Cardiovascular Summit

STRATEGIZE
INNOVATE
IMPLEMENT
TRANSFORM

The Evolution of CV Service Lines

Where have we been – where are we heading?

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MedAxiom

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Disclosures

- Ginger Biesbrock – None related to this topic
- Cathleen Biga - None related to this topic
- Richard Chazal - None related to this topic
- Jeffrey Kuvin - None related to this topic

Agenda

- Evolution of CV SL's
- Governance
- Structure
- Scope
- Quality & Finance
- Independent, employed, academia and CV SL's
- CV SL 2025

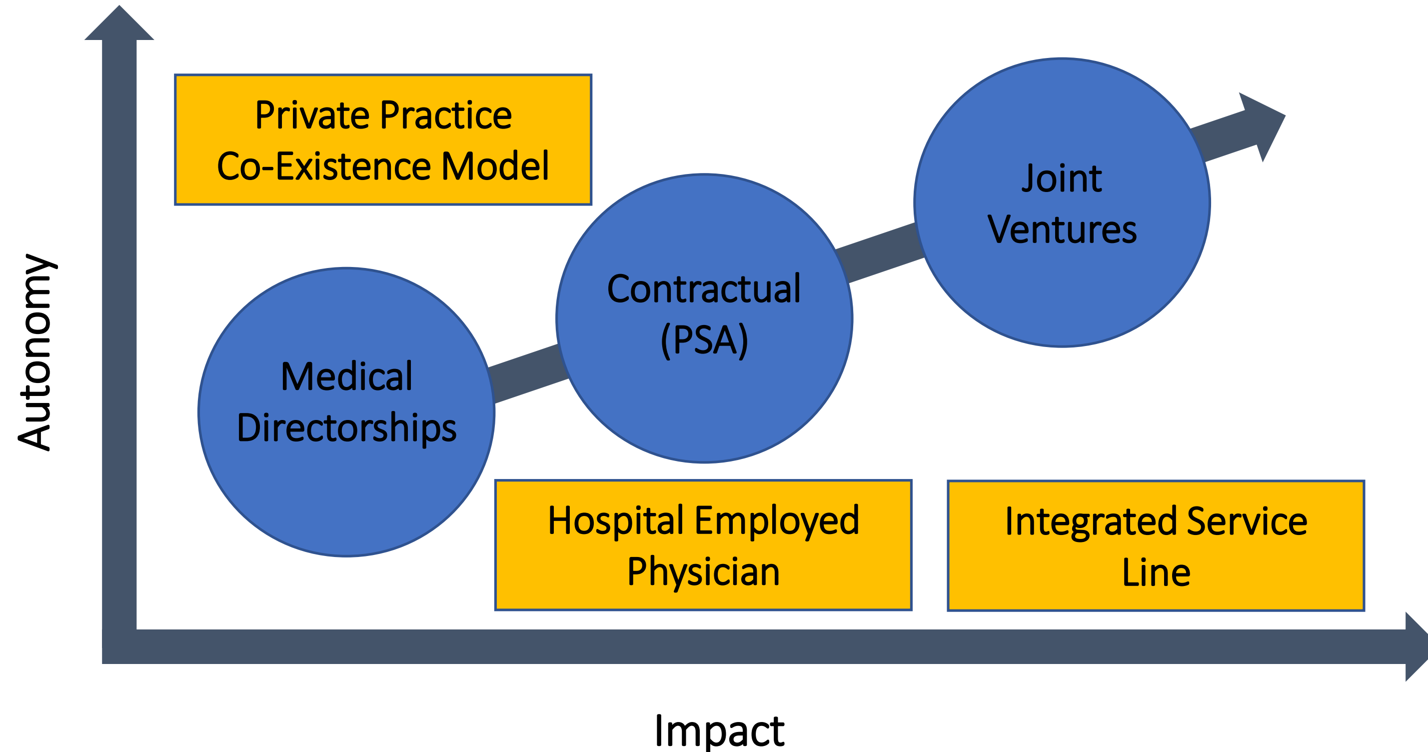
There are 7 factors that will shape our industry moving forward

The 7 Cs of Healthcare

1. ***Compression*** *of margins*
2. ***Contraction*** *of inpatient volume*
3. ***Changing care models***
4. ***Consolidation***
5. ***Consumerism***
6. ***Connectivity***
7. ***Competing on Value***

- The healthcare industry of the future will be ***fundamentally different in how it is organized, how and where care is delivered, and how it is funded***
- There will likely be ***fewer hospitals and more access points*** (both physical and virtual). Of the hospitals that remain, they will have ***higher levels of acuity and be more specialized*** (with few "general" facilities)
- Technological advances will make the industry ***more personalized, more precise, and more predictive***

Journey to an Integrated Cardiovascular Service Line



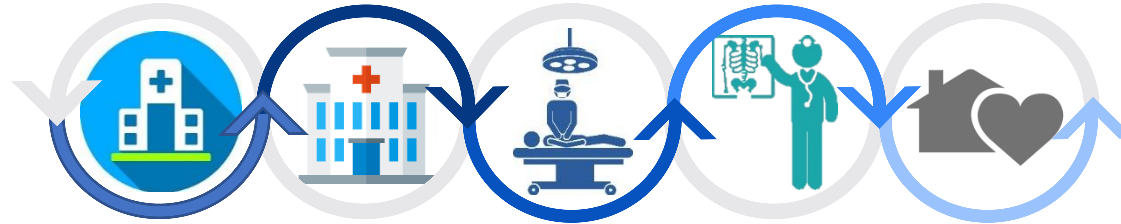
PSA=Professional Services Agreement

Adapted from https://www.beckershospitalreview.com/hospital-key-specialties/the-cardiovascular-service-line-approach-creating-value-in-organization-structure.html, Accessed 1/18/20

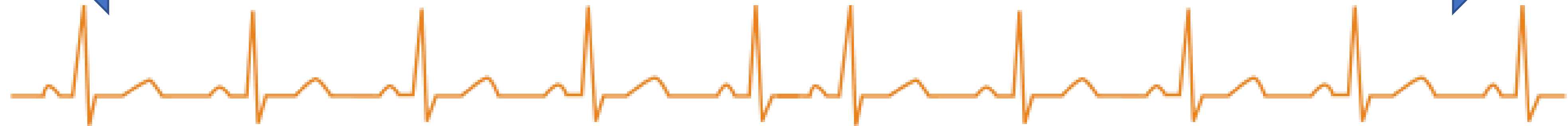
PATIENT-CENTRIC PILLARS

Care That Extends Throughout The Continuum

Organized Across The Continuum



Horizontal CV Care Stream Across Traditional Vertical Structures



Cardiovascular services organized the way patients experience them.

