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Product/Service Line Management

THE BASICS

by Annette Conklin

Many hospital administrators are grappling to determine an effective management model for managing oncology programs. Cancer product line management, in which oncology services are treated as a separate, marketable product within an institution, is one popular approach that has met with varying degrees of success.

Product lines have existed in the automotive and other industries for several years. Making the transition to a health care model, however, has been difficult because health care has traditionally been thought of as a service, not a product.

Various models and definitions of service lines exist throughout health care and other industries. Regardless of the industry to which it applies, the basic definition of a service line remains the same. A product or service line is usually viewed as an integrated delivery system of products or services that are provided for and purchased by the consumer.[1] The consumer may be a customer, client, or in the health care arena, a patient.

This delivery system is composed of both technical and professional staff whose primary function is to develop a product or service that will, first of all, make a profit and maximize resources. This function applies to for-profit as well as nonprofit entities.

A second function of an integrated delivery system is to provide a quality service to the consumer. Although cost must be a factor in this era of managed care, certain critical levels or standards must be applied to provide a perceived level of quality. As noted in *Fortune* magazine, "Customers don't want their money back, they want a product that works properly."[2] The same is true in health care; patients want to get well or feel better, no matter what the cost. In managed care, payers want patients at their optimal level—at the least cost.

The third and final function of the system is to provide the product or service at a cost the consumer is willing to pay and the market is willing to bear. Jack Welch, chairman of General Electric, paraphrased this function well when he remarked that "the value decade is upon us. You must sell a top quality product at a competitive price, otherwise you're out of the game."[3]

WHAT MAKES CANCER SUITABLE FOR A SERVICE LINE?

Service lines work best with a high-volume, high-risk population. In addition, service lines work well with a chronic disease in which a variety of treatment and care settings may be involved.

Cancer services meet these criteria. As we approach the year 2000, cancer is expected to exceed heart disease as the leading cause of death in the United States. In addition, a large, aging population will be at high risk for developing the disease.

For a variety of other reasons, cancer services offer a risk management opportunity that may favor increased development of service lines.

- Cancer treatment requires a comprehensive and multidisciplinary approach involving several care settings.
- Approximately 80 percent of all cancer care is done in an outpatient setting, and this trend is expected to continue.
- Managed care and capitation will limit inpatient care to critically ill and some experimental treatments.
- Technological advances in genetics and other areas will lead to earlier detection efforts and more preventive approaches.[4]

Moreover, the overall competition in the health care market is encouraging organizations to develop service lines in which managers carefully track expenses and revenues related to the cancer program as well as quality outcomes to measure the effectiveness of cancer care.

STARTING A SERVICE LINE

When developing a service line, the best place to start is with a review of your business environment and an overall needs assessment. Based on this review, you can then determine if a service line is even needed. Look at the who, how, what, when, and where of cancer care. If all needs are already being met, the next step is to determine if the delivery of oncology services can be improved. If a gap is identified, decide how it should be filled and by whom.

Part of the initial review of the business environment should involve a SWOT analysis: an assessment of the Strengths, Weaknesses, Opportunities, and Threats of both the organization and the program. The review can serve as the basis for an ongoing analysis of the program's market base and as an analysis of competitors in your area.

Whether this review is done with the help of a consultant, a strategic planning group within the organization, or both, an initial core group is needed to determine an overall strategy, the range of services to be offered, the mission/vision and goals, and the program's relationship to the organization. This group should be multidisciplinary in nature, yet small enough to be able to reach consensus on key issues. Key players should include representatives from medical, surgical, and/or radiation oncology, nursing, administration, and oncology program leadership.

Once an overall strategy has been determined, key components of the oncology program should be targeted for development, including medical oncology, radiation oncology,

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and surgical oncology.

When moving to a product line management approach, effective communication and collaboration among managers are keys to success. It is important to solicit input from general surgery, primary care, diagnostics, research, supportive and alternative services, nursing, and administration, as well as the community. After all, product management is a team approach to developing services.

DEFINING LEADERSHIP

Service line structure varies based on the extent to which product line management has been implemented and the level of authority allotted to oncology product line management. However, the organization of all oncology service lines should be complementary to both the present and foreseeable future. The system should be adaptable to several reimbursement strategies and organizational and environmental trends.

