The High-Performing Cardiovascular Service Line: Evolving Leadership and Governance in the Value Economy

How to create an intentional, carefully designed clinical strategy that establishes expected outcomes for care and creates standards for care delivery.

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When you consider very successful organizations throughout history, each shares one key attribute that propels their success. These organizations have a very clear vision of who they are and what they are trying to achieve, and every member of the team understands and believes in the vision. Because of this, everyone is working relentlessly to achieve it.

This clear and compelling vision is created through solid leadership and pursued and monitored by an organized governance structure. Without this foundation of leadership and governance (Figure 1), the greatest strategies in the world will simply evaporate. This is as true outside of health care as it is within and is equally poignant for cardiovascular services.

Health care is dizzyingly complicated in its scope and breadth. One simply has to look at the continued challenges that electronic health records create in terms of efficiency and improving patient safety for proof of the complexity—this after decades of evolution and enhancements. Cardiovascular services are only slightly less expansive and cover a host of subspecialized components. To effectively lead and manage this complex organism, intention and a lot of hard work are required. Additionally, organizations must consider the entire product spectrum, something that has been missing in the past.

HISTORICAL PERSPECTIVE

Traditionally, cardiovascular services have been managed at a departmental level, particularly within a hospital or health system. This made logical sense given that the majority of cardiovascular physicians operated from private groups, with distinct ownership and leadership from the hospital. Hospitals then were primarily focused on inpatient care and the ancillary services that supported them. Heads of ancillary departments typically reported up through a chief operating officer, while inpatient floors

Figure 1. The importance of a governance and leadership foundation.

and units reported to the chief nursing officer.

The connection between the two distinct worlds of physicians and hospitals came through medical directorships, where hospitals would contract with physicians for clinical leadership. Rarely did these directorship positions focus on financial or operational matters, and instead they tended to stick with quality and clinical outcomes. The scope of these directorships generally aligned around departments, such as the catheterization labs or subspecialty services such as electrophysiology. Often, accreditation requirements (eg, echocardiography) defined the directorship.

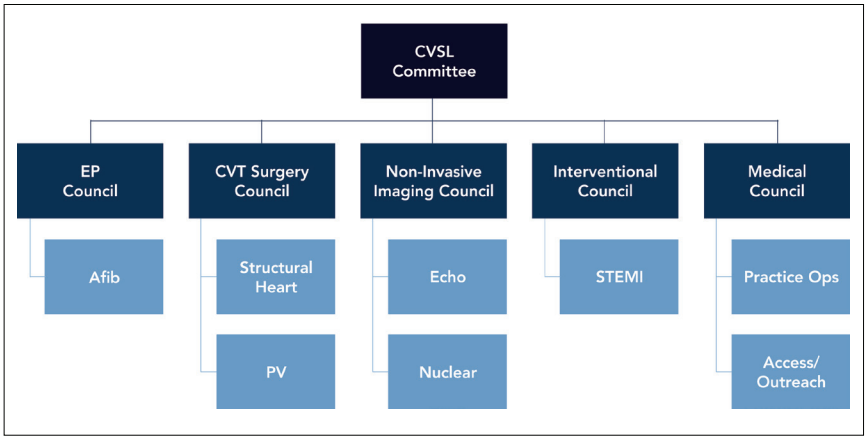

Figure 2. Organizational chart showing the phase 1 cardiovascular service line (CVSL) model with a subspecialty focus. Afib, atrial fibrillation; CVT, cardiothoracic; echo, echocardiography; EP, electrophysiology; PV, peripheral vascular; STEMI, ST-segment elevation myocardial infarction.

Around 2008, cardiovascular physicians began transitioning from independent private groups to hospital- or health system–integrated practices. In the majority of cases, this integration occurred through an employment model. This migration was so significant that today, nearly 80% of cardiovascular physicians are integrated with a hospital or health system. Now, with the majority of cardiovascular physicians within the same legal entity of hospitals, the cardiovascular service line began to emerge and accelerate.

Early iterations of the cardiovascular service line created a structure largely following cardiovascular subspecialty domains (Figure 2). In most cases, each subspecialty committee was composed of physicians specifically trained or deeply interested in the specific clinical content area, with many led by a physician/administrator dyad. Not only were these teams charged with overseeing clinical performance and quality outcomes, but their scope expanded to include operational and financial focus as well. Sitting at the top of this service line structure was some form of executive leadership that included physicians as well as hospital and/or health system administrators who were responsible for creating the cardiovascular vision for the organization, developing the strategy around that vision, and then monitoring full-spectrum performance at each of the subspecialty domains.

Although much more effective than the traditional departmental structures, these early service lines oftentimes did not cover the entire cardiovascular product spectrum. Missing then, and often still today, is the connection to the physician practice and ambulatory services (Figure 3). In integrated models, cardiovascular physicians usually become part of a large, multispecialty physician enterprise. Although owned by the hospital or health system, these physician entities regularly have very distinct governance structures from the hospital(s), with the only connection existing at the very top of the organization through a single executive. This chasm inevitably causes disruptions to patient care where the decisions in one organization have a negative impact on the other. Modern programs have figured out how to bridge this gap and have evolved beyond the subspecialty orientation.

