconsin, reported service line results include an 8% decline in unit costs per admission, improved quality of care, and rapid response to environmental change.
- The Health Care Advisory Board, a national hospital think tank, notes that “hospitals and health systems that have invested in developing and enhancing orthopedic services through comprehensive centers of excellence see performance improvements across multiple dimensions: better market share and higher volumes, but also enhanced patient and physician satisfaction, improved clinical outcomes, and increased efficiency.”
- After the University of Wisconsin instituted their first three service lines, the medical center reported the following results on pre- and post-service line outcomes, according to Turnipseed, Frangou, Westphal, and others:
 - Variable but steady growth in patient volumes, enhanced market share, positive net margins, and improved patient satisfaction

- Offsetting of consistent downward pressure on reimbursement by improved patient care efficiency (LOS, enhanced preferred provider status, market share)
- Scorecard quality measures that show enhanced teaching and research opportunities
- Increased patient satisfaction scores

The Fit of Service Line With Today's Challenges

The current version of service line responds directly to today's knowledge-based economy, includes quality and bottom line performance measures, and directs operations in a competitive manner. Today's service lines meld strategy, business development, and marketing with the science of specialty healthcare.

Service line executives develop service line-specific business and marketing plans, determine where and how scarce resources should be invested, and ensure that the care delivery process itself is of high quality. This strategic dimension yields a systems-thinking perspective and a powerful management direction orientation.

The most significant vector influencing service line development in the past decade has undoubtedly been the change in orientation from hospital-centric to a system-wide scope.

**CASE
STUDY**

Shift to systemwide service line model

In 2006, Memorial Hermann Health System (MHHS) in Houston shifted to a model where its service lines operated as one program with multiple sites capable of attracting a particular mix of new and existing patients through a variety of old and new tactics, wrote Mike Nugent in an article on seamless service line management. The organization needed to balance system resources and recognized that the old tactics of “recruit a physician and grow” or of “build it and they will come” no longer worked. Coordination across facilities was required to optimize future investment.

MHHS needed to allocate resources while responding with more agility to, and freeing up resources for, competitive challenges and opportunities. As a result of the shift in focus, the system:

- Combined redundant services set up originally by independently functioning member hospitals
- Recruited several key specialists to round out system service line offerings
- Employed systemwide service line executives
- Set systemwide clinical service line standards (e.g., for cancer treatment)
- Experienced “multimillion-dollar revenue cycle enhancements”

Today's service line leader has accountability across the healthcare system for the following:

- Strategy and business development, and marketing
- Responsibility for the patient experience across all consumer contacts with the system, from the distribution of healthcare information and promotion, through prevention and diagnosis, through the physician enterprise and care within the system, through home care and return to optimal function.
- Envisioning and garnering engagement around quality and operational performance over time and the patient care experience, as well as setting the goals and the bars for measurement.

Successful service lines also serve as the innovation hub for interrelated clinical business research and development, which is the catalyst for successful market launches of clinical and service innovation, the center of resource coordination and allocation, and the driver of overall quality of care and user satisfaction. Today, health systems usually have five to seven key service lines—more than that can reflect a lack of focus.

During the past decade, many departments—seeing the shift in organizational resources to service lines—developed “service line envy.” But organizations should focus on strengths rather trying to develop service lines around all of their offerings. Service lines should cross departmental lines, focus on outcomes, and connect patient care, either for a disease process or through a core identity or life stage,

spanning a horizontal period in a patient's life (see Figure D for service line characteristics).

FIGURE D
CHARACTERISTICS OF SERVICE LINES TODAY

- **Market-driven:** Organization around the patient's needs, experience, and outcomes over time.
- **Coordinated care over time:** Focused on more than a single visit or episode of care.
- **Interdisciplinary:** Collaboration with multiple related clinical and business disciplines.
- **Integrative:** Connection of the healthcare silos of institutions, disciplines, and departments.
- **Outcome-driven:** Engaged to envision and achieve desired clinical and business outcomes.

