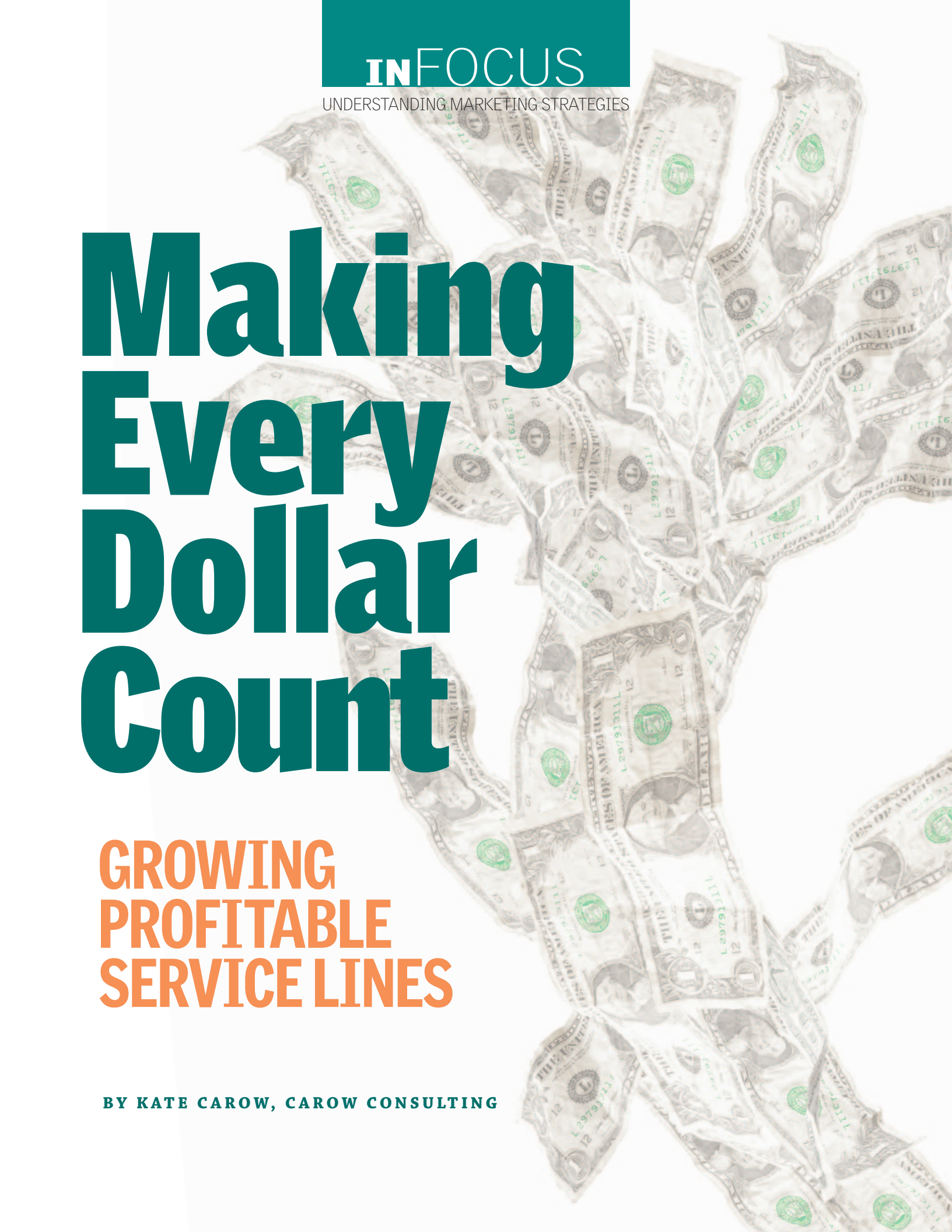
Making Every Dollar Count

GROWING PROFITABLE SERVICE LINES

BY KATE CAROW, CAROW CONSULTING



SPEND WISELY

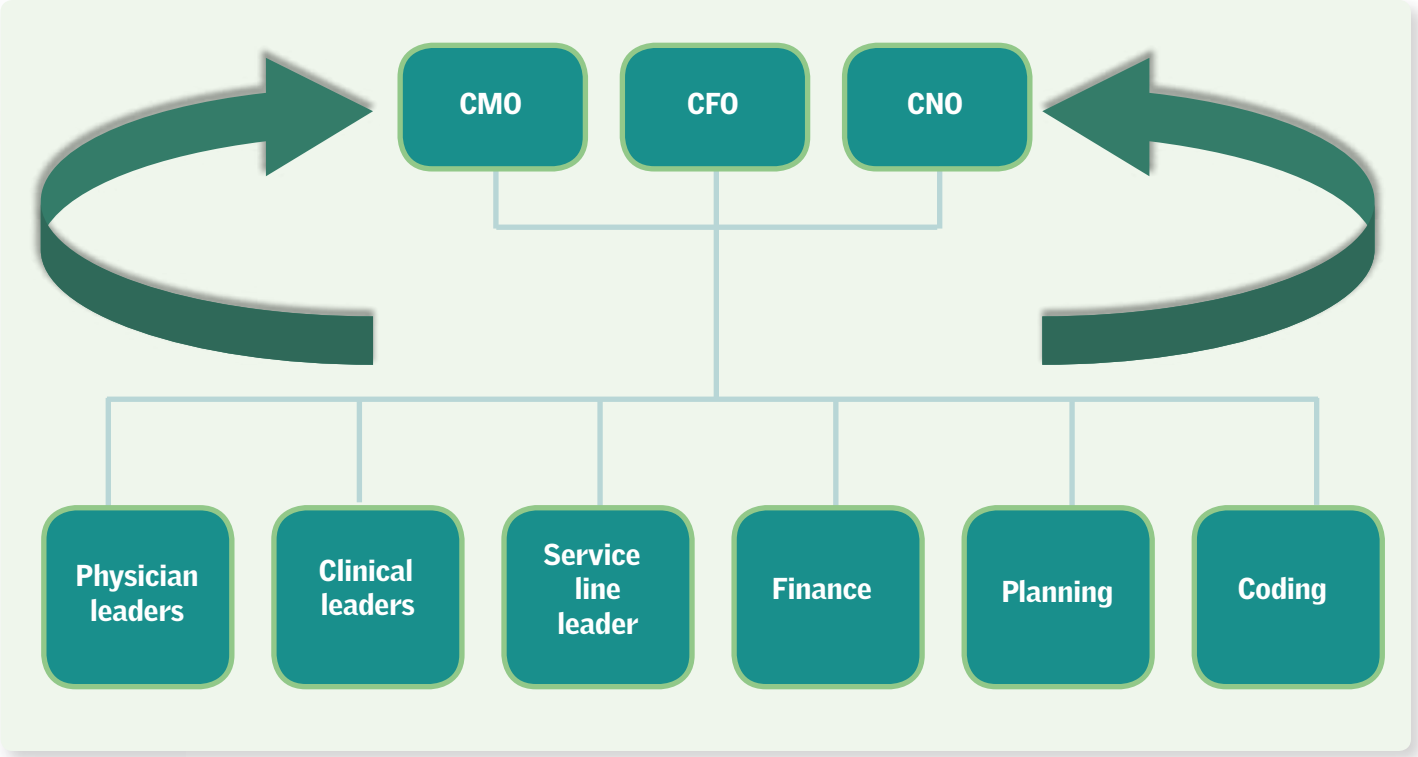
The past few years have been exceptionally difficult for hospitals and healthcare organizations. As a result of these challenges, it is more important than ever to wisely allocate your resources—human and capital. Rigorous review processes, performed in a condensed time frame, need to be developed and implemented to ensure that organizations are maximizing their investments. A good starting point is to evaluate and prioritize which service lines should be expanded, which should be outsourced, and identify those that should be maintained as necessary feeders or complements to other programs. Outlined below are seven steps to focus your organization around more profitable service line growth.

1. IDENTIFY THE TEAM

Solid service line growth strategies always begin with a multidisciplinary team, which allows for input from experienced leaders in clinical, financial, planning, and ancillary roles. This group must be nimble, have the authority to implement recommendations, and be three-dimensional thinkers. Typically, the group would be composed of key physicians, clinical leads in service line management and ancillary roles, as well as non-clinicians in finance/decision support, planning/marketing, and reimbursement or coding. Final approval of the process and recommendations should be reviewed by the chief financial officer, chief nursing officer, and chief medical officer to ensure senior leadership engagement.

2. DEFINE YOUR SERVICE LINES

Once the team has been identified, service line definitions must be established. For service line planning that is focused on inpatient care, outlining definitions is easier since there are a small number of MS-DRGs (approximately 750). However, on the outpatient side, service line grouping definitions can be more complex due to the magnitude of codes (14,000+) and the use of various codes (ICD-9 diagnoses, ICD-9 procedures, or CPT codes). Several companies, such as Thompson Reuters, The Advisory Board, and SG-2, offer inpatient and outpatient groupings to their clients that accelerate the process. In the absence of these external resources, you may need to seek assistance from a coder in the hospital. However, outpatient care often functions as a



feeder to inpatient care, so a blend of the two may need to be taken into consideration.

One point that must be raised—and will lead to a lively group discussion—is how to allocate services such as surgery or radiology. Do they become their own service line? Are the surgical cases and imaging scans allocated to the service line for which they were performed, such as cardiac, neurosurgery, and orthopedics? This must be determined and agreed upon in the initial stages of the evaluation process because it will have profitability implications. Service lines must be defined as mutually exclusive entities to avoid double-counting of cases.

