GROWING SERVICE LINES IN A VALUE-BASED ENVIRONMENT

Four experts describe how service line strategies may need to be modified amid the changes taking place in health care.

By Lauren Phillips

As health care continues the transition to value-based care, business as usual is headed out the window in most aspects of the industry—including service line growth. How have service line goals changed as hospitals and health systems look to position themselves to deliver high-value care, and what strategies are organizations using to achieve those goals?

We asked (clockwise from top left) Mark Meyer, executive vice president and CFO, Grady Health System, Atlanta (mmeyer@gmh.edu); Julie Miksit, vice president, heart & vascular, WellSpan Health, York, Pa. (jmiksit@wellspan.org); Brian Sweeney, RN, FACHE, senior vice president, hospital operations, Thomas Jefferson University Hospitals, Philadelphia (brian.sweeney@jefferson.edu); and Jonathon Yeatman, chief strategy officer, Mission Health, Asheville, N.C. (jon.yeatman@msj.org).

Sweeney expressed a common thread running through the four organizations featured in this article: “You need to focus on the inside, not just the outside. Everyone wants to buy, build, and create; it’s fun and exciting as well as important. But you need to do that in parallel with self-reflection—who you are as a provider, where you have gaps in access or quality or costs. The organizations that can pay attention to both will be the winners.”
What are your goals for service line growth in a value-based environment, and what are your biggest challenges in achieving them?

**Yeatman:** Our focus is on developing the appropriate care networks so we can grow our share of the population—and positively affect the health of that population. To do that, we’ve built a sophisticated performance improvement group to help ensure that clinicians operate at top-of-license and to optimize our use of expensive assets. At the service line level, this means expanding the most helpful approaches, such as using medical treatment and physical therapy before sending a patient to a surgeon for potential back surgery, and eliminating unnecessary activities, such as routine physician visits for people with diabetes whose disease is under control.

The challenge, for us and for the industry as a whole, is to change the culture of the delivery system to align with what people rightfully expect: excellence in both outcomes and, increasingly, patient experience, and, with the growth of high-deductible plans, more access and better service at lower cost.

There are a lot of things to figure out—incentive structures, workflows, processes, and IT. But if you can create a vision of the future that is inspiring, which I think we have, then it just becomes a matter of “how” rather than “whether.”

**Sweeney:** Our focus traditionally has been on aspirational things: building facilities, developing new programs, recruiting new physicians. More recently we’ve had to reorient our physician leaders and service line administrators to focus instead on quality and costs because the future of service line growth is going to be dependent on those things.

We are growing from three hospitals a year ago to 11 through three mergers, which means we need to coordinate our service lines to avoid duplication. We now have a pretty broad geographic spread, and while we realize that patients generally want to stay close to home, we also recognize that not every hospital in the system can do everything.

**Meyer:** In the near term our biggest challenge is access. As a safety net hospital in an inner city, we run about 93 percent occupancy. We have about 50 new ICU and med-surg beds coming online in the next year or two, which should help. And we have a number of initiatives to reduce length of stay by making sure we’ve got a robust discharge-planning process and can get patients to the next level of care quickly. In the long term, we worry about reimbursement: 85 percent of our revenue is driven by federal, state, and local resources, so the big DSH [disproportionate share hospital] payment cuts that will take effect in 2018 will be devastating for Grady.

So we’re working on both fronts at once—getting creative about reaching out to patients in the community with preventive and compliance initiatives and, in anticipation of bundled payments, focusing on access to post-acute care, especially for our uninsured and underinsured patients. We’re working to shore up our relationships with post-acute care providers. We own the largest SNF [skilled nursing facility] in Georgia—99.9 percent occupied—and we just opened a 24-bed subacute rehab unit. But we don’t have an acute rehab or LTAC [long-term acute care facility], so we’ve built preferred provider relationships with some high-performing companies that do. They give us a certain number of charity days, and when patients don’t have a preference, we let them know about those relationships.

We’re also working with a company to build a new SNF/LTAC facility with some of our licensed but unused beds.

**Miksit:** Our goal in the heart and vascular service line is to continually improve our market share in all the different markets. We’ve definitely seen that both in our open-heart program and in our cardiac procedural area; now I’d like to see an equally strong vascular program. And I’d like all of our programs—for example, heart failure, electrophysiology—to work hand in hand so we can transition patients from one to another and become a seamless continuum.

The major challenge we’re facing right now is recruiting specialists to the heart and vascular service line. Finding board-certified vascular surgeons is difficult because there is a lot of competition.
What specific approaches are you using to promote your service line goals?

**Meyer:** We have a number of programs to promote population health, one of them focusing on eye health. There are many diabetic patients at risk of losing their vision through diabetic retinopathy, so we coordinate between our ophthalmologists and our primary care centers to ensure those patients are being screened appropriately. If the screening shows someone needs a follow-up visit, we make sure they have an appointment and, if they need retinal surgery, we’ve expanded our capacity for that by bringing in new ophthalmologists.

Another example is an outreach program based in our emergency medical service that uses EMTs [emergency medical technicians] and other practitioners—social workers, nurse practitioners, psychiatrists, community health workers—to go out into the community and provide care at patients’ homes; if they’re in shelters or on the street, that’s where we work with them. It probably costs us $300,000 to $400,000 a year, including equipping the truck we use, and there certainly is a financial benefit—but more to the point we have been able to improve the health of the community and reduce both unnecessary emergency department (ED) visits and readmissions. We use predictive analytics to help us identify patients at high risk for either of those events and assign the right resources to manage them beyond their hospital stay. This approach is very effective in keeping patients with heart failure or hepatitis C, for example, on their medication schedule.