THE 21ST CENTURY SERVICE LINE

High-functioning cardiovascular service lines have not only pulled the oversight and management of the ambulatory setting under the same structure as the hospital, but also have begun to migrate more toward disease management (Figure 4). Although it may appear a rather subtle distinction from the first-generation cardiovascular service lines, this new orientation actually provides a monumental shift in scope and strategy, creating a foundation for population health and true patient centricity.

The new generation of service lines is bringing a much more holistic approach to the delivery of care, considering all aspects of the patient beyond the acute symptoms that brought them into the system. For instance, socioeconomic factors and psychosocial impacts are considered. The result is pulling in and linking with additional professional resources to help manage the entire patient. Examples include behavioral health, case managers, and nurse navigators.

Additionally, the next-generation service line is connecting with other specialties to coordinate patient care

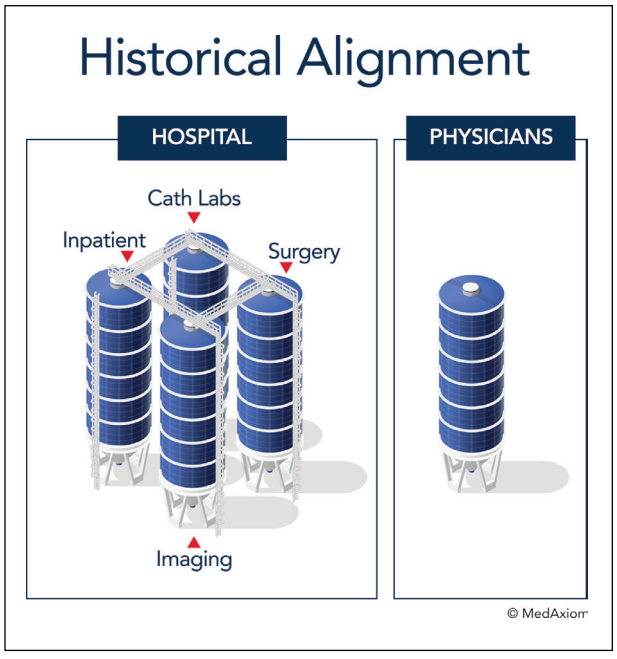

Figure 3. Historical siloed alignment separating physician and hospital services.

across the entire spectrum of need. The advent of cardio-oncology and women's health programs are the result of this cross-pollination and demonstrate the wisdom of organizing around the service line model.

This is a critical point. Note that we are demonstrating the evolution of the service line, starting more simply and then moving to greater sophistication. It would be difficult for an organization to move directly from a departmental or traditional governance structure to one oriented around disease management; the leap would simply be too great. It is necessary to first organize at the specialty level and develop a solid footing within the cardiovascular care spectrum, and then move out to the broader patient needs. To skip this step risks piling chaos atop disorder, and the results are quite predictable. As part of this foundation building, the creation of a solid clinical strategy is paramount in today's value-oriented health care world.

DEVELOPING THE CLINICAL STRATEGY

Cardiovascular care delivery is complex and has only become more complex as the offering of specialized procedures has grown, population health has emerged, and quality/cost have taken a priority over volume. Cardiology care includes chronic disease management and episodic care that encompasses procedure performance and management (Figure 5). In addition, cardiovascular care has a significant ambulatory presence as well. It is fair to say that cardiology is one of the only specialty areas in medicine that has to have systems in place for nearly all care settings.

High-performing cardiovascular programs start with a defined clinical strategy. This strategy can best be summed up as a set of specific criteria around identifying the patients who need treatment, what should be done for this population, how care should be delivered, where it should be done (and perhaps more difficult, where it should not be done), and who should perform the care. All of this is designed to deliver care in the most reliable fashion and at the highest value.

For instance, atrial fibrillation (AF) has multiple objectives that need to be met, including rate control, rhythm management, stroke prevention, and risk factor management. Evidence-based guidelines outline what should be done, yet studies suggest that up to one-third of patients are not treated according to these guidelines.[1] Developing the clinical strategy for AF management that includes definitions, objectives of care, and a delivery model will allow for a more consistent method to caring for this population and increase adherence,[2] which then results in more consistent outcomes (ie, value). The more programs define clinical structure to ensure evidence-based guideline adherence and create consensus-based standards when evidence does not exist, the better the outcomes for its patient populations. This is true whether it is for heart failure management, structural heart procedure delivery, or secondary coronary artery disease prevention.

The cardiovascular service line is structured extremely well to effectively perform this work. As previously outlined, rather than thinking of the service line as a series of departments that provide individual functions, it is the systematic leadership and governance structure that oversees specific disease management programs, determining which services are delivered where and by whom.

WHERE TO BEGIN

Using the previously described AF example, the first step in developing an AF service line is establishing a clinical committee with the appropriate stakeholders to provide program leadership and oversight. This committee may sit under an electrophysiology or clinical cardiology leadership committee or could report directly to an executive body. The AF committee should involve representatives from areas where this type of care is delivered and should include at least one cardiologist, electrophysiologist, and other care team members such as an advanced practice provider, emergency department physician, hospitalist, and possibly a primary care physician. In addition, nonphysician members should include an administrator and quality stakeholder. Bringing together this comprehensive group to develop effective care strategies and define objectives of care will provide an effective framework for operational leaders and team members to build the most effective program.