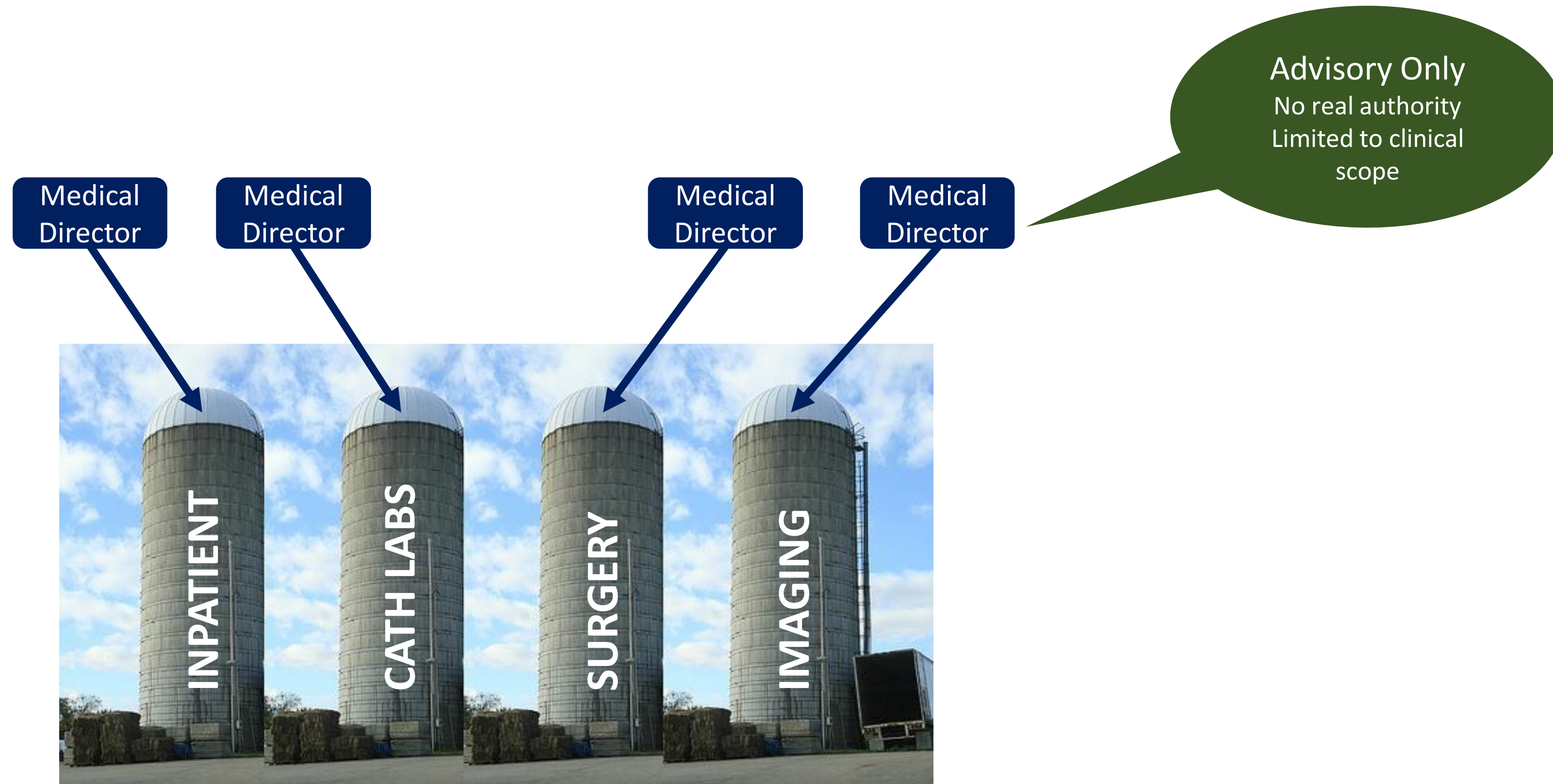
Consolidated Strategy – Budget – Operations - Management

Promises of a Service Line—Rainbows and Unicorns?

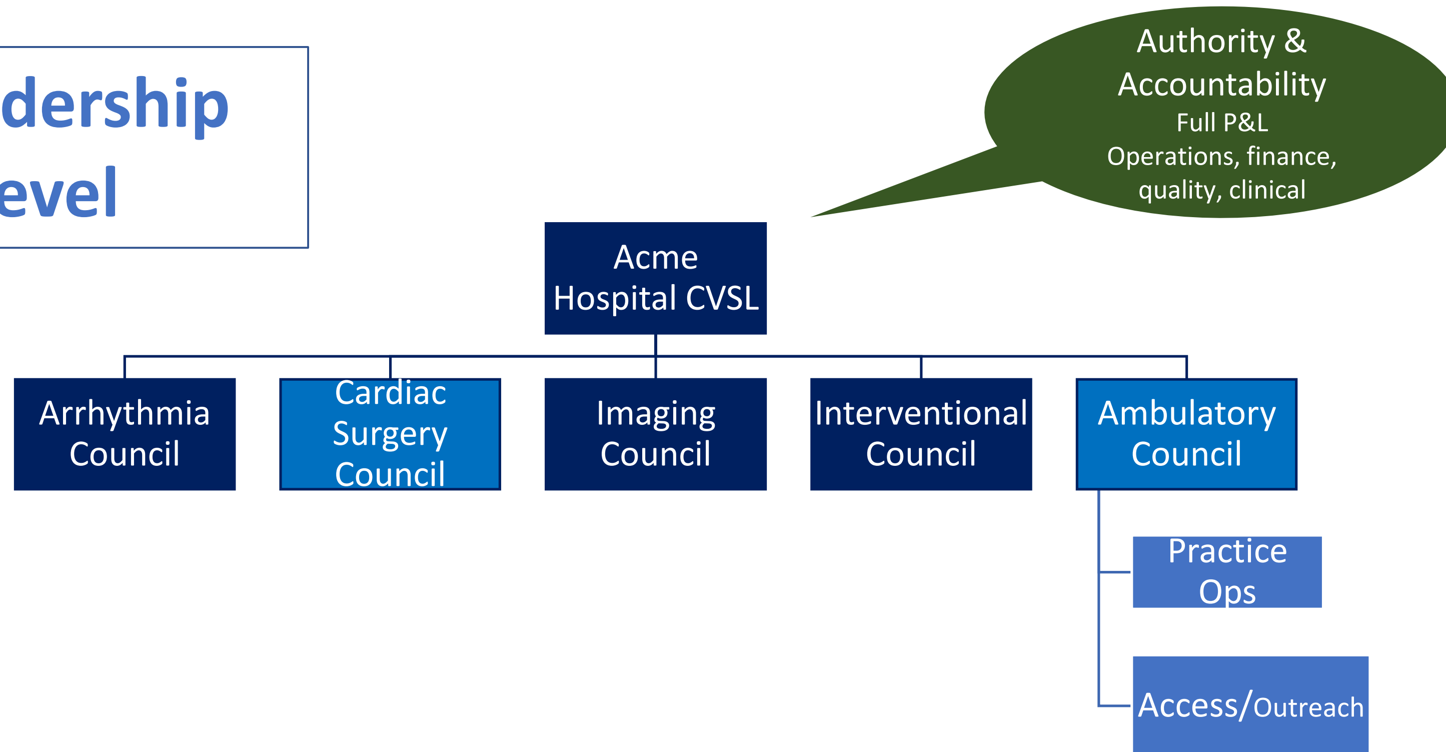
Aligned patient-centric model that enhances hospital AND clinician performance from a quality
• Adapt to new payment models (that often involve decreased reimbursement) • Stabilize or increase patient volumes • Improve quality, while maximizing efficiency and profitability • Acquire the latest technology • Recruit, train, and retain outstanding nursing, technical, and other clinical staff to provide and manage advanced specialty services • Facilitate the creation of "Centers of Excellence" • Stabilize clinician income

Adapted from:
https://www.beckershospitalreview.com/hospital-key-specialties/the-cardiovascular-service-line-approach-creating-value-in-organization-structure.html, Accessed 1/18/20
https://www.acc.org/~/media/14B6F431FBC24192A316DD3DFAF34780.ashx, Accessed 1/18/20

