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Designing the Right Healthcare Service Line Governance Structure: 4 Key Considerations

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Prior to the coronavirus pandemic, healthcare CEOs ranked financial challenges (e.g., reducing the operating costs for staff and supplies, declining reimbursement) and increasing competition from other providers, among the top issues facing hospitals. But with coronavirus expenses straining hospital budgets, in 2020, a new element, service line optimization has become critical to hospitals' ability to weather the economic storm.

As healthcare leaders evaluate their service line strategy in a changing environment, there are four key considerations for developing an optimal governance and leadership structure to support success.

Consideration No. 1: Defining the service. Healthcare service line development and optimization begins with deciding which services are "in" and, as important, which are "out." For example, a cardiac service line would clearly include cardiac imaging and treatment for heart failure, coronary artery disease, arrhythmia, heart valve problems, and heart attacks. Depending on the size and scope of the cardiac service line, some organizations may choose not to include thoracic surgery, pulmonary services, or stroke care, as these services might be more ideally suited for oncology or neuroscience service line structures.

Setting the service line boundaries that support effective and efficient care delivery is crucial. Doing so involves:

- Defining the service line's patient population
- Analyzing both patient demographic data and psychographic data to clearly understand the population's wants, needs, and behaviors
- Engaging key stakeholders in assessing the types of care that are most likely to draw to the population
- Assessing the financial impact of adding specific services and the feasibility of maintaining each service
- Identifying physician stakeholders for each identified service

Consideration No. 2: Establishing dyad leadership. Under a dyad leadership model, a healthcare administrator is paired with a physician leader to bring both service line-specific knowledge and leadership expertise to governance. These leaders jointly develop and execute clinical, operational, and cost improvement processes. They also nurture and build relationships among key stakeholders to align efforts to achieve service line goals.

Pairing a physician and administrator under a dyad administrative model requires effective communication between these leaders. One or the other may be designated the chief executive officer. If executed well, this leadership structure can promote trust and commitment among all stakeholders. One key factor for success: Leaders must have the authority to innovate and develop creative solutions to challenges as they arise.

Consideration No. 3: Broad physician participation for service line leadership. Active involvement of physicians should not stop with the dyad model. Physicians who provide care throughout the service line should be actively involved in all aspects of service line governance.

When hospitals and health systems are part of a clinically integrated network (CIN), strong physician leadership becomes even more important to coordinate services across the network. Without the leadership of a strong physician committee, as networks evolve to develop specialty physician performance measures and promote service line integration, CINs risk missing quality and cost goals and may face scrutiny from health plan partners and the Federal Trade Commission.

Ideally, each service line integration opportunity will have its own unique governance group to oversee detailed operations. For example, if an organization elects to participate in the Comprehensive Care for Joint Replacement program for major joint replacement of the lower extremity, the corresponding governance group could include orthopedic surgeons and support staff. Existing value committees could be appointed to serve as governance bodies, or new governance groups could be created specifically for each service line.

No matter how members are chosen, physician members of governance bodies should have equal voting rights. All decisions that involve service line optimization or care model efficiency should be made with strong physician input.

Consideration No. 4: Identifying the provider and management structure for the service line. Once a healthcare organization has defined the clinical program it wishes to manage under a specific service line, it should then identify the appropriate providers for participation. Provider participation is often defined by the goals or value proposition the organization seeks to achieve. For example, a health system whose goal is to reduce leakage and improve access may only require support from a group of physicians and

administrators whose primary responsibility is to improve processes and manage referral sources. On the other hand, as healthcare organizations begin to rely on the service line structure to manage facets of value-based payment contracts—including bundled payments, quality metrics, or total cost of care—provider participation may need to be much broader. In fact, the structure for provider participation may look like a specialty network, with representation by providers across the clinical services included in the service line, from physicians to acute, post-acute, and ambulatory providers. A more complex network of care also may necessitate a separate or defined organizational structure.

Service line management structure can be formal or informal, typically depending on the structure needed to support contractual requirements. For example, an organization where employed and affiliated network members participate in a value-based contract will find a formal structure is best suited for shared savings or incentive payments with independent physicians or institutions. Under current regulations, these types of payments may only be made to an independent organization such as a CIN, an independent physician association, or a formally structured limited liability corporation. Any shared incentive must be distributed to the affiliated organization, which must have an explicit distribution methodology. On the other hand, service lines that do not intend to distribute value-based contract payments or are backed by employed physicians or an owned network of providers and institutions may operate as a department rather than a separate business unit.

A VALUE-ADDED SERVICE LINE LEADERSHIP APPROACH

The most successful clinical service lines prioritize governance and leadership as the first pillar of success in value-based contracting. Effective service line structures have identified leaders at every level of clinical delivery as well as management and reporting systems to support organizational decision making. Ultimately, the service line structures are in place to optimize the care delivered to the patient population and achieve optimal performance.