

Service-line strategies for US hospitals

All signs point to a more specialized future for US hospitals. But getting from here to there won't be easy.

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**Article
at a
glance**

For US hospitals battered by competition, trying to be all things to all patients is no longer a viable strategy.

One way hospitals can more effectively compete with smaller, more focused competitors is to organize themselves by service line, focusing on building world-class capabilities in just a few clinical areas.

Hospitals that succeed with this strategy can reap tremendous fiscal benefits while enhancing their ability to serve their communities. But as three disguised case studies show, the successful implementation of a service-line strategy is no mean feat.

Choosing the right service lines to emphasize requires a superior understanding of a hospital's economics and competitive environment. Hospitals also need to overhaul the management of both strategic and nonstrategic service lines.



The full-service, general hospital—still the mainstay of US acute-care delivery—is under attack. Immense clinical complexity; the advent of performance transparency for evaluating quality, service, and costs; and growing competitive intensity are challenging the notion that any hospital can excel across a broad spectrum of clinical service lines.¹

Consider a US hospital of average size, with roughly 160 staffed beds and a mean daily patient census of about 100. On any given day, it might admit only a handful of patients with similar conditions. Contrast this with the current crop of sophisticated, focused, multispecialty institutes for heart, cancer, or neurological care: they treat up to several hundred patients each day. “Pure play” specialty hospitals and outpatient centers with low-cost structures, limited complexity, and focused, high-quality service are also emerging. Competitors like these are raising the performance bar for general acute-care hospitals and, in some cases, posing serious questions about their sustainability.

While traditional general hospitals are unlikely to disappear anytime soon, a new approach—a commitment to clinical service lines as an organizing paradigm, much as many corporations organize themselves by business unit—is becoming a necessity for many such organizations.² Specializing in a few service lines allows hospitals to build a critical mass of patients in select areas and to enjoy economies of skill and scale. In our experience, hospitals that make the leap to a service-line orientation become more productive, improve their quality of care, recruit physicians more effectively, and build market share. By developing a focused service-line strategy, hospitals can also limit their investment in nonpriority areas, with savings to be found in areas ranging from marketing to new technologies. Some hospitals may even choose to take facilities off-line if they are unlikely to reach minimum effective scale in any individual service or combination of service areas.

The transition to service lines is about much more than introducing a new vocabulary or high-level concepts into business planning and strategy. Full implementation of a service-line approach requires real changes in organizational structure, incentive plans, physician relationships, and business development, as well as in many support functions, including IT and human resources. To make wise decisions about which service lines to emphasize, hospitals must have a deep understanding of their own economics and competitive environments. Furthermore, running a hospital with a service-line orientation requires new approaches for recruiting the clinical staff, for aligning its interests with those of the hospital, and for measuring success. Hospitals that succeed—whether or not they are nonprofit institutions—can reap tremendous quality, cost, and service benefits and avoid turning themselves into specialty hospitals, closing their emergency rooms, or lowering the level of care they offer their communities. They will become far more effective competitors as well.

Three portraits

Few organizations have captured the full potential of a service-line transformation. Issues complicating the transition include the effort required to reorient a hospital's structures and systems, the leadership commitment needed to shepherd the change process, the difficulty of assembling the high-quality data needed to support good decision making, and the risk aversion of many staff members and physicians. Patience is also necessary—many changes won't yield results for months or even years.

As three disguised case studies show, full-service hospitals face a range of challenges and opportunities when developing a service-line focus. Like many general hospitals, these three organizations have been caught in a vicious cycle of declining resources and patient volumes, as well as a diminished ability to offer high-quality care and to serve those members of their communities most in need.

The cycle of decline often begins when transparent information about the quality and pricing of hospitals becomes available—making payers and patients more value conscious and fueling the rise of focused competitors that can attract the most valuable patients. What's more, competition is rampant for skilled physicians, who see investing and working in specialty and pure-play facilities as an increasingly attractive career option. At a recent gathering of 250 cardiology practice managers, roughly 70 percent reported that their practices had either been purchased by pure-play or specialty hospital groups or had entered into discussions for purchase. Meanwhile, reimbursement rates for Medicare, Medicaid, and commercial patients aren't rising as quickly as a hospital's costs for treating them.