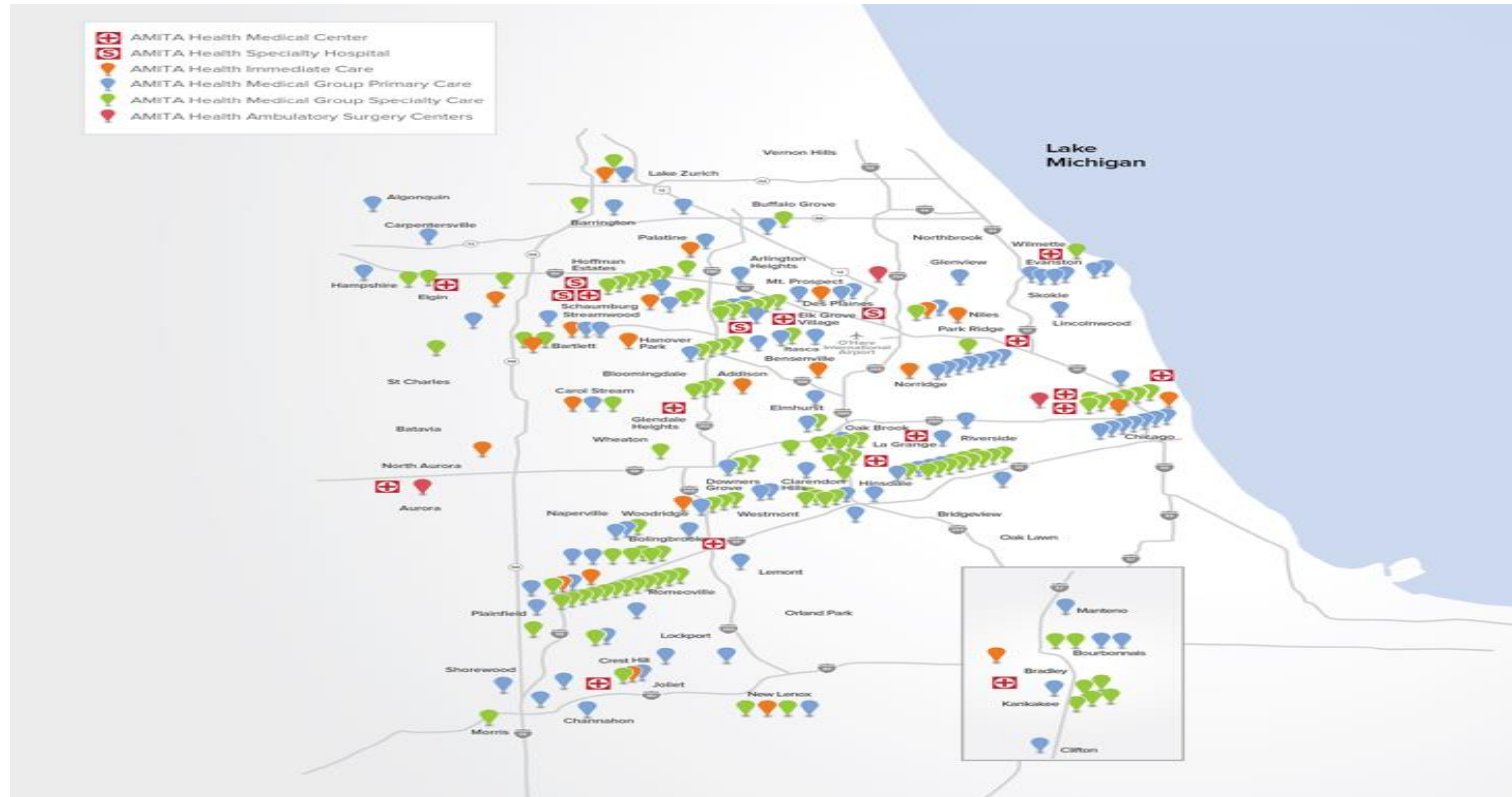
Traditional governance



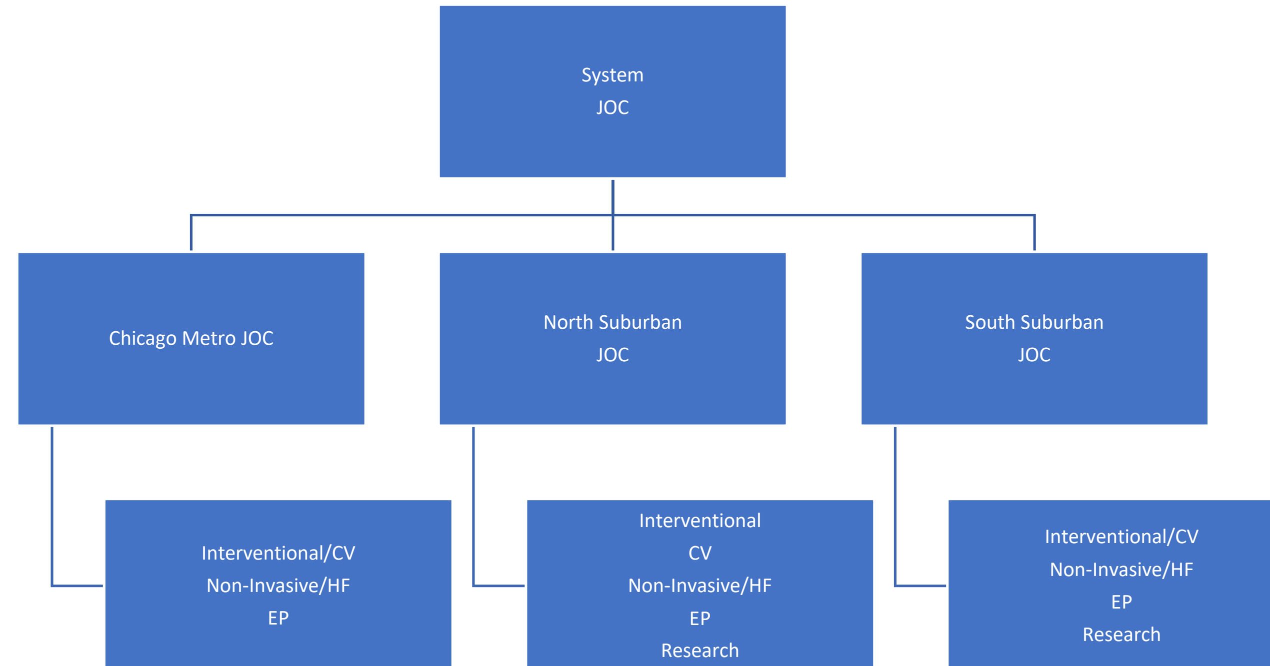
Dyad leadership at each level



AMITA CV SL



CV Service Line JOC Committee Structure

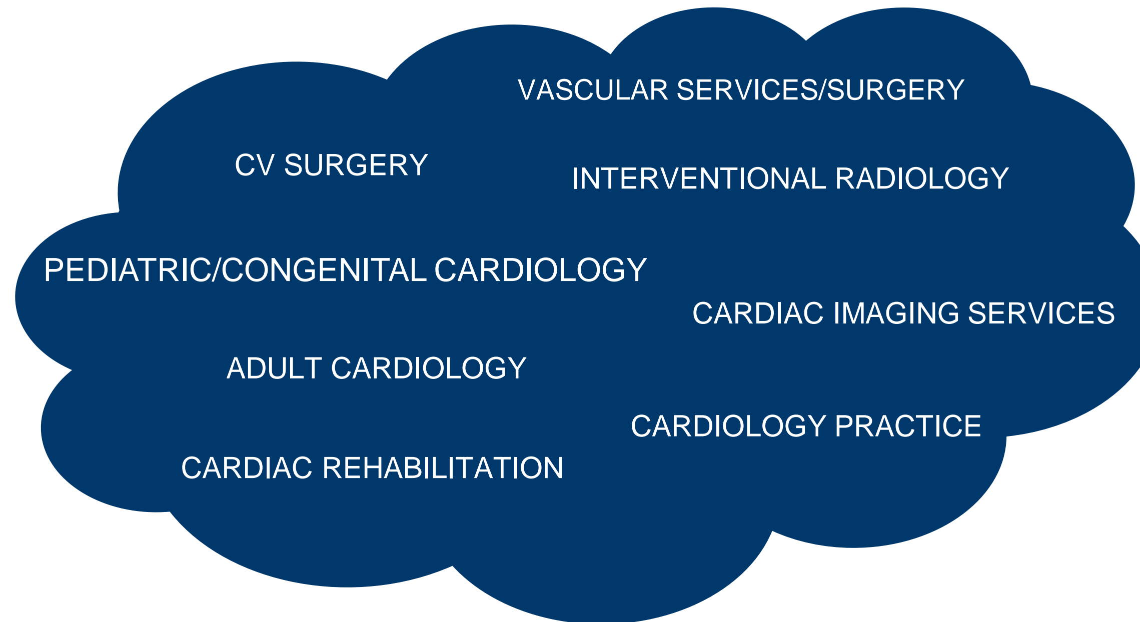


CVSL Scope

- What is included? Is it comprehensive? (*that can be good…or a problem*)
  - Quality
  - Program Development
  - Reimbursement
  - Operations
  - Inpatient, Ambulatory
- Who is included?
  - Specialties: Cardiology, CV Surgery, Vascular Surgery, Radiology…
  - Employed, Independent

Determining CV Service Line Composition

What Services Should be Included?