**Sweeney:** We’re trying to restructure our cardiovascular (CV) program right now. We’ve actually unified the programs at all hospitals and appointed a single clinical leader to handle the entire continuum of care, from outpatient to inpatient to intraoperative. It’s too early to say which hospitals will have which program elements, but he’s focused on making it possible for CV surgeons to move among campuses and to standardize clinical care, so we’re delivering the same outcomes at all the different sites—so that it’s one Jefferson.

Our major focus right now, however, is on post-acute services—developing a strategy that will better position us from a payer perspective, exploring different kinds of partnerships. We don’t necessarily have to own all the elements, but we have to have complete confidence in whichever provider is going to deliver care in the skilled nursing, rehab, home care, and hospice environments, because we’re going to be accountable for that care in terms of reimbursement eventually. One of our hospitals has a bundled payment program for joint replacements, and we anticipate more bundles in the future.

**Yeatman:** We’re working on program development designed not just to grow volume in, say, total joint replacements—although that is, of course, a goal—but, as important, to differentiate our programs from the next provider. And the way we do that is to develop standardized processes and care pathways across the entire care continuum, building connections from family medicine to sports medicine to the post-acute rehabilitation care often required with orthopedic procedures. We’re able to do this because we have a fully integrated, comprehensive system with acute care, primary care, and specialty networks and because we’ve expanded into risk management: Mission Health Partners is the largest accountable

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Are there service lines you’re planning to significantly expand or dial back?

Yeatman: One area we’re investing heavily in is behavioral health, where developments in both programs and infrastructure are expected to drive a reduction in inappropriate use of the ED service line. We’ve created a number of partnerships with other entities in the region, including law enforcement and social services, and we’ve contributed $1 million to a comprehensive care center for behavioral health.

We’re also heavily supporting virtual health by embedding technology into care delivery across all our clinical programs—not a service line, really, but an enabler of care. We have a multiyear, multimillion-dollar investment program that targets specific conditions like high-risk pregnancy, behavioral health, and obesity with pre- and post-assessments and compliance activities so that people don’t have to travel. Other uses of the technology include:

- Real-time video consultations by on-call cardiologists with primary care physicians in rural areas while the patient is actually in the room
- Diagnostic-specific packages of remote home-monitoring devices
- Tele-stroke, tele-psych, and other hospital-to-hospital services, including to outlying EDs

Another innovation is Community Caramedics, which provides in-home visits by trained paramedics to support patients in managing their health at home. The paramedics do everything from assessing the patient’s resources and abilities to doing lab work, medication review, wound management, falls prevention, and nutrition. This service is used with ACO [accountable care organization] members and others for whom Mission Health bears risk.

Meyer: We know that outpatient care is becoming more important, and we don’t have an ambulatory surgery center, so we’ve acquired some property right across the street from the Grady campus—and we’ve made everyone aware that we are looking for donors and potential partners to help us develop it.

As part of our ambulatory strategy, we’re debating whether we should invest more in joint replacements, a business that increasingly is shifting to the outpatient setting. Up to now, any growth in orthopedics at Grady has been in trauma-related orthopedics, and maybe that’s where we should continue to focus.

Miksit: For the next year we’re going to focus on developing a comprehensive vascular program, identifying what we need to do in all of our facilities to grow this part of the cardiovascular service line. This is one of those areas that is shifting from the inpatient to the outpatient setting, and it is a largely untapped market, in part because vascular problems are often misdiagnosed.
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Sweeney: We have multidisciplinary service line teams that include physicians, nurses, and administrators, and they are charged with putting together the strategic plan and budget for the line and for implementing the plan. Each team does a quarterly report-out, where they come in and talk with senior leadership about their progress and discuss their key indicators. We have a dialogue: Do we need to go in a different direction? How can we help you?

For example, we are expanding our ambulatory service line and adding new surgery centers in particular markets. The physicians help us design, develop, and operate each center—and they are accountable for how it performs. Some physicians have an opportunity to buy into the center, which gives them a stake in its success. We’ve found there’s more respect, consensus, accountability, and engagement with ownership.

We co-manage orthopedics with the orthopedic surgeons, which is a more formal and structured arrangement, and will probably do the same thing with other service lines over time. The only way to successfully standardize clinical processes or the supply chain is to have physicians fully engaged in those initiatives, especially with independent community physicians who are now part of our system as a result of mergers.

We also developed a specialty network, a softer form of affiliation than a merger or acquisition; many community physicians appreciate the opportunity to engage in care coordination, research, or education with an academic medical center, and it’s a way for us to start a relationship with them. Finally, physicians can participate in our clinically integrated network, which allows us to work together to manage risk in caring for a particular patient population.

It really depends on the individual physicians. We try to meet them where they are, based on what’s important to them.

Miksit: WellSpan physicians are actively involved at all different levels of the organization. The crux of this approach is having multidisciplinary committees responsible for each of our eight service lines: breaking down silos so everybody is sitting at the table and collectively looking at what’s happening in the industry and what our current market share is and how we can improve on that, identifying best practices, deciding where we’ll focus our attention, and developing strategic and operating plans.

The cardiovascular committee has cardiologists, anesthesiologists, intensivists, cardiac surgeons, perfusionists, and nursing. Recently we set up metrics for managing and monitoring our first bundling initiative, which is an internal coronary artery bypass grafting bundle, and now we’re looking at blood transfusions—how we’re doing in that area and how it impacts the bundle. Through that initiative we’ve also streamlined a lot of processes, learning to hardwire practices to make the patient’s experience seamless. +

How do you go about engaging physicians in your efforts?

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