

Case Study: Toward Second Curve Service Line Development

Background: *Service line development is a critical area for both hospitals and physicians, and is thus fertile ground for both conflict and collaboration. Carried out within a First Curve framework, service line development is almost guaranteed to optimize the interests of specific physician groups, or of the hospital, while suboptimizing the interests of other physician groups, the medical staff as a whole, or of the entire community. Second Curve service line development anticipates and designs remedies for these potential flaws while maintaining the strengths of existing clinical and practice development approaches.*

DHS specializes in this kind of service development. We have several ways to enhance and optimize the usual approaches, for instance our use of the First Curve-Second Curve metaphor. This framing points out what is wrong with the current paradigm, but does not stop there. Instead, Dr. Merry begins from what is already working and builds from there, in a collaborative design process with the client system. Other DHS consultants share this orientation and add expertise to that of Dr. Merry in helping hospitals and physician groups to move together toward a Second Vision.

The DHS process emphasizes linkages between areas and points toward potential synergies from the outset, while maintaining a clear sense of appropriate differences. It has been shown to produce substantial gains over typical service line development processes. The following case illustrates the initial phase of a typical journey.

Situation: A Mid-Atlantic community hospital was experiencing divisiveness among the physicians comprising its medical staff. There was considerable income disparity between primary care physicians and specialists, and established physicians were reluctant to recruit partners needed to fill serious shortages among particular specialties. Despite this reality, senior hospital management felt constrained regarding moves into such traditional physician “turf” as bringing new (potential competitor) physicians into the community.

Intervention: The Vice President of Medical Affairs contacted Dynamic Health Systems (DHS) to design and facilitate an already-planned off-site medical staff leadership retreat. At this retreat the metaphor of 1st to 2nd Curve transition was presented to attendees, along with concepts on how to build positively from internal strengths already within the community. Physicians in attendance gained a greater sense of their interdependency and an increased feeling of empowerment. They expressed a willingness to work more collaboratively, both with colleague physicians and the hospital. High income specialists even recognized a potential value in subsidizing the lower income primary care physicians upon whom they relied for referrals, at least as a temporary remedy for the income disparity within this medical community.

Interim outcome: Those attending the retreat reached a consensus on committing to the formation of a task force to plan how to move from 1st to 2nd Curve, including education for the rest of the medical staff and time lines for task force reports on new structures and processes. In particular, attendees recognized a need for greater alignment between the hospital’s strategic planning process and physicians’ practice goals and objectives. As one attendee expressed, “I feel optimistic that we are in a good position to effect change.

I'm encouraged that we are at the beginning of a process that will improve our ability to function effectively and care better for our patients." DHS has been engaged to support this post-retreat process.