PEDIATRIC/CONGENITAL CARDIOLOGY

Governance Issues

"Control"

- System benefit/focus
- Avoid individual self interest

"Inclusive"

- Physician buy-in
- Clinical Expertise

Governance Largely Dictated by Scope

- **Clinical**, **Quality**, **Programmatic** Scope:
  *Favors Strong **Clinician** Oversight ("Inclusive")*

- Highly **Operational** Scope (Staffing, Competitive Programs, Finance):
  *Favors Strong **Administrative** Oversight ("Control")*

Scope Model

Lee Health Heart and Vascular Institute

- Quality
- Program Development
- Reimbursement (above employment contract)
- Inpatient

- Cardiology
- CV Surgery
- Employed Physicians
- Independent Physicians

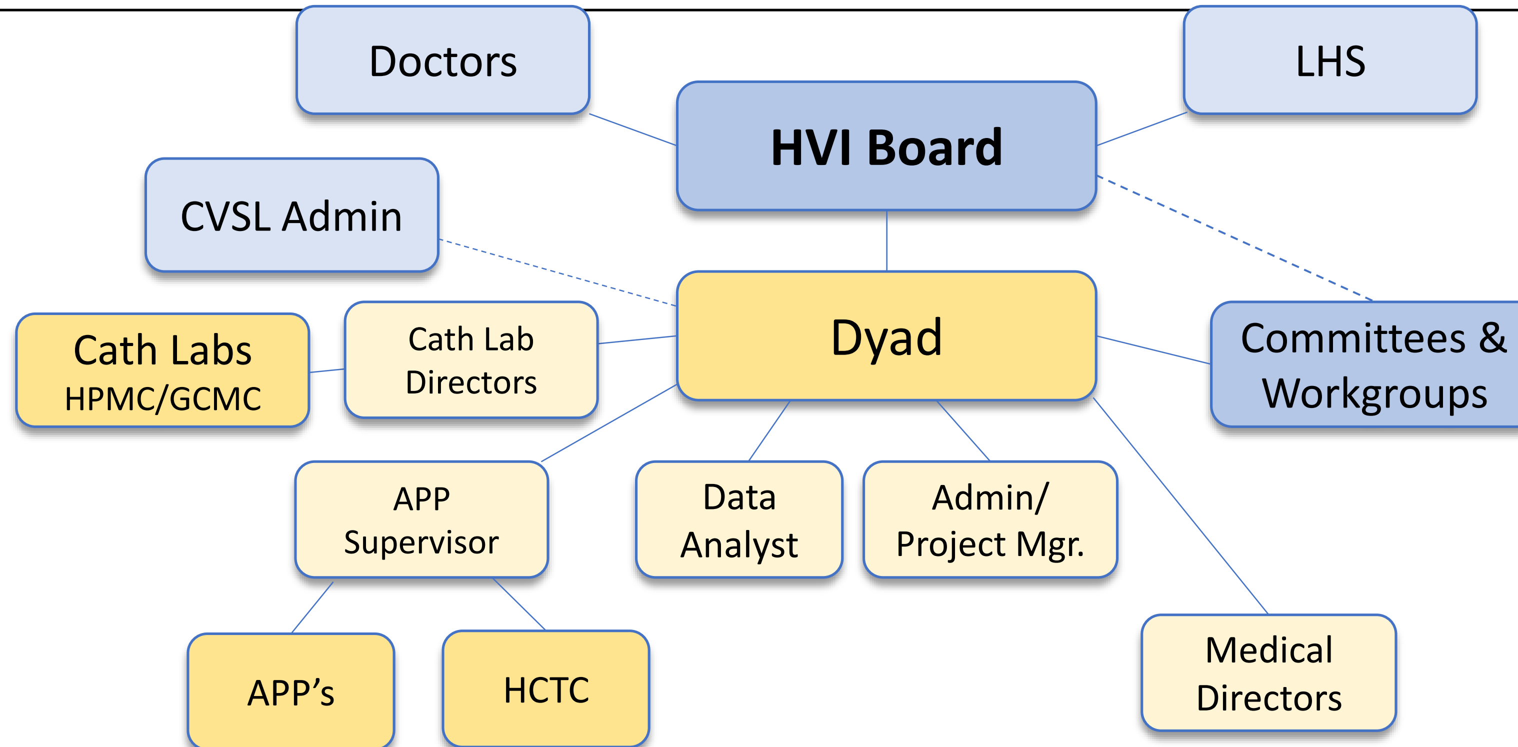
What's "out": (most) operations, ambulatory, radiology, vascular surgery