Departments such as surgery and emergency play a crucial role in many health systems, and hospitals all have departments that are critical for value as differentiating niche or that generate margin that must be protected. Often, these departments will benefit from systemwide management and expertise, and can be marketed successfully as niche department services. Examples are minimally invasive surgery centers, emergency departments, transport or transplant services, and mission services in a faith-based hospital. Often, health systems differentiate these departments as centers of excellence, rather than service lines. Whatever the name, they can benefit from systemwide management and support, and often can be marketed as a niche service to the community.

Summary

- Multidisciplinary service lines cut across traditional functional healthcare organizations—like hospitals and disciplines—to focus on outcomes of healthcare.
- Service line is a commonsense approach used for almost a century in industry and coming of age in healthcare. In fact, service line looks more and more like a requisite structure to achieve today’s expected outcomes and the next stages of IDS development.
- With a well-developed service line, expect quicker responses to environmental and competitive change, improved clinical and business outcomes, and enhanced patient and physician satisfaction.

REFERENCES

Bauer, Mark, McGreevy, Thomas, Chirico-Post, Jeannette, "Establishing a Function-Based Mental Health Service Line in a VA Medical Center." *Psychiatric Services* 51:1307–1309, October 2000.

Charns DBA, Martin P, Interviews with author, 2010.

Charns, MP and Young, GJ, "Organization Design and Coordination." Chapter 3 in Burns, LR, Bradley, EH, and Weiner, BJ (eds) *Shortell and Kaluzny's Healthcare Management: Organization, Design, and Behavior*. Delmar Publishing, 2010.

Francis, Joseph, "QUERI II: The Next Generation." *Forum*, August 2006. VA Health Services Research & Development Service.

Frangou, Christina. "Hospital Profits From Service-Line Business Model." *Annals of Surgery* 33(10) (October 2008), *Anesthesiology News*.

The Health Care Advisory Board, "The Future of Orthopedics: Strategic Forecast and Investment Blueprint," The Advisory Board Company, 2008.

Nugent, Mike, Nolan, Kevin, Brown, Frank, Rogers, Stephanie, "Seamless Service Line Management," *Health Care Financial Management* (May 2008).

Turnipseed, William D., Lund, Dennis P., and Sollenberger, Donna. "Product Line Development: A Strategy for Clinical Success in Academic Centers." *Annals of Surgery* 246(4) (October 2008): 585–590; discussion 590–592.

Westphal, Judith, "Resilient Organizations: Matrix Model and Service Line Management," *Journal of Nursing Administration* 35 (2005): 414–419.

The Air We Breathe

The healthcare environment is going through a seismic shift. Whether you have had service lines for a while or are new to the concept, determining how this new healthcare landscape will affect your organization and your leadership role is imperative—and context is everything.

In the course of a busy day, the context in which we deliver healthcare becomes the air we breathe—we don't notice it or have the time to consider it, but ultimately, the context will drive everything we plan or do.

The National Context

I am not a healthcare economist or a policy wonk, and you don't need to be either to effectively manage a very successful service line. But being aware of the global issues and connecting the dots on key healthcare macro-trends will help you accurately analyze your environment and predict the future trends that will impact your service line.

There are three basic categories of macro-trends driving the national healthcare discussion both in the United States and in many other countries:

- **Populations.** This category can be defined as all of the individuals of one group in a given area, including many subsets that are important in healthcare planning such as epidemiology, utilization, demographics, and psychographics.
- **Economics.** This category includes the megatrends within healthcare as well as outside of healthcare—particularly the worldwide economic slump. The impacts of increased costs (e.g., capital and technology) and decreased revenues are included here.
- **Policy.** While policy is often a result of both general and healthcare-specific factors, governments and other entities can drive policies that prompt a response, such as the current movement toward accountable care organizations.

State of affairs

Within healthcare organizations, institutions, disciplines, and service lines, movement in these three macro-trends impacts everything we do from a planning and caregiving perspective. The following is a brief overview of the current state of affairs.

Populations

It's impossible to ignore the impact of 80 million baby boomers—about 25% of the total U.S. population—in healthcare. The oldest boomers turn 65 in 2011.

There have never been so many people in one demographic segment, and boomers are going to live a very long time—longer than any other generation in the history of the United States.

