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Establishing a Cardiovascular Institute: Foundational Elements

By James Burns

Only about 15 years ago, when a cardiovascular program branded itself as an “institute,” the expectation was that a great deal of research was taking place, or, at a minimum, the program had a strong academic focus. But, that perception has undoubtedly changed. The ubiquitous nature of today’s research trials, coupled with ever-evolving technical advances in all types of hospital settings, along with aggressive marketing amid increasing competition in many markets, have redefined the heart and vascular programs of today.

What does it mean to be branded as an “institute” in 2016?

Corazon believes the answer to that question, at its core, is surprisingly simple! Today, most institutes are built around cooperation between clinical specialties, the commitment of a strong leadership team, and solid accountability among all from quality, financial, and operational standpoints – hallmarks to any successful program. But, how can these general concepts truly transition a program into a fully-functioning Institute? While each program is unique, some critical components are common to all top performers, thereby lending the service line to an institute model.

Leadership

Administrative. Certainly, any hospital-based initiative needs administrative buy-in and support to be successful. But to be a true institute, however, administrative commitment needs to stretch far beyond a benign approval. Hospital leadership must be fully engaged in the vision of the institute, guiding strategic and tactical plans to that end. Further, in order to achieve and maintain the respect of the institute’s clinical partners, hospital leaders need to be realistic about the financial commitment required in terms of development and legal costs, as well as the time commitment required to build and maintain an exemplary institute structure. This is often easier said than done, as some well-respected institute models have taken many months to several years to fully implement.

The commitment of time and energy can be expansive. Maintaining momentum and tying-up resources for ongoing planning or implementation sessions can be exhausting. Additional challenges can emerge in keeping a high level of interest while a multitude of other projects are introduced, which can exhaust resources, deplete funding, and/or dilute focus.

That said, however, diligence to planning efforts can keep projects moving forward, while driving engagement and preventing any stalling of momentum. Corazon believes a key success factor is being able to demonstrate milestones of achievement and then relaying these to stakeholders to show what’s been accomplished. Showing evidence of progress, regardless of scope, can be motivating for all involved.

On the other hand, while continued progress is important, programs should be careful not to rush development and “gloss over” issues that have the potential to become problematic down the road. The converse of not investing the necessary time and money commitment is hastening development without exploring all potential options. For instance, vetting the various structures available and understanding the short-term and long-term impacts of bringing physicians into roles of leadership and accountability that they, or their administrative partners, may not be prepared to engage can sacrifice a quality foundation in favor of choosing quickly to ensure progress.

Clinical. To be truly effective, leaders need to understand clinical operations, or at a minimum, have strong allies that can speak to the patient-care decision-making aspects of healthcare. But this too can be a pitfall in a fully-realized institute development process. A physician leader who is too clinically focused can derail projects by becoming lost in details that should be addressed at departmental levels. Conversely, leaders without a strong clinical understanding can quickly lose the respect of their colleagues by not recognizing the challenges faced in all of the different areas of the institute spectrum. Even worse, when administrative hospital leaders do not recognize the value of clinical leadership or the importance of the creditability that physicians and clinical managers bring to the table, they can very quickly become disregarded by medical staff, which will most definitely taint any opportunity for advancing the cooperation that is necessary for institute development.

Board of Directors. This collaborative group of stakeholders can be defined differently, depending on the organization; however, the scope of responsibility should always be to provide a level of checks and balances in decision-making and to achieve participation and inclusion from all areas impacted by the institute. Some advanced centers also incorporate “ad hoc” membership to this group as a means to include additional perspectives as needed for complementary services, as in Podiatry representation for vascular services, or from support areas such as marketing.

