Service Line Strategy: Governance, Integration & Scale
AMGA Virtual Executive Roundtable Summary
July 22, 2026

The AMGA Hospital & Health System Advisory Committee convened physician executives and health system leaders to discuss advanced service line strategies—from governance and dyad leadership to portfolio rationalization and cross-market alignment. The session was led by Ken Ackerman, administrative chair, Mayo Clinic Health System, drawing on his 26 years across Mayo Clinic's destination practices in Florida and Rochester and its community-based health system. Rather than a formal presentation, the session was structured as an open dialogue, with Ken sharing Mayo's governance model and trade-offs while inviting participants to raise their own challenges and approaches.

Key Themes & Takeaways

1. Governance as the Foundation

- Physician engagement surfaced as the top attribute of successful service line strategy, per an AMGA Consulting white paper outlining nine key attributes drawn from interviews across the country. Physicians cannot be a means to an end; they have to feel they are part of it.
- Mayo's governance rests on physician-led committees: A Clinical Practice Committee oversees inpatient, outpatient, and surgical/procedural subcommittees, with specialty councils (cardiology, oncology, etc.) operating across the full geographic footprint so that "Mayo knows what Mayo knows."
- Strategy flows both directions: System-level objectives come down each October, while local hospital practice leadership builds "future-back" five-year plans in retreats, fitting local initiatives into a shared strategic grid. Local leaders' engagement is critical for communicating the "why" and driving buy-in, not just execution.
- One participating organization is consolidating separate academic-department tax ID structures ("UFPCs") into a single entity, having found that fragmented reporting lines to individual chairs were undercutting enterprise service line goals.

2. Preserving the Integrated Multispecialty Model

- Mayo treats the highly integrated multispecialty group practice model as non-negotiable: A service line strategy that hardens into a standalone "institute"—one that simply intakes, treats, and discharges patients—risks disintegrating the brand.
- The service line distinction is intentionally blurred for patients: They should know only that they are receiving Mayo Clinic-level care, personal and differentiated, regardless of which service line or specialty is involved.
- Protecting enterprise-wide access required centralizing physician scheduling, which came with real trade-offs.
- One group described a comparable tension as being "four-dimensional"—medical center-anchored service lines, systemwide service lines, academic department chairs, and operations—and is actively working to converge those dimensions.

3. Coordination Across Silos and Avoiding Duplication

- One organization holds an annual "service line showcase" day where every service line presents its work, surfacing both duplicative effort and gaps (omissions) in business planning across the School of Medicine, practice plans, and hospital.

- Cross-cutting functions such as radiology, pathology, and the ED are deliberately represented within each service line's planning so their impact isn't overlooked when a program is expanded or created.
- Mayo manages escalation through tiered daily huddles, from frontline teams up to an 11 am senior-leadership huddle; only issues carrying enterprise-wide risk (e.g., a safety concern) escalate fully, while most matters are resolved locally.

4. Defining, Prioritizing, and Resourcing Service Lines

- Service line selection is data-driven: Market differentiation opportunity, patient leakage, capital and personnel budget alignment, and ROI all factor in.
- Participants debated the underlying purpose of service lines. One participant raised the question directly: Are they primarily a market-share/business-development construct or specialty-led structures built around clinical content expertise? Several organizations said it's both, with the goal of leveraging expertise across entities in ways a purely departmental structure can't.
- One organization currently organizes around four defined service lines (heart/vascular, cancer, and others), not every clinical area, reflecting a deliberate resistance to proliferation.
- Service line-level reporting remains an open challenge. Most current reporting (CMS Stars, HCAHPS, Leapfrog) is institutionally based rather than structured around the service line, and several systems are still working toward a true enterprise-wide, service-line view of care.

Outcomes Highlighted

- **Integration preserved at scale:** Mayo sustains a single, non-negotiable multispecialty group practice model across 38 outpatient practices and 16 hospitals (17 facilities) spanning its Upper Midwest health system, rather than letting service lines fragment into standalone institutes.
- **Reduced duplication and closed planning gaps:** One organization's annual enterprise-wide "service line showcase" day surfaces both duplicative effort and omissions in business planning across the School of Medicine, practice plans, and hospital.
- **Consolidated governance to remove competing reporting lines:** One system is collapsing its separate academic-department tax ID structures ("UFPCs") into a single entity, addressing fragmented reporting to individual chairs that was undercutting enterprise service line goals.
- **Deliberately focused portfolio:** One organization has limited itself to four defined enterprise service lines to date, resisting pressure to proliferate beyond areas with clear growth and mission fit.

Overall Conclusion

Advanced service line strategy is less a portfolio question than a governance and culture one. Mayo Clinic's experience shows that durable service lines depend on physician-led governance, a deliberate refusal to let specialty structures fracture an integrated practice model, and disciplined data-driven prioritization, even when that means centralizing control (such as physician scheduling) that physicians would prefer to keep local. Participants affirmed the same recurring tensions: reconciling academic, hospital, and medical-group reporting lines; avoiding duplication and silos between service lines; and building enterprise-level reporting that doesn't yet exist in most organizations. There was broad interest in continued peer exchange on governance structures, the boundary between specialty-led and market-driven service lines, and how to measure performance at the service-line level rather than the institutional level.

This summary was prepared with AI assistance and reviewed by AMGA staff.