The baby boom was a worldwide phenomenon after World War II, and many European and Asian countries are dealing with the same demographics. A look at the lopsided population in Japan, for instance, gives us another lens to consider the impact of boomers on a population. While Japan has socio-economic forces both similar and dissimilar to ours, the fertility rate there now is 1.21 children per woman—well below the population replacement rate, which is two children per woman. In the United States, there are indications that fertility rate may be declining as well (a concept discussed further in Chapter 4). As in Japan, the trend is a result of the economy and the increase in the number of women giving birth to their first child at an older age. Bottom line: In Japan, the aging boomer population is predicted to overwhelm the next generation of healthcare workers. As a country, we may now be headed in the same direction.

Similarly, healthcare organizations cannot ignore the impact of around 40 to 50 million previously underinsured and uninsured Americans who will have access to care beginning in 2011 as a result of the Patient Protection and Affordable Care Act (PPACA) of 2010, commonly referred to as “healthcare reform.”

Together, these groups, which are also predicted to be high utilizers of healthcare, represent roughly one-third of the U.S. population of about 310 million. Pair that with expectations of care, life-prolonging technologies, and a greater overall life

expectancy, and the increased demands placed on the healthcare system may be more than the system can support.

Economics

The United States is in the midst of costly long-term war. We are currently struggling with a down economy. And we are predicted to be in world and economic distress for at least another 10 years, according to William Strauss and Neil Howe, who have five centuries of proof for their theories about a recurrent cycle of generations. They refer to this point in this century as a “crisis turning.”

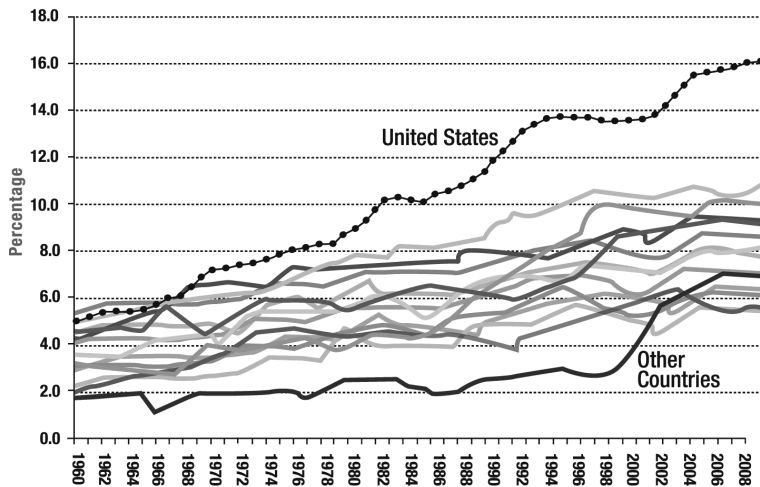
The United States also has the highest healthcare costs of any civilized nation—estimated at a staggering 17.6% of the gross domestic product (GDP) in 2009 (see Figure 1.1). While the rate of growth in the healthcare sector as a percent of GDP has slowed in the past 10 years, the portion of the GDP consumed remains higher than other countries by a factor of almost double.

Hospital costs represent the bulk of healthcare costs in the U.S., putting hospital costs squarely in the bulls eye of payment cuts (categories of U.S. healthcare spending are illustrated in Figure 1.2).

PERFECT STORM

Starting in 2011, the first of the baby boomer population reaches the age of 65; at the same time, roughly 40 to 50 million uninsured patients start being able to access healthcare as a result of healthcare reform. Together, they represent more than one-third of the total U.S. population. These two groups—combined with the already escalating cost of healthcare and the down economy—present a potentially seismic change in how we do business.