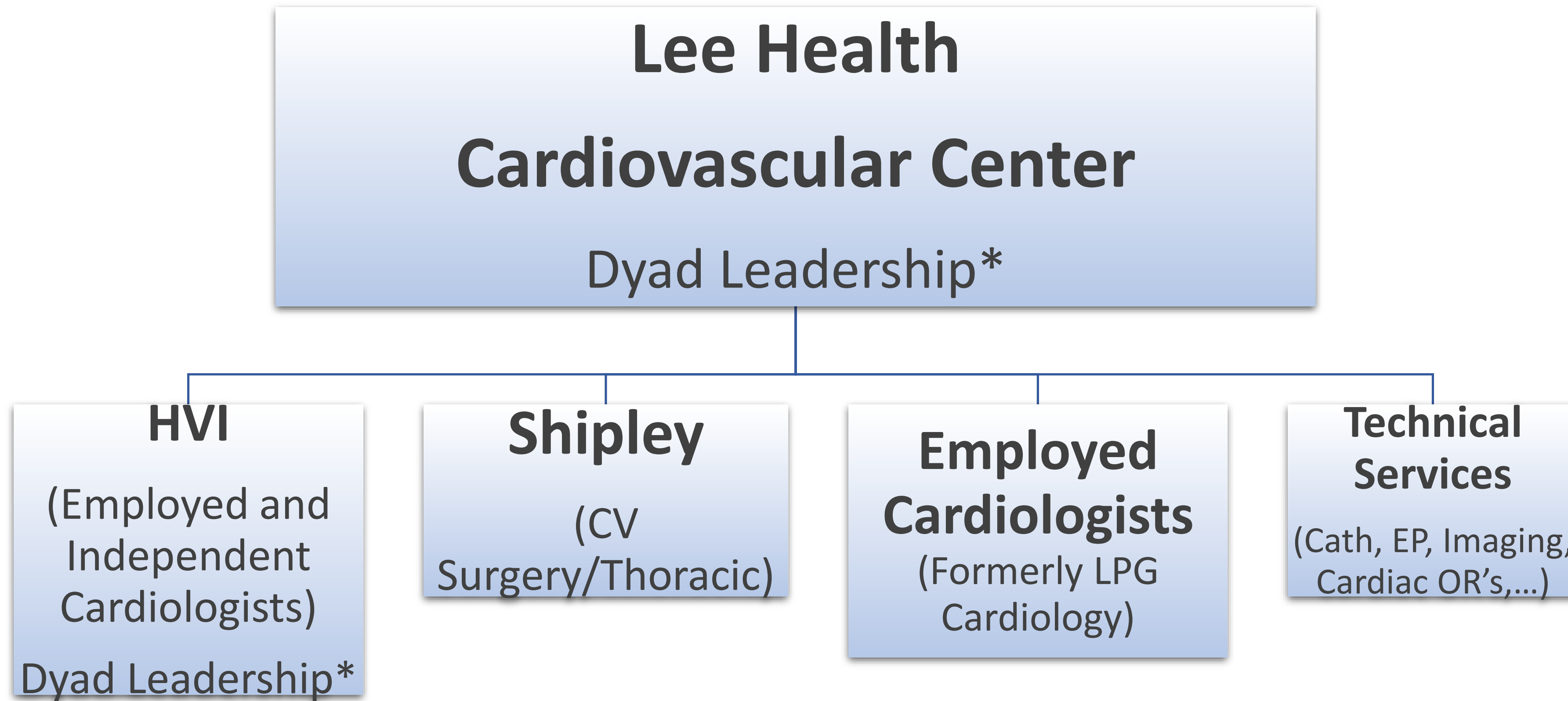
Governance Model

Lee Health Heart and Vascular Institute

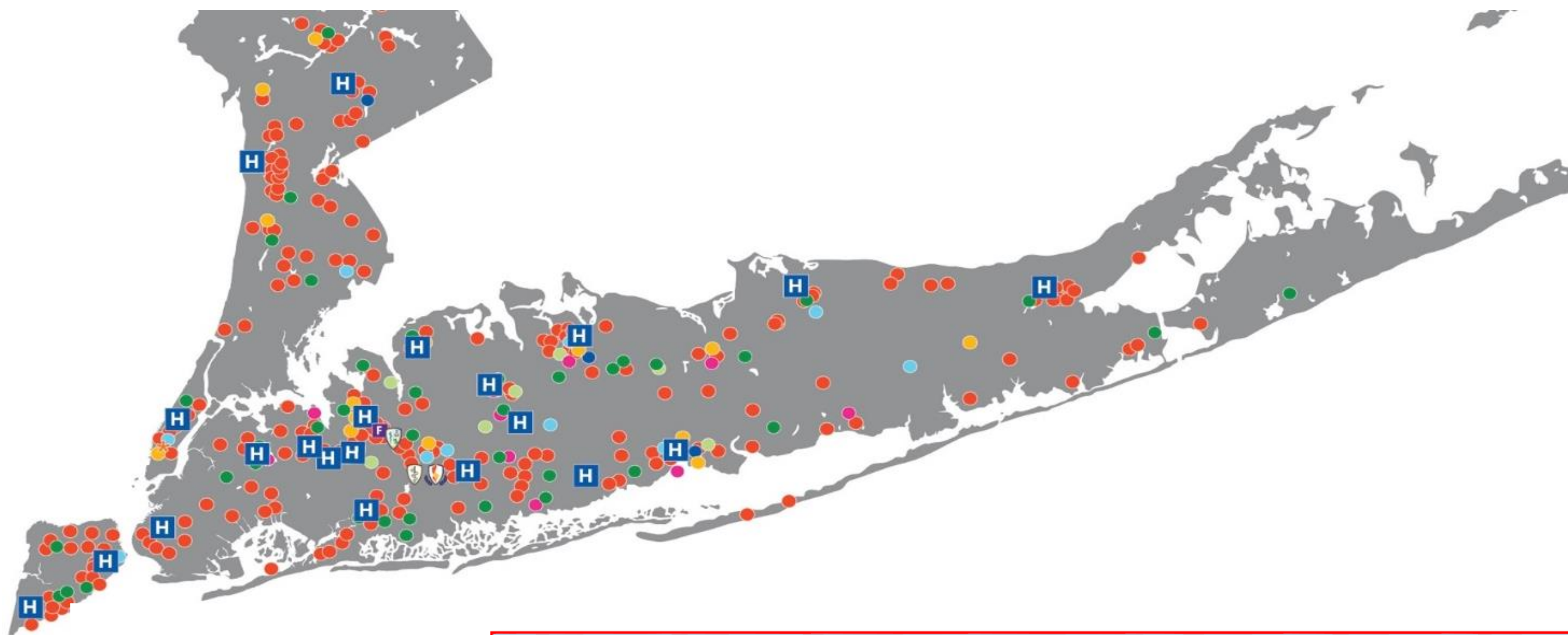
- "Balanced" Board: 4 senior administrators; 4 elected cardiologist; 1 CV Surgeon
  - Programs
  - Quality Initiatives
  - Metrics/Payouts
- Dyad Administration: Cardiologist and Administrator
  - Day to day HVI operations
  - Planning
  - Problem solving

Heart and Vascular Institute Structure





*Med Director may be same individual



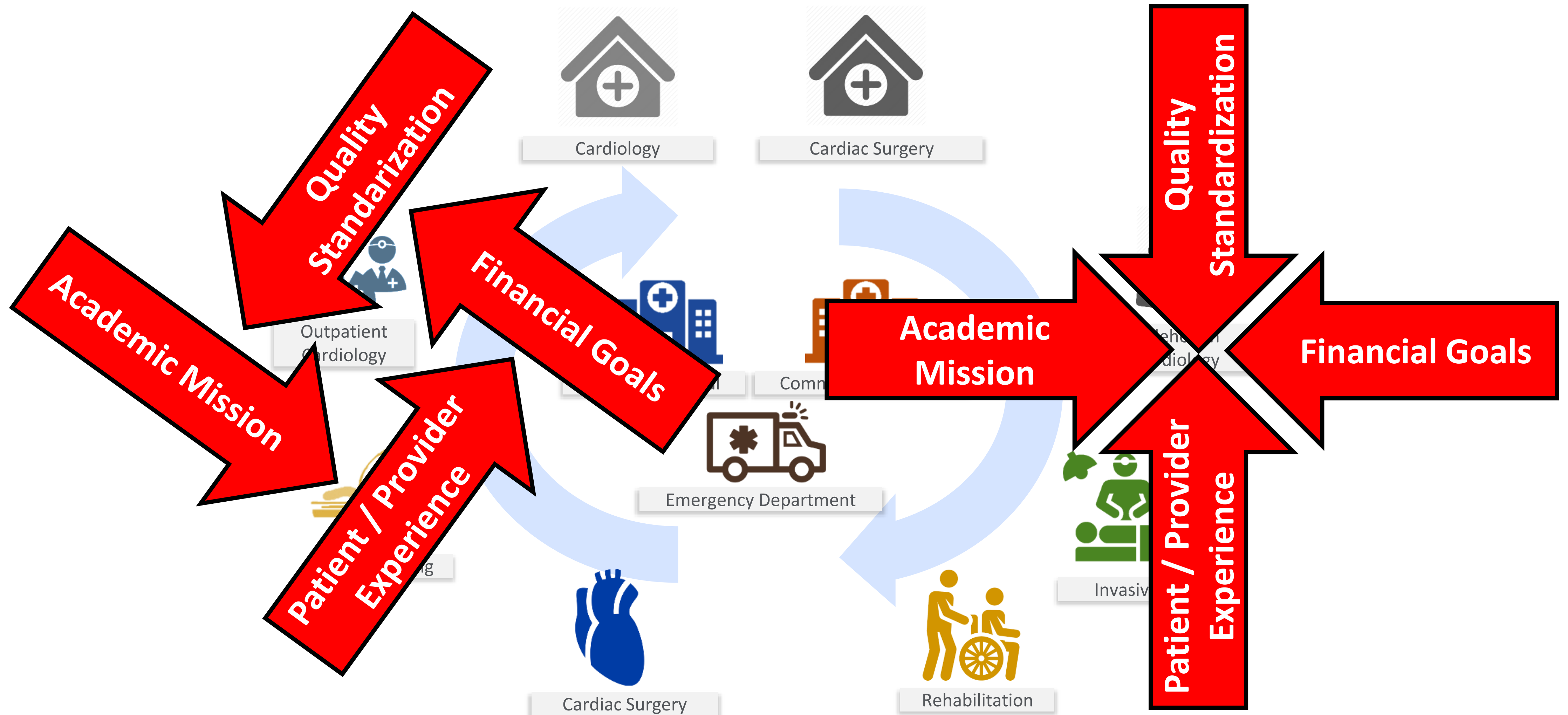
Non-profit, academic, integrated healthcare network
NY's largest healthcare provider, private employer
23 hospitals (4 tertiary, 1 quaternary)
250 cardiologists, 25 cardiac surgeons
24% of NY'ers