Ideally, the service line should be both horizontally and vertically integrated in order to provide a seamless continuum of care. If all services are not available through the organization, there must be some means of access to services such as home care, hospice, clinical trials, and subacute, support, and transplant services. This access may be ensured through contracts, acquisitions, or affiliations/mergers with other facilities, academic medical centers, payers, employers, or community organizations.

To avoid losing the patient in a logistic maze, access must also include mechanisms to ease transfer between levels of care. It is advantageous to ensure, for example, that the patient who has to get to radiation oncology on the second floor and the patient taking the van pool to the breast center across town can both access services as effectively and as quickly as possible.

The typical leader of an oncology service line may be a physician, other health care professional, business administrator, or a combination of the three. Ideally, the service line administrator should be clinically based and be able to plan strategies that include all aspects of the oncology process, ranging from inpatient and outpatient needs, future developments, marketing, and overall concerns of the administration, the board of directors, and the community. The ability to build collaborative and collegial relationships with those in and out of the organization is also helpful.

If this ideal brings to mind Superman, the image is quite fitting. A service line administrator must overcome the insurmountable, reach new heights in financial management and planning, and be powerful enough to make necessary, albeit, unpopular changes when needed. The service line administrator must be an advocate for change. Often he or she enters an environment that is set up along traditional, functional departmental lines in which department managers have trouble accepting the service line, team approach to developing services.

Rarely do service line administrators have total budget authority over all cancer-related services. Most oncology service line administrators must share their authority over the cancer program with hospital department directors—a situation that carries the potential not only for dissension, but actual turf bat-

LESSONS LEARNED

Memorial Hospital Alliance in Mt. Holly, N.J., developed a service line as part of its delivery system redesign. One of the biggest lessons Memorial Health Alliance learned from this transition process is to obtain buy-in from department staff at the beginning. They are often the people closest to the patients; they can tell you how the system is really operating.

We established a system for receiving input from staff, which included setting up a forum for employees to join others as teams and discuss the process of service line development. These teams were made up of as many as 30 physicians, staff members, and corporate administration. The teams discussed such important areas as protocol, information systems, documentation, quality, outcomes, legal issues, and training.

Since inpatients made up only 10 percent of all cancer patients in our hospital, we realized that an inpatient-exclusive service line would not be feasible. We decided to include both inpatient and outpatient services in the process.

We also found that delivery of services is more efficient when the pharmacist, social worker, discharge planner, dietitian, and satellite lab technician report directly to the nursing manager, who reports to the executive director.

As program manager of oncology services, I have total budgetary control over the cancer registry, community outreach, the cancer committee, clinical trials, and the oncology unit. I provide input into developing the budget for both the medical oncology and radiation oncology units. I frequently interact with these groups and provide general oversight to keep them coordinated as part of the program's goal of seamless care. A certain amount of MBWA (Management By Walking Around) is still needed.

Because development of a service line is an evolving process, there will always be adjustments and fine-tuning. Today our biggest problem is with the information systems and financial infrastructure. Defining actual costs and generating reports based on those costs have been difficult. To better understand the new financial requirements under managed care, many of our nurses and administrators have had to take financial management courses.

Most recently, the entire organization is involved in a transition to a matrix or systems style management format. In this scenario, an oncology program manager (service line administrator) still retains accountability for the oncology program (service line), but may work through several groups to achieve the desired result for the program. The manager of the oncology unit now reports directly to a patient care vice president. In my present role, I interact with both as needed. In the long run, this may help eliminate some political barriers that previously existed.

—Annette Conklin

tles. An oncology program should prepare for this kind of friction, enlisting the support of corporate management early on. Without it, selling the idea of a service line to department managers, physicians, and other key players becomes almost impossible.

The varying levels of authority allotted to oncology service line managers from institution to institution could be a factor in the lack of a uniform approach to oncology service line management. In some instances, the service line administrator reports directly to the vice president of operations; in other cases the service line administrator is purely a marketing position. The administrator's level of authority tends to reflect the hospital's commitment to the service line and the extent to which service line management has been implemented.

The service line administrator is responsible for the oncology products that the various departments deliver. Therefore, when a problem arises in a particular department, such as unacceptable delays in processing biopsies, the service line administrator must work across the political lines of the department without being perceived as interfering or stepping on anyone's toes. Creating in-depth job descriptions that clearly define the service line administrator's relationships to the medical director, nursing administrator, clinical directors, and the cancer committee is one way to help clarify lines of authority and will delineate the service line administrator's role in the process.