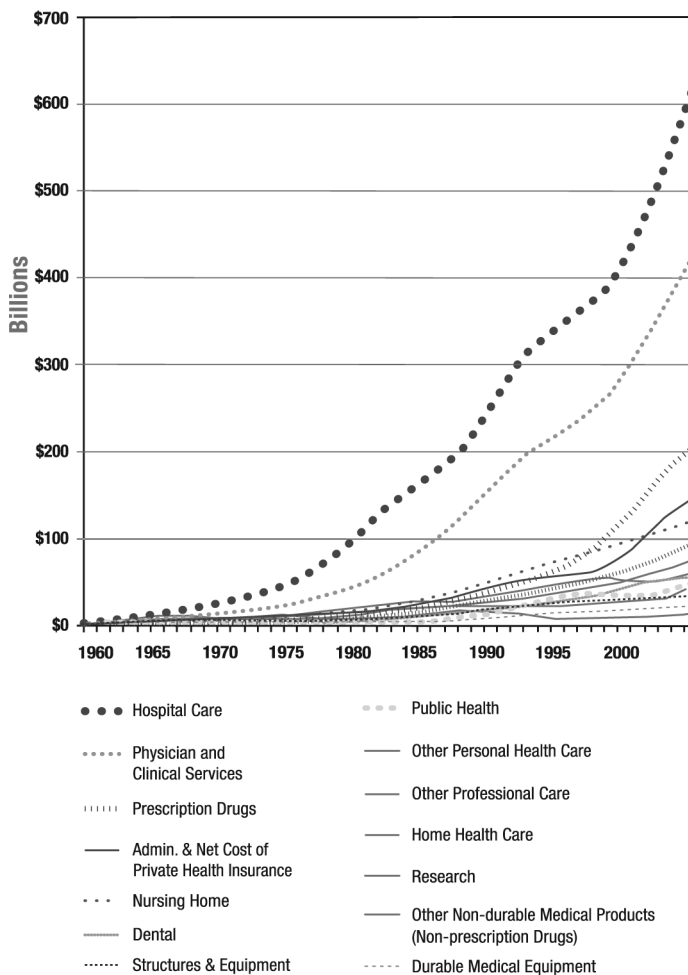
FIGURE 1.1
NATIONAL HEALTH SPENDING AS A PERCENTAGE OF THE GDP



Other countries include: Australia, Canada, Finland, Greece, Ireland, Korea, Netherlands, Poland, Spain, Turkey, Austria, Czech Republic, France, Hungary, Italy, Luxembourg, New Zealand, Portugal, Sweden, United Kingdom, Belgium, Denmark, Germany, Iceland, Japan, Mexico, Norway, Slovak Republic and Switzerland.

Source: Organization for Economic Cooperation and Development.

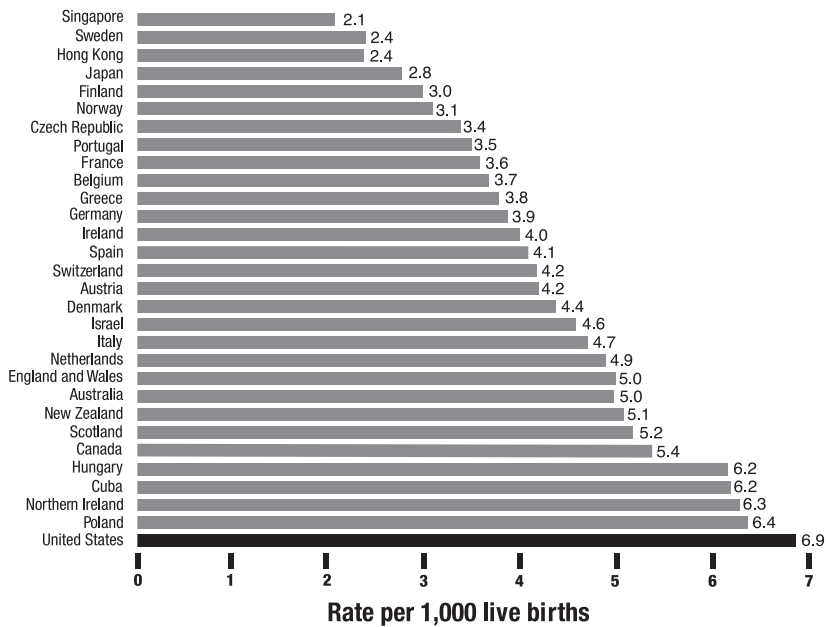
FIGURE 1.2
CATEGORIES OF HEALTHCARE SPENDING, U.S.



Source: University of South Carolina, Arnold School of Public Health, 2008.