Traditional Academic System

Academic hospital/medical school
The system follows the AMC/medical school
Long-standing faculty
Academic infrastructure
Focus on basic science, translational science

SL = Departments of Cardiology and Cardiothoracic Surgery
Collaborative, dyad leadership model
Distributed local leaders
Separate finances & academic promotions

Alignment Across a Service Line



I. The Advanced CV Service Line: Quality Opportunities

Good for patient care

Good for service line

Good for reimbursement

Good for brand

Focus on metrics

Focus on data

Focus on improvements

Focus on programs

Service-Line Quality/Standardization Task Forces

To optimize clinical operations and measure quality across the SL to ensure patients receive the best care at all sites

Cardiac Catheterization Laboratory Task Force

Clinical Cardiology Task Force

Diversity, Equity & Inclusion Task Force

Electrophysiology Task Force

Heart Failure Task Force

Structural Heart Task Force

Cardiovascular Imaging Task Force

- Medical leadership
- Regional lead
- Administrative oversight
- Dashboards
- Frequent meetings
- Scorecards
- Accountability
- Celebrate wins
- Discuss strategies

II. The Advanced CV SL: Financial Opportunities

Different models	not one fits all
Align incentives	quality metric-driven
Program growth	vs. individual growth
Transparency	individual, program, group
Focus on sum	not parts

III. The Advanced CV SL: Academic Opportunities

“Academics”: redefine, broaden scope

Education: learn, teach together

Training: cross-training, expand skillsets

Innovation: novel rx, devices

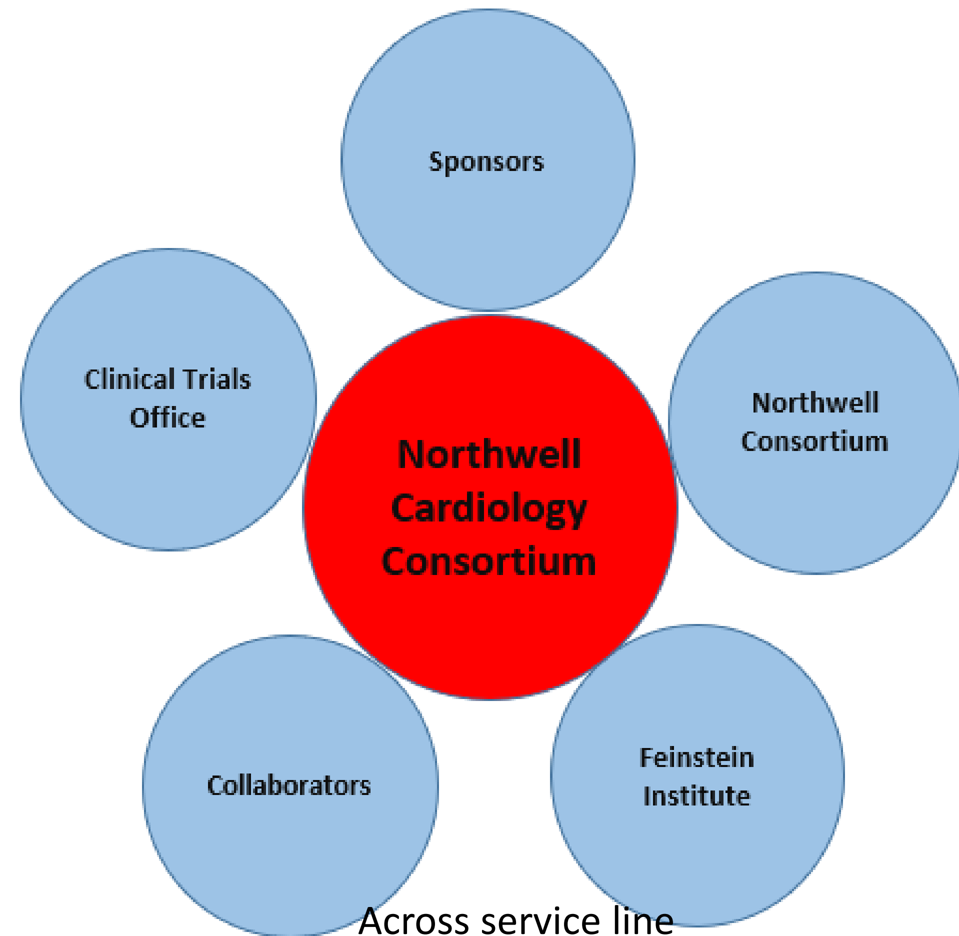
Research: collaboration across disciplines

De-Silo: *inclusivity, across disciplines*

Northwell Cardiology Research Consortium

To promote creativity, innovation, collaboration and discovery to improve the well-being of cardiovascular patients.

Provides research oversight, biostatistical expertise and data analytics, as well as investigator mentorship and guidance.



Across service line
Monthly meetings
All regions represented
Clinical trials, PI initiated
Research awards