A small-hospital system

“Capitol City Health Network” (CCHN) served one million residents across three separate hospital campuses and had a 55 percent share of its city's inpatient cases in 2006. Each of the CCHN hospitals determined what services it would provide, and the result was duplication and subscale programs. All three facilities offered open-heart surgery programs; as a result of this overlap, each hospital performed fewer than 100 such procedures a year, far from the 300 to 400 needed to keep surgeons and staff clinically competent. Complications and mortality were 40 percent above average. Maintaining three separate subscale programs was also expensive, and the CCHN open-heart service line operated at a loss of \$1 million a year.

While there were a few disciplines in which CCHN did enjoy a leadership role, those positions were in danger. A “star” neurosurgeon who had once attracted large numbers of patients to CCHN, for example, had by 2006 begun losing them to competitors using the latest techniques and equipment.

An urban community hospital

In 2001, “Springfield General,” a 400-bed urban hospital, started a \$30 million emergency-department expansion. Within four years, it had successfully raised its market share to 25 percent, from 20 percent. But it hadn’t scrutinized the demographics or payer-reimbursement dynamics—and therefore the profitability—of the new patients it attracted. The expanded emergency department brought in a disproportionate number of uninsured patients, and by the end of 2005 the hospital’s overall profit margin had fallen to 8 percent, from 12 percent.

While Springfield General was pumping money into its loss-generating emergency department, it was failing to invest in upgraded operating-room and imaging equipment for its highly profitable spinal-surgery unit. This new equipment would have raised productivity significantly and helped to attract and retain valuable physicians. Instead, Springfield was losing market share in spinal surgery and in a number of other profitable specialized service lines.

An academic medical center

In 2006, “Shelbyville University Hospital” was trying to compete across a range of transplant services, including heart, kidney, liver, and bone marrow transplants. Fierce local competition sent the hospital into a downward spiral; it took on unprofitable cases and performed too few procedures to maintain clinical expertise or even the recommended safety standards. In 2007, the hospital performed only eight liver transplants, for example—four below the minimum threshold of the Centers for Medicare and Medicaid Services (CMS). Poor clinical outcomes were the result. Liver transplant surgeons and hepatologists began taking their cases to other hospitals, where heavier case loads and experienced support staff helped ensure a higher quality of care.

Shelbyville recognized that to improve its clinical quality it had to attract more transplant patients. But its efforts yielded disappointing financial results because the hospital focused on disciplines where revenues were highest, without regard to profit margins.

Choosing where to compete

Each of these case studies illustrates how conventional hospital wisdom (such as “all volume is good volume”) can yield unintended negative consequences. For these three hospitals, a new paradigm—focusing on service lines—is proving to be a powerful competitive tool.

However, to execute a service-line approach, hospitals must first gain a strong understanding of their economics—down to the level of specific clinical activities—and of the growth potential of various service lines. This change of focus involves learning more about the competitive environment, referral patterns, and the possibility of cross-selling other hospital services to current patients.

Understanding current economics

Hospitals should aim to understand their profitability by diagnosis-related groups, payers, physicians, and service lines before they undertake a new service-line strategy. Standard billing approaches usually make revenue numbers straightforward, but costs—and hence profit margins—are another thing. For many hospital services, each patient and procedure is different; therefore allocating costs is far more complicated and expensive for them than for manufacturers or retailers. An accurate cost-accounting system is a prerequisite for effective service-line planning. Simply relying on surrogates (such as volume, payer mix, or revenues) can be deceptive and leads, in many cases, to incorrect conclusions.

When Springfield General realized that the expansion of its emergency department was shrinking its profit margins, the hospital began analyzing cost-accounting data to determine the profitability of patients and service lines. The study uncovered a 20 percent margin in certain pockets of orthopedic surgery—considerably higher than the hospital’s average of 7 percent. In an attempt to attract more patients to the orthopedics service line, Springfield General launched a new joint center and a spinal-fusion program.

When a hospital understands where its true profitability lies, it can also negotiate contracts more effectively. Before Shelbyville University Hospital implemented a service-line strategy, its negotiations with payers involved simply pushing for higher per-diem reimbursements. Armed with the new service-line-specific economics, Shelbyville greatly improved its strategy for negotiating with the managed-care plan that provided 65 percent of its commercially insured volume. By projecting cost trends on a procedure-by-procedure basis, the hospital learned that for certain cases (where resources used and lengths of stay were more predictable), it would derive greater benefit from per-case reimbursements. It pushed the payer to make the switch, and the new contract soon increased profits by more than \$10 million—a 16 percent jump in the annual yield.