At the same time, the United States falls short of other civilized countries in some of the most basic measures of a nation’s health. One example is infant mortality, where the U.S. rate is worse than 43 other countries (see Figure 1.3).

FIGURE 1.3
INFANT MORTALITY RATE, 2005, SELECTED COUNTRIES



Source: CDC, *Health, United States*, published 2008.

Policy

Although no one knows for sure where the ship will finally dock, it's been obvious from the beginning of the 2008 campaign that President Obama ranks healthcare as one of the nation's top priorities. His leadership group has included people with extraordinary backgrounds on healthcare issues, such as Peter Orszag and deficit-balancing Jacob Lew. The passage of the PPACA—barely 14 months into the Obama administration—was another clear message that healthcare is a priority. It is likely the most significant healthcare legislation in decades. President Obama appointed Donald Berwick as administrator of the Centers for Medicare & Medicaid Services (CMS), reaffirming his plans to significantly restructure the healthcare system. Berwick, a pediatrician by training, is the founder of the Institute for Healthcare Improvement, a leading force in healthcare quality and process improvement—a direction we can expect him to continue at CMS.

The challenges are evident: The economy is troubled and rising healthcare costs continue to cause heartburn for the public, employers, payers, and providers. The last time this happened, in the 1970s, HMOs were the result—although the potential impact of HMOs at the time was congressionally mitigated by passing any willing provider legislation.

In fact, the stages of managed care in the '70s and '80s describe changes eerily similar to the disruption and reorganization we are seeing now in healthcare.

One key difference today from the managed-care era is the push for electronic health records (EHR) and the advancement of digital infrastructure in the healthcare industry. However, EHR implementation costs for one integrated delivery

system (IDS) can be hundreds of millions of dollars, and there are mixed views on whether these systems actually yield savings for the health system. Healthcare futurist Jeff Goldsmith notes, “Right now, it takes remarkable imagination to find actual provider-level operating savings from installation of clinical IT.” Some organizations are already using an IT infrastructure to significantly lower costs and improve quality, but most healthcare organizations are still reeling from the cost and implementation of EHRs.

Following Everett Rogers’ theory of diffusion of innovations, EHRs are between the early-majority adopters and the later majority, with about 50% market penetration. Considering the technology improvements that will be made during those later stages of adoption, it’s easy to assume that what we are seeing now in EHRs is nothing like what we will see in a few years. But we’ll never realize those benefits if we don’t go through the process of automating healthcare.

Adding those EHR costs and the necessary timeline for implementation and improvements to an already unstable healthcare economy sets the stage for the new pressures and policies we will see in the future.

What does all of this mean for women’s health?

There is no need to despair at all of the challenges impacting healthcare today; there is a silver lining—especially in women’s health. No one questions that the woman is the healthcare gatekeeper for the family. So far, service line leaders have viewed that gatekeeper role as a way to acquire new patients. But now, in an era of laser focus on quality, costs, and unnecessary utilization, that same family gatekeeper will also be the key to meeting these new health system goals.

You're in the right field. The service line that led to the discovery of reaching women as the gatekeepers for revenue now also has the opportunity to lead in reaching and engaging the gatekeeper for unnecessary healthcare spending as well.

The Organizational Context

It's impossible to talk about the women's health service line without talking about service lines in general. Where you and your organization are in terms of the major change from a functional organization to a service line organizational model is absolutely critical in understanding your role and—more importantly—where your organization should be going with service lines. The latter plays a key role in building your professional credibility, and also in watching for danger signs. Both should be part of a service line leader's professional toolbox.

Martin Charns notes that the only difference between a product line and a service line is the sector of the economy in which the organization operates. Both product and service lines are specific examples of a general program organizational forms, or organizational structures.

In 1993, Charns and Laura J. Smith Tewksbury identified nine organization forms or types found in industry. Charns stresses that these are not developmental stages but that any of these organizational forms can be found in organizations.

Charns and Tewksbury describe the stages, or forms, generally as follows. Note that the first eight stages are seen in both healthcare and other industry segments.

Charns says that the ninth stage, although common in other industries, is theoretically possible but unlikely in healthcare. As you read about these stages, consider where you are now and what your next stage is likely to be.