IV. Quality, Finances, Academic Mission: Lost Opportunities

Stagnation

Limited growth

Unfavorable outcomes

Lack of innovation

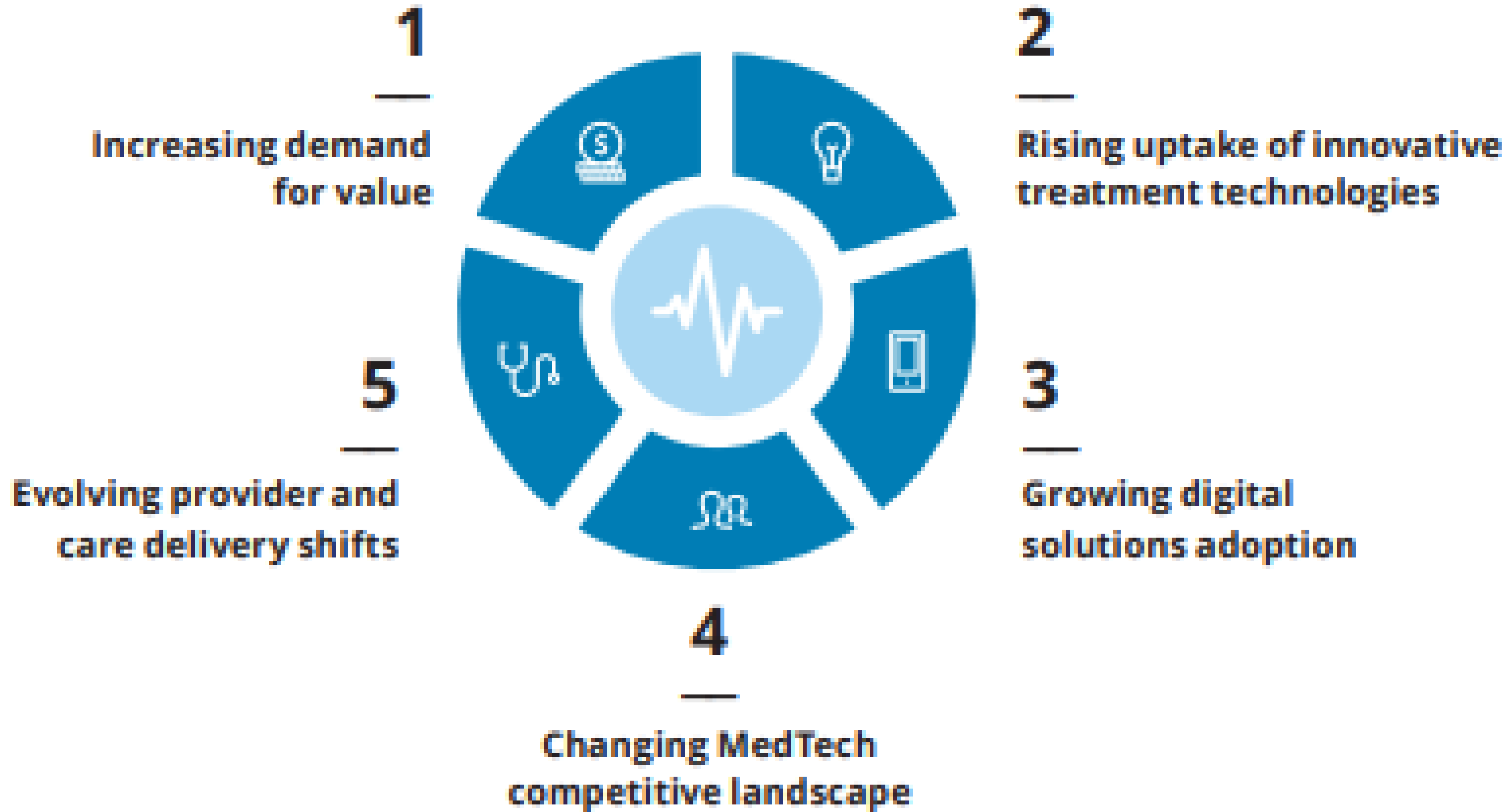
Staff burnout, resignation

Fiscal distress

CV SL of 2025

Remote Patient Monitoring – New way to deliver care

CV SL of 2025



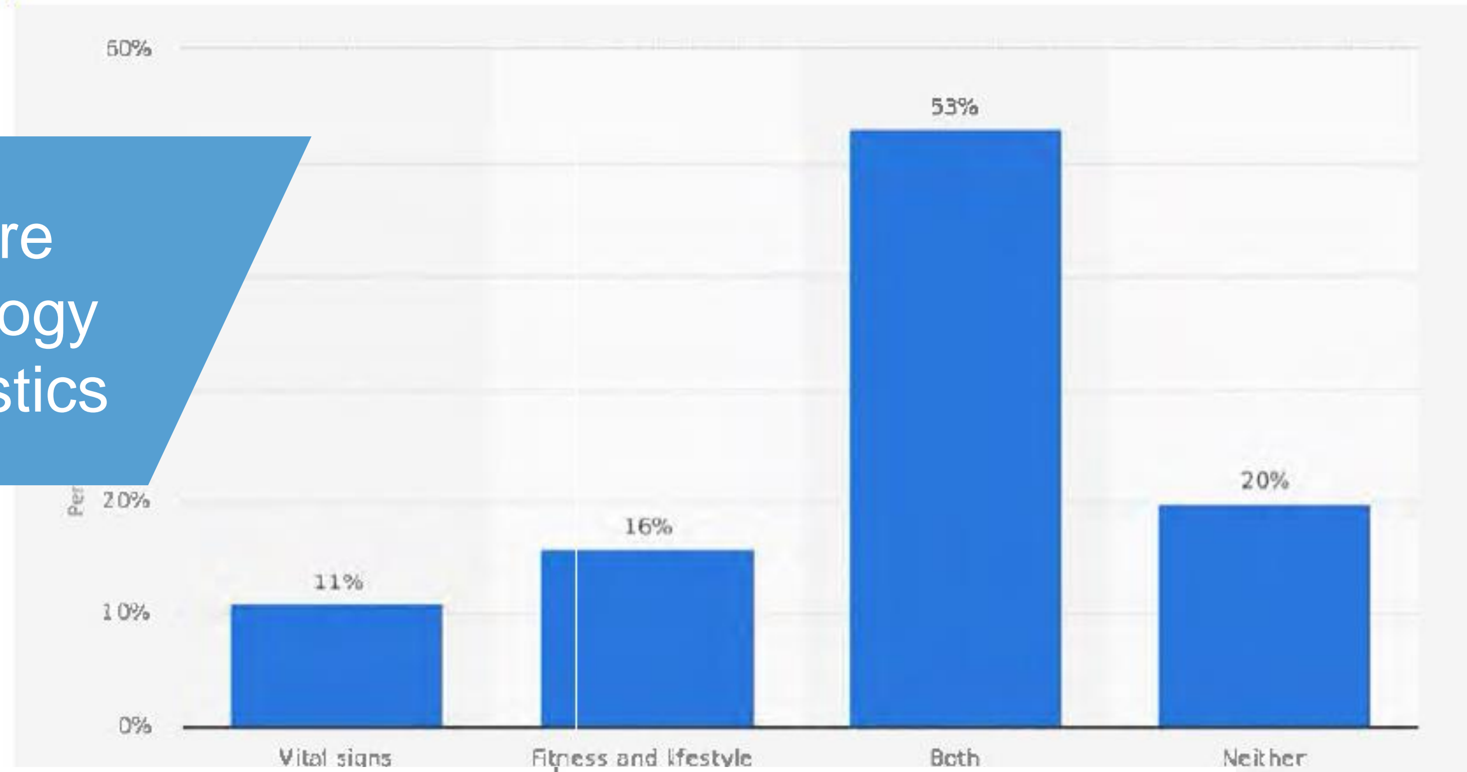
Deloitte – New Realities

CV SL of 2025

- The need for CV services will double from 2011-2025 (Deloitte)
- Increasing Demand for value
  - Cardio-onc; Cardio- OB; PHTN, Dysthymia, Cardio-metabolic, Resistant HTN
- FFS → Shared Savings → Bundles → Shared risk → Global capitation
- Patient journey mapping
- Digital transformation
- Data….data…data

WHAT IS REMOTE PATIENT MONITORING (RPM) REALLY?

- RPM is a system that uses one or more devices to transmit patient-generated health data to healthcare professionals for review
- Many choices – more than 400 EHR compatible devices on the market
- Scales, B/P, heart monitors, watches, etc.
- COVID-19 thrust the strategy into the spotlight