DATA COLLECTION

The service line administrator should have a supporting infrastructure of data collection and analysis that enables effective management of a service line. The first of these structures is the cancer registry. By using the information available in the registry, the administrator can better understand numerous trends in population and incidence, ranging from survival to disease incidence to provided treatment. For example, data may show increased incidence of brain cancer in a particular area of a hospital's region. For the hospital to best respond to this increase, it needs to know if it is simply a coincidence or a long-term trend resulting from factors putting those residents at increased risk, such as environmental hazards.

In some cases, financial information may also be gathered and analyzed. This information may be crucial in negotiating with payers and proving quality and cost of the service line or in program development and marketing to specific areas and needs.

Determining costs and collections data is a core function of a sound financial infrastructure. Some examples of data that should be readily accessible for analysis include:

- outpatient diagnostic services
- chemotherapy
- radiation and surgery volumes
- costs, charges, and revenues
- quality of life indicators
- benchmarks and standards
- lengths of stay
- physician practice patterns
- costs per case and per day
- overhead and overall costs
- profits and losses as they relate to the service line.

A working relationship must exist between the administrator and the financial analyst so that the information requested is properly relayed, transmitted, and analyzed.

A good information systems department should be able to access and compile data from the registry, finance, and departmental areas and load them into an accessible format. Cancer program administrators must be able to track expenses and revenues related to the cancer program; they must know whether cancer care resources are used effectively. Unfortunately there are few systems with this total capability.

The service line leader needs to be aware of factors and trends that may affect the service, including changes in the population, regulatory issues affecting health care and other industries, environmental trends, and emerging technologies. Keeping abreast of changes can be accomplished through membership in community, local, and national organizations and by reviewing health care as well as other industry publications. Networking, professional organization membership, and conference attendance are also supportive strategies for all administrators and professionals.

HOW TO SUCCEED

The most crucial factors for why a program succeeds or fails depends on the following factors:

- commitment and support from the organization to the service line
- an informational and financial infrastructure
- accountability, risk acceptance, and span of control
- definition of the service line's key components and crucial indicators
- planning and timing
- communication.

If any or all of these factors are missing or inadequate in any way, it becomes difficult to successfully manage an oncology service line.

Having unwavering institutional support for oncology enables development of strategies and appropriate use of resources. The service line administrator needs to be experienced, selected early in the planning process, and involved in planning from the outset in order to build relationships, foster ideas, and define parameters for success. Outcomes analysis should be developed, with indicators for success or failure determined as part of the planning process.

Finally, developing the service line to its fullest capacity requires time. The first year will be spent refining and clarifying roles, relationships, and data. The second year might still be considered an emerging system, and the third year should truly begin to define success or failure. Refinements will still occur as needed, and data should be analyzed to answer the questions: Has the development of the service line been successful from a quality, financial, and staff and patient satisfaction viewpoint? What are the indicators for these success factors?

No doubt, developing a service line will be an ever-changing, evolving system with many challenges and benefits. So, be prepared and be flexible.

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Four Viewpoints

Stephen Nash
is vice president of planning and finance at H. Lee Moffitt Cancer Center in Tampa, Fla.

As a free-standing cancer center, we have always had product line management or a product line approach to patient care to some degree. But we have taken a more serious approach to product line management over the last four years. One of our first steps involved redesigning the registration pathways. We assign product lines, using primary cancer site, to track patients distinctly, for example, as a breast or thoracic patient regardless of their attending physician.

Our center director has been most supportive of product line management, otherwise referred to as a programmatic orientation at our cancer center. He is the one who has guided the organization into a programmatic structure, encouraging the shift away from a departmental way of thinking. As a result, physician program leaders have emerged as the more important figures in the administration of the cancer center.

This shift has caused some friction among some of the medical staff, because physicians are being asked to work more closely with other medical or surgical specialists to address a common site-specific malignancy. But having a "closed" staff, one that works exclusively at our cancer center and as faculty of our university's College of Medicine, has been advantageous for us. As a result we have a very close relationship with our medical staff, and we feel comfortable investing heavily in their programmatic efforts. The College of Medicine tends to be more department oriented, but when physicians enter our cancer center, their departmental affiliation is often secondary to their programmatic assignments.

Developing a product line or programmatic approach involves a significant investment. But we believe that the value of a product line orientation is much more important to the management of patient care—truly a multidisciplinary approach to diagnosis and treatment of the disease.

Luci Gunderson
is oncology program coordinator at St. Mary's Medical Center in Duluth, Minn.