As organizations re-examine their organizational structure, it will be critical to carefully balance the benefits gained from the integration across disciplines with the benefits gained from like professionals interacting within their divisions.

STAGES OF DEVELOPMENT: WHERE IS YOUR ORGANIZATION?

1: Traditional functional organization

This represents what we commonly refer to as the unconnected “silos” of healthcare. Examples are hospitals and the professional disciplines (e.g., department of OB/GYN or department of radiology).

2 and 3: Integrator

Integrators represent the first organizational attempts to cross institutions, disciplines, or departments. Examples are often in marketing or analytics—for instance, when finance first analyzed diagnosis-related groups together back in the 1980s. In marketing, an example is marketing packaging (only) of comprehensive women’s care versus just obstetrics.

4: Multidisciplinary task forces

Multidisciplinary task forces emerge when members from different departments and/or disciplines come together to form or change programs or services. They are temporary and disband after the project is completed. A multidisciplinary task force might come together to start neonatal transport services or to discover ways to decrease costs associated with deliveries.

5: Reorganized of departments (services)

In this stage, key departments are restructured to correspond to service lines. Marketing or finance may assign particular staff to the women’s service line, or geneticists who are particularly interested or skilled at maternal-fetal medicine or breast-related genetics might be assigned to the women’s service line. This stage starts to formalize the matrix structure for the first time, as reporting lines remain within the functional department, but a formal matrix report to the service is established.

6: Multidisciplinary clinical and management teams

This stage occurs when permanent multidisciplinary team assignments are made. While there are still formal reporting lines to professional departments—marketing,

STAGES OF DEVELOPMENT: WHERE IS YOUR ORGANIZATION? (CONT.)

finance, pediatrics—the service line executive is the team leader and now also has input into the performance evaluation of members of the service line team.

One difference between industry and healthcare structures emerges here in terms of service line leadership. Charns says that only healthcare has service lines managed by dyads or triads—two or three managers (he’s also seen teams of four leading a service line). Dyads are often from the clinical and business areas. Triads are often a physician, a nurse, and an administrator. In industry, you could take a young manager with a general management background and immerse that manager in two or three disciplines for a period of time so the manager could learn more about the functional disciplines involved in a service line, but in healthcare you can’t do that because the manager really can’t do nursing or perform surgery, explains Charns. There are issues of licensure, for instance. “Dyads and triads are pretty powerful ways to put together a leadership team. Of course, you get new issues: getting the team to get along,” he says.

Finally, if the team was more oriented toward marketing before, this is when a strengthened clinical focus emerges.

7: Matrix organization

Now the vertical organization and the horizontal service line organization become balanced and coexist, although not always peacefully. While the forms were changing, the organization was bringing together the importance of process (functional forms) *and* outcomes or outputs.

8: Reorganization into modified service line divisions, maintaining discipline leaders

In this stage, the focus shifts to the service line being primary. Few departments remain outside the service lines. Disciplines like nursing and medicine are reassigned to service lines, but still maintain discipline leaders. An example of this is a heart center

STAGES OF DEVELOPMENT: WHERE IS YOUR ORGANIZATION? (CONT.)

or orthopedic hospital in which all departments are organized to support a facility that is actually a service line.

The complexity of disciplines within healthcare makes this stage less clear-cut than within other industry sectors, says Charns. Nursing councils—essentially functional structures—still exist to link facilities and support professional nursing. Medicine and other healthcare professions need the continuing education, research, and development that typically occur within a functional discipline. Charns says it is a balance: The gain for service line cannot completely override the loss from like professionals interacting within a discipline. At some point in healthcare, the loss of the latter can become too great to balance the gain in integration.

9: Fully implemented service lines in a divisional structure

While this form is found routinely outside of healthcare, this is where Charns notes healthcare differs. Fully implementing service lines with removal of all functional institutions and disciplines is “theoretically possible,” he says, but “just not pragmatic in a hospital or integrated healthcare delivery system.”