80% of U.S. adults are willing to wear technology that tracks health statistics

KEY FEATURES OF SUCCESSFUL REMOTE CARE DELIVERY

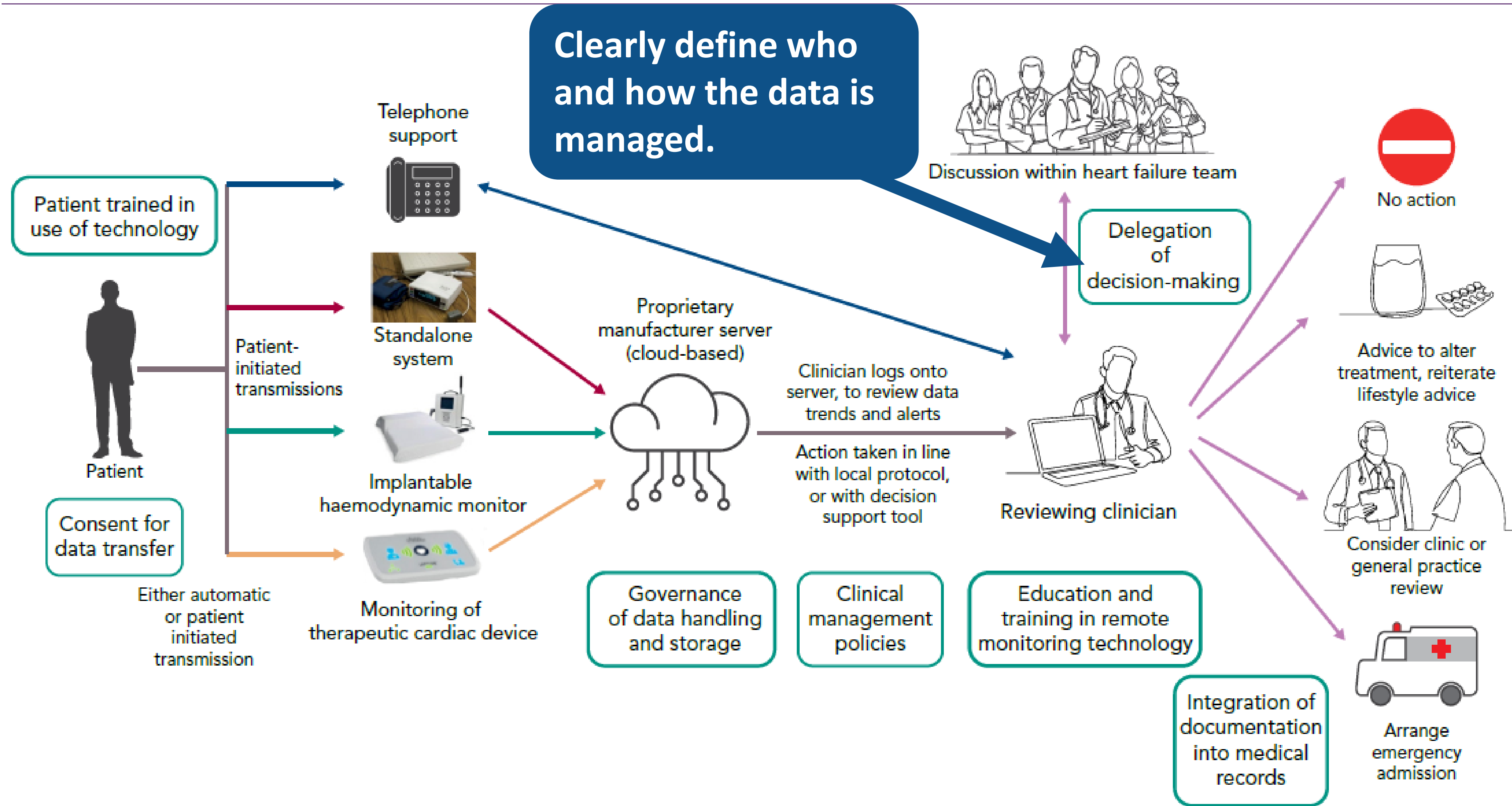
- ✓ Clearly defined problem and disease state
- ✓ Integrated system of healthcare delivery
- ✓ Technology support and service
- ✓ Personalized experience
- ✓ Enhanced end user experience
- ✓ Aligned payment and reimbursement models
- ✓ Clinician champions and stakeholder support

Smuck, M., Odonkor, C.A., Wilt, J.K. et al. The emerging clinical role of wearables: factors for successful implementation in healthcare. npj Digit. Med. ***4,*** *45 (2021).*

COMPONENTS OF AN RPM PROGRAM

RPM EXAMPLE – BLOOD PRESSURE MANAGEMENT

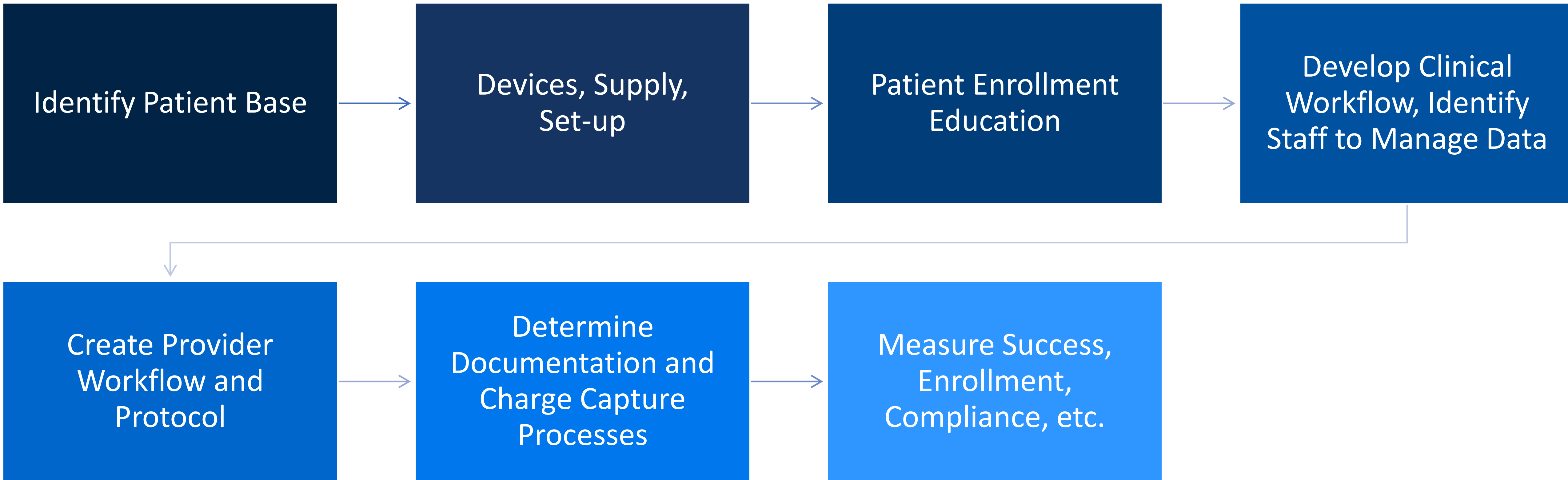
- Bluetooth monitoring records BP throughout the day as directed by their provider
- Medication reminders to ensure patient remain adherent to their medication plan, ensuring compliance to new and existing medications
- Monitor a patient's progress and adherence to the treatment program
- Education modules – actions to support better outcomes
- Virtual visits – provider can communicate in real time if a BP is out of range, if symptoms are exacerbated, or to answer questions about care



Boxes show key considerations for a remote monitoring clinical service. Arrows indicate the actions taken.

https://www.cfrjournal.com/articles/remote-management-heart-failure-overview-telemonitoring-technologies

PROGRAM PLANNING



RPM REVENUE CYCLE CONSIDERATIONS

REMOTE MONITORING SERVICES (RPM)		
Patient Set-Up & Education	99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. May be used with either 99091 or 99457.
Device & Transmission of Data	99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient). May be used with either 99091 or 99457.
Interpretation and Management	99457	RPM treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
	+ 99458	each additional 20 minutes (List separately in addition to code for primary procedure)
	99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored59 and/or transmitted by the patient and/or caregiver to the physician or QHCP, requiring a minimum of 30 minutes of time, each 30 days. Limited to ONLY providers (MD, APP) - not reportable for clinical staff
	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward) by a physician or other qualified health care professional

REMOTE PATIENT MONITORING (RPM) MPFS CY 2021 FINAL RULE
DURING PHE ONLY
Must be an established patient physician relationship for RPM services to be furnished.
16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454
GENERAL
Finalized consent to receive RPM services may be obtained at the time that RPM services are furnished.
Auxiliary personnel may provide services described by CPT codes 99453 -54 under general supervision. May be contracted employees.
Clarified that the medical device supplied to a patient must be a medical device as defined by Section 201(h) FDA.
The device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.
Confirmed RPM can be ordered and billed only by physicians or non-physician practitioners who are eligible to bill Medicare for E/M services.
Clarified RPM services may be medically necessary for patients with acute conditions as well as patients with chronic conditions.
Clarified that for CPT codes 99457 and 99458, an “interactive communication” is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012.
Clarified 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication
RPM services are not considered to be diagnostic tests; that is they cannot be furnished and billed by an Independent Diagnostic Testing Facility on the order of a physician.

V. The Advanced Service Line: Takeaways

Integration
Empowerment
Communication
Discipline
Mission-focused
Sub-specialization
TEAM