Estimating growth potential

Deciding where and how to focus also requires an understanding of the growth potential for different service lines. An analysis of competitors and referral patterns, as well as a comprehensive clinical understanding of disease pathways (the biological mechanisms that allow diseases to progress), can all uncover growth opportunities.

Competitive factors and referral patterns. Understanding the competitive footprint of a service line requires knowing whether community needs are currently being met. Although information about the number of potential local patients and market share is available through public sources (such as the CMS and state-maintained databases), data from these sources often lag by up to two years. To develop more current growth forecasts, hospitals should gather their own demographic data, including the number of underinsured and uninsured patients in an area.

The referral patterns of physicians are another key to estimating a hospital's market potential, since their preferences, together with those of patients and insurance plans, play a major role in a patient's choice of hospital. Moreover, physicians help determine whether cases are referred for treatment, thereby limiting the effective size of the market when cases are indicated but not referred.³

For each geographic area that Springfield General served, the hospital's business-development office mapped referral volumes of key physicians—from primary-care doctors to specialists to doctors affiliated with the hospital—to better understand shifts in market share. Hospital analysts, in contrast to their previous approach, which relied on rarely codified anecdotal evidence, interviewed staff and physicians, much as medical-device and pharmaceutical sales forces commonly do. Learning how rival hospitals influence physician referrals offered insights that helped Springfield develop countermeasures to gain market share. Hospital administrators responsible for building relationships with physicians started reaching out to them, and the hospital enhanced its continuing medical-education programs for certain strategic service lines. In addition, a revamping of the Web site, direct-mail system, and advertisements of the hospital raised awareness of it both among referring doctors and prospective patients.

In the course of an ongoing volume analysis, CCHN conducted detailed interviews with the heads of several local primary-care groups and learned that a small number of highly loyal ones accounted for over 75 percent of surgery patients. Many other primary-care groups were virtually untapped and had received almost no attention from the administrative team in recent years. In response, CCHN began new relationship-building efforts, which included sharing data on quality, satisfaction, and outcomes with these physicians, and encouraged CCHN surgeons to market themselves to these primary-care providers more effectively. As a result, CCHN increased referrals from the overlooked groups and raised its surgical volume by 15 percent within six months.

Loyal patients. Well-prepared hospitals evaluate the growth potential not just of initial care episodes in a given clinical area but also of related services. To do so, they must understand how patients typically flow within and between service lines. Such an understanding requires hospitals to study disease pathways, likely treatment regimens, and relevant treatment technologies.

In 2004, Shelbyville University Hospital analyzed the market for cardiovascular services. It supplied 20 percent of the cardiac care for heart failure cases in its region but was providing a much smaller percentage of elective cardiovascular services, such as electrophysiology (EP), where its market share was only 10 percent. After determining that EP was a growth area, Shelbyville interviewed department heads and physicians to understand the interdependencies between heart failure and EP services, as well as the root causes of the low conversion between them. This assessment helped Shelbyville realize that it needed to track and care for heart failure patients more effectively after their initial emergency room visits.

Along with a local physician group, the hospital then invested in a heart failure clinic and began making more regular contact with patients. It turned out that many of Shelbyville's congestive heart failure patients could benefit from device therapy (such as implanted defibrillators or ventricular resynchronization). By 2006, Shelbyville had increased its share of EP services to 14 percent—helping its patients stay healthy in the process—and netted an additional \$1 million in contribution margin from EP procedures. The hospital's focus on its long-term relationship with heart failure patients was critical to its success. Just as retailers and financial-services companies use customer data to their advantage in building enduring relationships, providers increasingly recognize the value of advanced customer-relationship-management techniques.

When and where changes are necessary

Identifying the most competitive service lines is only half the battle; hospitals also need to change the way they operate these service lines. Rewards for success can be substantial. For example, Springfield General increased its annual profits by about \$15 million within two years of undertaking an ambitious service-line reorientation.

Changing people processes

Implementing a service-line strategy requires changing how a hospital manages human resources. Hospitals may need to recruit more people for critical service lines and fewer for others. Not least important, the professionals and staff of each service line must understand the new strategy and accept the plan so that they will be willing to change the way they work. Incentives that encourage the staff, particularly physicians, to act like owners—including more formal joint-ownership structures, such as equity sharing, investment partnerships, or even full employment—are typically necessary to align the physicians' interests with those of the hospital.

