

The Pendulum Swings Back for Cardiovascular Services

By Ross Swanson

2018 has been filled with both turmoil AND prosperity within the healthcare arena. In fact, it seems that a giant pendulum is swinging back to again present opportunities contrary to the conservative budget and narrowed scope of innovation forced by the economy a decade ago in 2008 (now referred to as the “Great Recession”). This year, Corazon has noticed hospitals and systems re-investing in core services, coupled with an economic upturn across the country and paralleling the increased attention to healthcare in the media.

Cardiovascular services in particular have experienced a significant shift in reinvestment over the past year. The saying “what goes around comes around” seems to be relevant when comparing the accomplishments of the current cardiovascular industry to the stifled activities of just ten years ago.

So many changes have occurred within cardiovascular services during 2018 that it is hard to narrow the list down to the most significant. However, throughout the last year, we have worked extensively with hospitals in three strategic areas, including: 1) re-engineering cardiovascular service line infrastructure; 2) enhancing existing cardiovascular facilities or building entirely new ones; and 3) renewing focus on cardiovascular quality outcomes through accreditation.

Cardiovascular Service Line Infrastructure

During the period entering the 2008 recession, many facilities neglected, or worse, completely dismantled, the traditional cardiovascular service line infrastructure. This was based on the myopic view that centralizing cardiovascular management away from the traditional departmental management silos would add additional costs due to matrixed reporting structures across departments. To illustrate this, many facilities have the manager of the cardiovascular operating room(s) (CVOR) report directly through the department of surgery while also maintaining a matrixed reporting relationship to the cardiovascular service line. This matrix approach to reporting has been thought to duplicate communication and provide additional (i.e., unnecessary) layers of management. In fact, this could not be further from the truth, as the service line structure, by its very nature, is designed to strengthen the emphasis on service line growth, and better monitoring and control of costs. But of course these gains are only realized if the service line is structured correctly to begin with.

Throughout the last year, Corazon worked with many organizations where the service line was under scrutiny and re-engineering the structure was necessary. Such re-engineering can be as straightforward as placing an administrative leader over the service line or as complex as determining an effective dyad leadership model (i.e., an administrative lead partnered with a physician lead). Our team also witnessed how one reinvigorated cardiovascular service line successfully petitioned for the recruitment of vital staff positions that were sitting as open full-time equivalents (FTEs). Of course, the resultant growth in cardiovascular service volumes also bolsters the need for additional staff in these roles.

There are also cardiovascular service re-engineering projects that have reexamined the direct revenue and expenses associated with core cardiovascular offerings. The entire industry has been idle for decades in terms of proper cost-accounting methodologies associated with key clinical services. The time has come to harness the momentum to determine optimal revenue and bring costs under control.

In fact, the Corazon team has worked with several hospitals and health systems, performing a cost assessment or “financial forensics” to better assist facilities with getting infrastructure in place for true cost accounting of key cardiovascular procedures. Since 2018 demonstrated better economic prosperity, it may be useful to bring the financial picture into better focus.

New Cardiovascular Facilities

In the early 2000s, a slowdown in new facility construction (or renovation) occurred. The economic infrastructure across industries was already viewing constrained financing in advance of 2008, and then healthcare construction, specifically for cardiovascular services, came to a grinding halt. As the pendulum has swung back, hospitals and health systems are earmarking dollars to once again “build big” in terms of core service lines like cardiovascular. Financial constraints still exist, but are being prioritized to anticipate the best return on any significant investment.

At Corazon, we have been asked to partner with architects and facility planners at a pace that is reminiscent of the early 2000s — and with good reason. New procedural advances can bring a reevaluation of existing facility space as facilities seek to determine how new techniques and/or technology will fit — a necessary strategic move in order to remain competitive. For example, our team is working with several large facilities to determine how existing cath labs

or operating room space can properly accommodate a hybrid suite (i.e., fixed imaging with OR suite capability). Corazon believes that any facility performing invasive cardiovascular procedures will need to have true hybrid suite space to remain relevant into the next decade and beyond. Furthermore, regardless of hybrid room capabilities, the need to increase the square footage of existing diagnostic and procedural space is rising, especially given the increased use of innovative and often large technologies such as robotics.

Hospitals and health systems are also once again evaluating the “heart hospital” concept. In the 1990s through the early 2000s, physician ownership drove the build of the specialty hospital concept until Centers for Medicare & Medicaid Services placed a moratorium on physician-owned facilities at the end of 2003. Yet even as the potential ownership structure of specialty hospitals remains constrained from a regulatory standpoint, health systems continue to look at additional capital (and potentially funded dollars) to support the building of subspecialty facilities on or immediately adjacent to their current campuses.

Corazon has partnered with architects through the year to develop a heart hospital facility for several health systems, in sharp contrast to the lack of this type of activity just two years ago. It is widely recognized that a specialty “heart hospital” can be a significant differentiator for hospitals or health systems in highly competitive markets, as patients can receive their cardiovascular care in a seamless, one-stop model.

Renewed Focus on Cardiovascular Quality Outcomes

Cardiovascular services have always been subject to strong oversight in terms of clinical outcomes. Cardiovascular leaders have been conscientious in collecting and scrutinizing clinical data, evidenced by virtually universal participation in the American College of Cardiology-National Cardiovascular Data Registry (ACC-NCDR) and Society of Thoracic Surgeons (STS) clinical registries. In 2008, there was a reduction in the growth of invasive coronary procedures, in part due to the adoption and promotion of appropriate use criteria (AUC). The focus on AUC continues to be strong, with renewed energy in the evaluation of whether the appropriate patients are receiving the appropriate treatment at the right time. Public interest in AUC has been reinvigorated, particularly as two television series in 2018 (both on major networks) produced spotlight reports on inappropriate stenting by cardiologists.

Perhaps in view of these findings and the need to ensure that patients are receiving the best possible treatment, the accreditation of cardiovascular services has become a highly sought-after service over the past year. Our team has found that many facilities want a form of “insurance” that their providers are performing competently and efficiently.

The Corazon Accreditation process provides a consistent, independent (outside party) quality review, and if necessary, an action plan development for improvement. Not surprisingly, some states require a third party to accredit key cardiovascular services if a significant change is planned for those services (i.e., advancing procedure offerings or increasing space/equipment), or if facilities seek to perform PCI with off-site cardiac surgery. Five states currently have mandates for outside party verification or accreditation for the cardiac cath lab, and the number of states expressing interest in evaluating regulatory components (which would include an accreditation requirement) has grown over the last year.

Finally, if facilities have a concern related to advancing services (such as an electrophysiology [EP] simple implant facility shifting to perform implantable cardioverter defibrillators [ICDs] or even ablation), then having accreditation performed for the EP area would also prove beneficial, offering a means to provide a gap analysis of the items requiring critical changes prior to advancing those services.

Preparing for the Future

There is no doubt that the dynamic environment of 2018 has provided opportunities in cardiovascular services that are reminiscent of the early 2000s. As facilities look for future opportunities to sustain (and grow) programs beyond 2019, Corazon recommends reviewing past strategic initiatives that were never implemented. For instance, it would not be surprising to see continued focus on “untapped” services in many markets such as advanced EP and even basic service line development, to fully include peripheral vascular procedures.

We must also remain prepared for large paradigm shifts in the care delivery model. These shifts include the ongoing increase of cardiovascular procedures moving to the outpatient setting, including procedures performed in ambulatory surgery centers (ASCs).

For the cardiovascular service line, 2018 has been the year that “the pendulum swung back.” Rekindled cardiovascular opportunities are setting the foundation for a dynamic future.



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