“It is one thing in General Electric Company where a product line involves three or four disciplines, but hospitals have multiple disciplines, all with ongoing professional development needs,” he notes. “At GE, the jet engineer isn’t interacting with the appliance engineer across divisions, so that benefit is lost, but the gain is higher than the loss. Every service line in hospitals has multiple professional disciplines. In healthcare, there are too many disciplines involved, and too much to lose, if hospitals reorganize completely into service lines.”

Summary

If you look at the overall trends, five conclusions arise:

1. Economics and policy are driving healthcare integration or development of what we are calling integrated delivery systems.
2. The IDS is itself at least a matrix-level model, with both functional institutions and departments as well as cross-IDS services, and IDS development parallels service line adaptation in healthcare.
3. Service line may not be the only model that works in the IDS environment, but some outcome-focused model is critical for the changes being demanded by economics and policy.
4. The functional organizational model in healthcare is quickly being integrated with service line, just as it has long been in non-healthcare industry. Healthcare can only achieve the dramatic changes required only through an output-focused model, combined with continual focus on process improvement.
5. As noted by Charns in the Introduction, any time an outcome focus (quality and cost) is overlaid on a process focus (the disciplines and institutions of healthcare), conflict ensues. Successful management of that conflict is critical to establish new, effective organizations well-positioned for the future.

References

Burns, Lawton R., Bazzoli, Gloria J., Dynan, Linda, and Wholey, Douglas R. "Managed Care, Market States, and Integrated Delivery Systems: Is There a Relationship?" *Health Affairs* 16 (1997): 204–218.

Central Intelligence Agency. "Country Comparison: Infant Mortality Rate." *The World Factbook* (est. 2010). www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html.

Central Intelligence Agency. "Total Fertility Rate." *The World Factbook* (updated February 2010). <https://www.cia.gov/library/publications/the-world-factbook/fields/2127.html>.

Charns DBA, Martin P. Private interview with author, July 2010.

Charns, Martin P., and Tewksbury, Laura J. Smith. *Collaborative Management in Health Care: Implementing the Integrative Organization*. San Francisco: Jossey-Bass, 1993.

Goldsmith, Jeff. "Peter Orszag: A Powerful New Health Policy Voice at OMB." Health Affairs Blog, February 9, 2009. <http://healthaffairs.org/blog/2009/02/09/peter-orszag-a-powerful-new-health-policy-voice-at-omb>.

Passel, Jeffrey S. and Cohn, D'Vera, Pew Research Center, "U.S. Unauthorized Immigration Flows Are Down Sharply Since Mid-Decade," *Pew Research Center Publications*, Sept 2010. <http://pewresearch.org/pubs/1714/annual-inflow-unauthorized-immigrants-united-states-decline>.

Rogers, Everett M. *Diffusions of Innovation*, 5th Edition. New York: Free Press, 2003. (First published in 1962.)

Strauss, William, and Howe, Neil. *The Fourth Turning*. New York: Broadway Books, 1977. Also see www.fourthturning.com.

HCPro

Order your copy today!

Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit www.hcmarketplace.com. If you received a special offer or discount source code, please enter it below.

Title	Price	Order Code	Quantity	Total
				\$
Your order is fully covered by a 30-day, money-back guarantee.			Shipping* (see information below)	\$
			Sales Tax** (see information below)	\$
			Grand Total	\$

Enter your special Source Code here:

Name

Title

Organization

Street Address

City

State

ZIP

Telephone

Fax

E-mail Address

***Shipping Information**

Please include applicable shipping. For books under \$100, add \$10. For books over \$100, add \$18. For shipping to AK, HI, or PR, add \$21.95.

****Tax Information**

Please include applicable sales tax. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

BILLING OPTIONS:

Bill me Check enclosed (payable to HCPro, Inc.) Bill my facility with PO # _____

Bill my (✓ one): VISA MasterCard AmEx Discover

Signature

Account No.

Exp. Date

(Required for authorization)

(Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at www.hcmarketplace.com

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945

CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787

FAX THE COMPLETED ORDER FORM TO: 800/639-8511

E-MAIL: customerservice@hcpro.com

© 2008 HCPro, Inc. HCPro, Inc. is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks. Code: EBKSMPL

P.O. Box 1168 | Marblehead, MA 01945 | 800/650-6787 | www.hcmarketplace.com