In Duluth three organizations are trying to form a cancer center—Miller Dwan Medical Center, The Duluth Clinic, and St. Mary's Medical Center, which are located within a three-block radius of each other and connected by skyways. Miller Dwan offers the only radiation therapy in the region, the Duluth Clinic provides outpatient chemotherapy, and St. Mary's houses the inpatient unit and ancillary services. We have one common cancer coordinating committee that represents all disciplines from the three organizations. We cooperate to offer multidisciplinary care. At this point our affiliation with one another is informal, but we are working toward a more formal arrangement, which has been endorsed by leadership in all three organizations.

The oncology program coordinator position was created in 1992 to coordinate and advocate for the inpatient oncology product line. I coordinate and integrate oncology services among the various departments such as nursing, outpatient, and pharmacy and report to the vice president of nursing. I work closely with the medical oncologists in order to achieve a high degree of collaboration among clinical staff.

In my position I am really a program planner. The job can be frustrating because I do not always have authority over certain changes in the departments. My position, however, does allow me to look at the product line objectively and more creatively, such as planning prevention services. I can expand other people's thinking without coming from a budget- or department-focused orientation. I am able to bring departments together with less bias. More often than not, departments tend to view me as patient focused. Unfortunately, we lack a good cost accounting system. If we are going to prepare for managed care, we need to share information, and we need a more formal way to share costs and expenses.

All three organizations have unique cultures, their own set of procedures, and thus different ways of operating. We need to establish more commonality, because we share patients. None of the organizations can stand alone in rendering comprehensive cancer care.

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Janet Dees
is administrative leader at Brookwood Medical Center in Birmingham, Ala.

At Brookwood we have redesigned our whole organizational structure so that our products and services are coordinated and managed as separate business entities. We created strategic business units, with each unit operating as a distinct business within the larger hospital. We based our decision upon extensive research that examined historical data, market share, growth size, product profitability, and life cycle. We did a strategic plan and looked at our strengths, weaknesses, and opportunities, and concluded that strategic business units were best for our hospital.

One significant change for us is that we became a very decentralized, matrix organization. We always had a very traditional centralized nursing department. With this new structure, the responsibility for nursing went to each individual strategic business unit. Decentralization of our nursing services was our toughest obstacle because it was our most radical change.

Although it was a big change, it wasn't a bad one. Decentralization has given more accountability to staff at all levels of the organization. For example, my operations leader for the oncology unit (formerly the nursing manager) also is responsible for our centralized transportation department. People were encouraged to take on new responsibilities. Our nursing group still makes a point to meet regularly and use each other as resources. This close communication has greatly decreased any fragmentation that might occur because of the decentralization.

We found that it was extremely important to communicate with everyone as much as possible. Our CEO held open meetings for all interested staff. It was especially important to reach out to the physicians, because our nurses and staff turned to them for answers. If we could get the physicians on board, they could help us share information with staff.

Peter Diestel
is vice president of administration at The Valley Hospital in Ridgewood, N.J.

For the past year we have been looking to develop a more comprehensive, better coordinated oncology program in order to further improve the level of care provided to our patients. In the past, oncology services have been somewhat fragmented with different components scattered throughout the hospital. Given this arrangement, it was difficult, if not impossible, for our patients to identify with the hospital as having a true oncology center. While we do not have the luxury of creating a freestanding oncology center, we are now trying to consolidate some of our services through an outpatient oncology center based in our radiation therapy department. This will hopefully establish at least a main point of contact for our oncology patients.

In addition, we are considering the expansion of our oncology services to include a hospital-based comprehensive breast care program and stem cell and cancer risk assessment programs as well as other services. Physician support and buy-in will become critical success factors in building these programs. Our physicians have been fairly independent in the past and perhaps not overly concerned with the fragmentation of services, but they are beginning to come together in much more of a team approach to the delivery of cancer care. Although there are some political issues that must be addressed, everyone is at least willing to sit around the table and discuss how to improve our services and develop a true oncology center. Fortunately, we also have an extremely committed, multidisciplinary cancer committee that is focused on achieving this goal.

The hospital also enjoys a strong working relationship among administration, medical staff, and the board of trustees, which is due largely to the leadership of our CEO. He continues to be a principal advocate for the further development of oncology services. Through this strong working relationship and initial successes with other initiatives such as patient-focused care and patient care pathways, I am confident that we can achieve our goal of developing a comprehensive, well coordinated community cancer center.