One point **that must be raised—**and will lead to a lively group discussion—is how to allocate services such as surgery or radiology. Do they become their own service line? Are the surgical cases and imaging scans allocated to the service line for which they were performed, such as cardiac, neurosurgery, and orthopedics?

3. DETERMINE EVALUATION CRITERIA

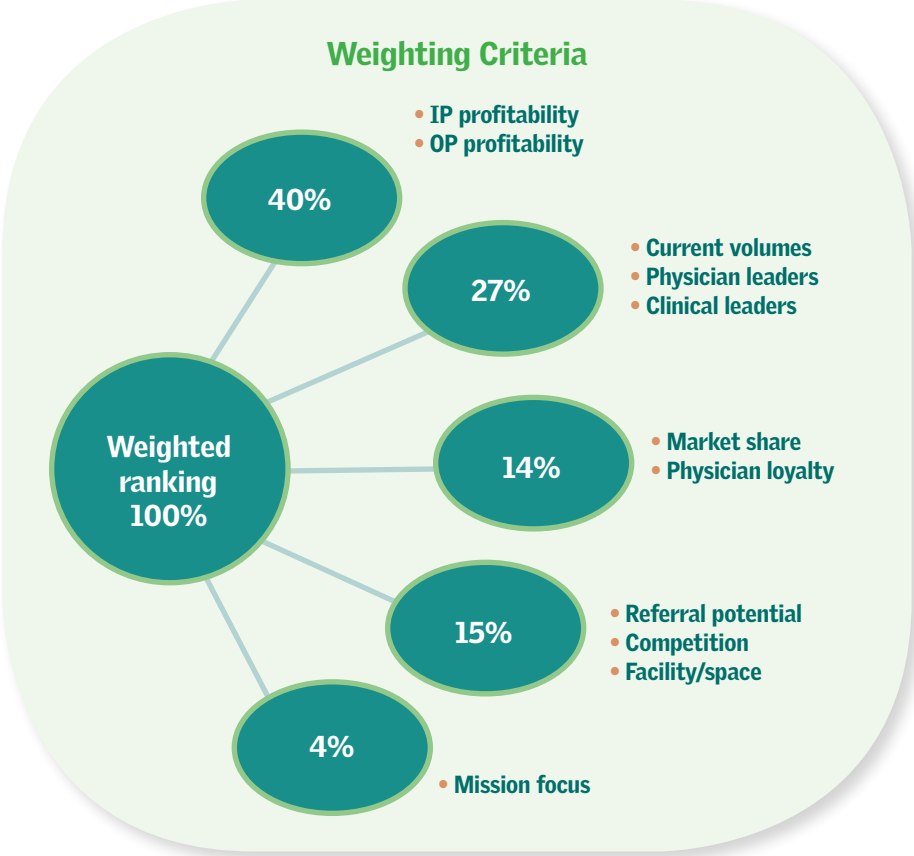
Many factors need to be considered when determining which programs are elevated to become major initiatives for a hospital. Both qualitative and quantitative factors should be incorporated in the decision-making process. Most often, profitability, market share, and volume potential are the greatest determinants in deciding which programs move forward. Outlined below are some of the key criteria.

Key Evaluation Criteria

Quantitative	Qualitative
• Profitability	• Technology
• Market share	• Facilities/space availability
• Current volumes	• Physician leadership
• Projected volumes	• Contribution to mission
• Expansion expenses	• Referral streams
• Physician loyalty	• Clinical leadership
	• Competition

4. WEIGHT THE CRITERIA BASED ON IMPORTANCE

Once the team has agreed on the evaluation criteria, the next step is to determine the relative influence the criteria will have on the overall ranked score. Two methodologies to carry out this step involve: 1) incorporating a multiplier to increase the influence that key criteria have on the total score; or 2) assigning percentages, summing to 100%, with the key criteria being allocated the greatest percentage. To maximize profitable growth, a greater proportion of the weighting should be allocated to profitability and attainable volume. However, if a hospital is more concerned with maintaining referral streams, the weighting may be shifted more heavily toward referral source criteria. Depending on the overall goals of the organization,



the evaluation tool can be weighted differently.