Springfield General changed its personnel processes to support its advanced cardiovascular service line and its elective general-surgery program, which focused on breast cancer. The hospital filled talent gaps by recruiting new physicians (including, for instance, a radiologist with experience and interest in mammography) and increased training to ensure the clinical competency of the operating-room support staff. Before updating an existing joint business plan to improve the alignment between the new goals and the interests of the relevant specialists, the hospital conducted extensive conversations with them.

Measuring progress

When it comes to performance, most hospitals track only gross patient volumes, net revenue, and, sometimes, hospital-wide profit margins. But to ensure that a service-line strategy is working, they must also track patient-level performance.

For every patient admitted and diagnosed, a hospital might assign a score indicating the clinical outcome and monitor both the cost to treat the patient and the patient's total charges. These cost-accounting figures, plus yields from managed-care contracts, are vital to tracking a hospital's progress. Furthermore, because service-line strategies may take years to implement and show results, it is important to track process milestones (such as the recruitment of key physicians) and traditional measures such as profit margins or the total volume of cases. Like many hospitals, Springfield General found that quarterly performance scorecards helped it track both its financial and nonfinancial performance at a greater level of detail than had previously been possible.

Measuring performance with this degree of precision is challenging, so hospitals should consider taking interim steps. A hospital might use the ratio of costs to charges from each department to gauge a service line's performance. Knowing how every patient is admitted (through the emergency department, electively, or by referral from a specific physician group) can help the hospital to uncover patterns of unusually high or low profitability or possible sources of additional volume.

In addition, tracking how much a hospital actually collects for a service line (after writing off bad debt) can help to judge its true profitability and inform future contract negotiations with payers.

An added benefit of detailed performance metrics is that their use often generates a virtuous cycle of improved clinical outcomes. Hospitals should track outcome-specific patient-level data (for example, the time from the arrival of a postsurgery coronary-bypass patient in the intensive-care unit to the point when the patient no longer needs the help of a ventilator to breathe) rather than more generic measures (such as whether discharge instructions were delivered). The more specific approach allows hospitals both to pinpoint areas of care that need improvement and to reward effective performance by the administrative, managerial, and clinical staff.

Managing service lines that aren't a priority

In most cases, service lines that are not a strategic priority will continue operating at some level to help hospitals meet basic community needs and cover fixed costs. Hospitals should avoid investing large amounts of capital, their physicians' management time, or executive leadership in nonpriority service lines. But such clinical areas often employ dedicated nursing staff, support personnel, and physicians, most of whom have a vested interest in the status quo. Hospital leaders must develop an effective communication plan to lay out the rationale for change and to set the staff's expectations. The hospital should tell its employees that it will maintain high safety and quality standards but probably won't be an early adopter of expensive technologies in these service lines and won't respond to competitive forces.

For the emergency department, Springfield General chose to limit capital investments, marketing budgets, and efforts to reach previously unaffiliated physicians, as well as to reallocate a portion of the department's expanded space to a gastrointestinal diagnostics unit. The initial reaction of the emergency department's physicians was predictably negative, but by communicating the strategy effectively and sharing the data underlying the decision-making process, the administrative team eventually gained the confidence of the medical professionals, including those in the emergency department.

Springfield General also used this transparent approach to reassure the broader community that the new strategy was in its best interest as well. Although the emergency department was scaled back, the community benefited from expanded colorectal-cancer-screening outreach programs and gastrointestinal-disease seminars for both the public and the primary-care community.

Hospitals are under siege. Focusing on a few clinical service lines can help them compete while also improving operations, raising clinical quality, and enhancing service to their communities. 

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Notes

¹For more on the traditional strengths of US hospitals and the modern challenges they face, see Kurt D. Grote, Edward H. Levine, and Paul D. Mango, "US hospitals for the 21st century," mckinseyquarterly.com, August 2006.

²For more on organizing by service lines, as well as other potential solutions for US hospitals, read Kurt D. Grote, Paul D. Mango, and Saumya S. Sutaria, "Transforming US hospitals," mckinseyquarterly.com, February 2007.

³In many places in the United States, the number of patients treated for vascular disease, for example, can be as low as one-tenth of the number of people who may need treatment. The remaining nine-tenths are either symptomatic and untreated or asymptomatic.

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