Based on Corazon experience, development of this area of an institute can be the most time- and resource-intensive, but the effort is necessary, as failure here can be detrimental if the Board is not carefully established as assurance of a balance of power and decision-making. Providing fair representation to administration members and medical staff members, as well as between members of different institute specialties is critical. Be advised, though, that representing specialty groups by votes can be a tenacious point of contention, as the numbers of votes by specialty and by specific practice can lead to a perception of bias. For example, there are generally more Cardiologists than CT Surgeons, but is it fair that each group gets only one vote? This issue should be carefully considered and resolved, and the solution will vary depending on organization-specific dynamics.

Overall, the tactical impact of this effort should not be ignored. No one solution fits all and "best practice" institutes carefully vet all alternatives to understand where the selected model could be weak or where it could provide an uneven distribution of power within the organization. Lastly, the representation of hospital leadership needs to be carefully considered, and the ultimate rights of the CEO understood and preserved.

Technology

A sub-group dedicated to the evaluation of technology and decisions about what to incorporate into practice is essential to any institute model. The scope of this group, whatever its title, should include clinical practice benefits as well as the financial impact (weighing value against cost, etc.), both of the initial investment as well as the ongoing effect on the service line. An example of how this group can impact success is the evaluation and coordination of documentation systems across the continuum, or determining how new device interrogation modalities can improve existing practice business within the institute as a disruptive technology, not a new revenue stream. This is not to say that decisions should be made exclusively with the bottom-line in mind, but rather, that creating a full understanding across an organization of what a new technology can bring, both in monetary and in clinical excellence considerations, is a must.

Quality

In this era of full transparency, there are few, if any, programs without a dedicated team focused on quality. At a minimum, centers have someone to manage data collection and reporting in order to remain compliant with governmental and payor requirements. There are a select few that have raised the bar on quality analysis and reporting, evolving from a siloed specialty approach to a full spectrum view across the service line, including all key areas of the continuum and the matrix relationship between outcomes of one area compared with another. This is certainly an advanced approach, but one that can give major insight into operations and the resulting quality (or lack of). An example of where this approach has been implemented successfully is being able to review data in the diagnostic competent of the program and link issues there with results in the context of surgical and interventional outcomes or referral volumes. Or, using quality data as a means for the physicians of the institute to encourage changes based on specific performance areas of individual institute members is another advanced way to use data as an indicator of quality.

Promotion

Marketing is a facet of institute performance that can be great capital to a program. Well-organized institutes include directives for promotion and cooperation within the bylaws of the organization. As the number of employed or aligned physicians grows, programs often struggle with keeping naysaying minimized or having their physician team members "on message" with the overall vision or goals of the institute in terms of market promotion. While incorporating an institute model does not change these behaviors immediately, there is great impact achieved when these expectations are clearly laid out at the inception of the model. Ensuring that all team members know and understand the messaging shared with the marketplace, and are aware of easy and effective ways of delivering the same or similar message can lead to big returns. Effective institute structures also create a greater medical staff accountability and mechanism for "calling out" or addressing poor attitudes or unwarranted negative vocalizing about the program.

Successful institutes have also benefited greatly from the pooling of resources and dollars traditionally dedicated to discrete segments of the program, such as surgery, for promoting the entire service line. This can include education to consumers about what an "institute" is, or even promoting quality indicators such as complications or even appointment wait times, which can be attributed to the entire program. Research participation notices and clinical success stories are also great ways that Corazon advocates our clients use to raise awareness and increase positive reputation in the local or regional (or even national) marketplace.

In conclusion, the total effort to develop an institute should not be underestimated; but conversely, the potential for very positive outcomes across the service line should not be overlooked either. However, as with most worthwhile efforts that produce results, this is no easy task!

Corazon recommends that the first step is always be a solid planning effort. Physicians and administrators cannot adequately plan and support the move to an Institute, or even recognize the intensity of the work involved, without a detailed plan and framework for moving forward. Indeed, the decisions about whether, when, and how to implement an institute model are very important, as implementing a failing model, or one that cannot achieve its vision or goals, is often more detrimental to hospital relationships than forgoing the model altogether.

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