5. POPULATE QUANTITATIVE METRICS AND SEEK QUALITATIVE INPUT

Two simultaneous processes can occur to incorporate the input of all of the team members in determining the ranking of the service lines. The quantitative analysis can be compiled through a joint effort of the planning and finance areas. Inpatient and outpatient profitability, expansion expenses, current and potential volumes, loyalty by specialty, and market share can be gathered using internal systems. Concurrently, the physicians, clinical leaders, and ancillary leaders can begin to assess the

Evaluation Matrix

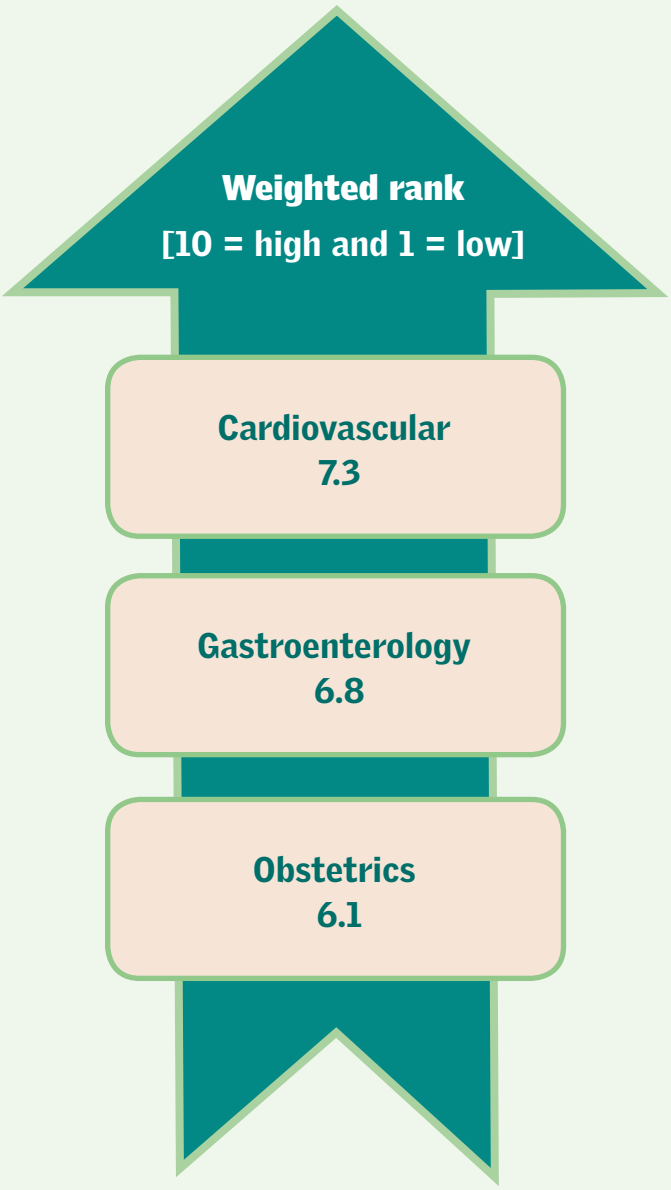
[Scale: 10 = high and 1 = low]

Criteria	Criteria weight	Oncology	Cardiovascular	Gastroenterology	Gynecology	Psychiatry	Obstetrics
IP profitability	20%	6	10	8	7	2	3
OP profitability	20%	5	10	9	6	4	9
Current volumes	9%	8	7	9	4	3	10
Market share	7%	7	8	10	6	4	9
Physician loyalty	7%	3	6	4	8	9	7
Competition	5%	2	3	1	8	9	4
Physician leaders	9%	8	9	8	9	3	10
Clinical leaders	9%	7	6	8	5	9	4
Referral potential	5%	9	6	5	3	4	10
Facility space	5%	4	5	9	6	2	7
Mission focus	4%	8	5	4	2	10	6
Weighted ranking	100%	5.4	7.3	6.8	5.7	3.8	6.6

technological strengths, facilities, internal leadership, referral capacity, and mission focus. Since the group must work together to subjectively evaluate service lines, time must be allowed for group processing.

The team will then be asked to rank individual service lines, compared to others, on an agreed-upon scale (10-point or five-point) for each one of the criteria. Based on the rankings identified and the weights that were previously defined, an overall prioritization list for future growth will be formed.

Identifying Future Areas for Growth



6. RANK AND ROLLOUT

Once the weighting rankings are completed, future areas for growth are identified. The timing for each of the major initiatives will need to be revisited with the senior leadership to determine which programs should be expanded initially. If physician recruitments are required or facilities need to be expanded, implementation plans may need to be staged to address gaps in service delivery. Conversely, senior leadership may decide that struggling service lines need to be discontinued or outsourced to another provider. This allows for financial redistribution of funds to higher-performing programs.

One of the primary benefits of analyzing service line performance using multiple criteria is that programmatic strengths and weaknesses are highlighted. Low-scoring criteria indicate weaknesses, whereas high-scoring criteria represent strengths. This provides all service line leaders—not only areas for expansion—with potential opportunities for improvement and key strengths for differentiation. As a result, the organization as a whole moves toward stronger performance.

REALIZE RETURNS

By evaluating service line investments, a future revenue stream will be realized that allows for continued growth. The financial cushion resulting from calculated growth will allow hospitals to offer more services, improve quality, refurbish facilities, and enhance service delivery. *hma*