As the program is built out, committees like those previously described will provide oversight and performance management. In addition, as new challenges or opportunities emerge, the committee will provide the venue for further development or changes required. For example, if a program has noted excessive hospital admissions from the emergency department, such a committee would review current processes and care delivery, which may show need for an AF protocol for effective emergency department management and patient triage that allows for safe discharge and early follow-up. The key stakeholders are already in place with a common vision to develop the protocol and implement it.

CARDIOVASCULAR SERVICE LINE PERFORMANCE MANAGEMENT

Performance management requires the knowledge of program effectiveness and outcomes along with the right combination of leadership and governance to provide oversight and action when performance is subpar. A good cardiovascular service line performance strategy requires data—not so much data that all meaning is lost, but also not too little data where critical insights might be missed. The key is creating the right amount of information and presenting it in a way that is actionable.

Clinical, financial, and operational metrics are all required to have a full view of program performance. The development of a dashboard should include all three areas presented in a way that highlights successes and opportunities very quickly and without a lot of effort. The metrics should be trended month after month to demonstrate areas of concern or underperformance.

The power of performance management shared with the entire team that provides the care should never be underestimated. Most clinical providers truly want the best for their patients and are quite competitive, whether against themselves or compared to others. Leveraging this healthy competitive environment can be very effective. In addition, sharing data creates a culture of transparency that builds trust. A good service line dashboard will become the venue for performance oversight, performance improvement, and building trust.

CONCLUSION

Service line orientation is not a new concept, but it also is not a static state of being. High-functioning programs have built upon the solid foundation of the programmatic orientation within the first-generation service lines and are evolving to a more holistic disease management focus. This broader patient focus pulls in experts from other organized service lines to deliver care in a consistent and coordinated fashion—something that has been sorely missing in the United States health care system.

A critical aspect of this delivery model is a solid clinical strategy in which organizations intentionally and carefully design the services they provide. This clinical strategy establishes the expected outcomes (performance) for its care and then creates the standards around which care will be delivered. Clinical strategy identifies what care is appropriate, where it should be provided, and by whom. It further defines the expected pathways the care teams should follow to provide care in a consistent fashion with the expectation of dependable outcomes around quality, service, and cost.

High-performing service lines have created performance management tools that provide regular and meaningful feedback to its leadership on the fulfillment of its clinical strategies. Tools include balanced scorecards and dashboards where complex data are synthesized into meaningful analytics for quick interpretation of deviations from the standards. With an organized governance structure in place, corrective action is swift and effective.

The new generation of service lines is poised to deliver on the promise of value-oriented population health. Certainly, no structure can guarantee success, and

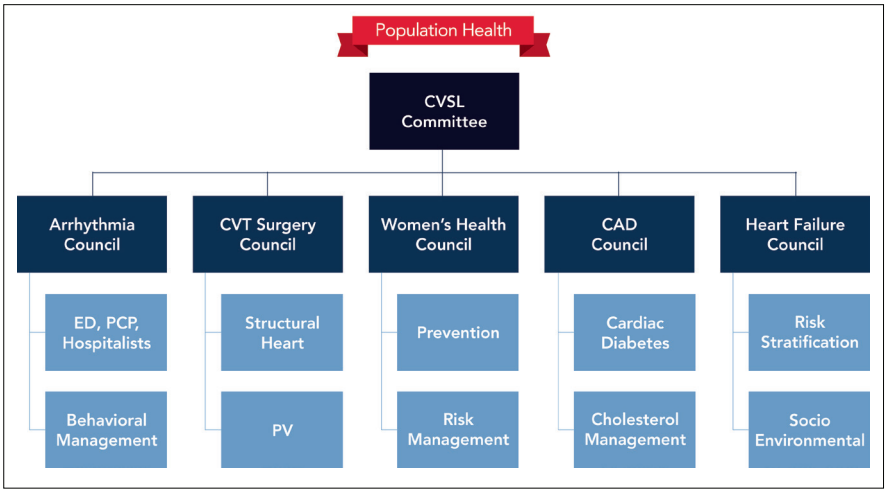

Figure 4. Organizational chart showing the phase 2 cardiovascular service line (CVSL) model with a disease management focus. CAD, coronary artery disease; CVT, cardiothoracic; ED, emergency department; PCP, primary care physician; PV, peripheral vascular.

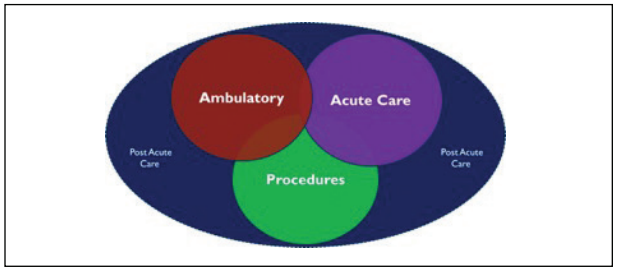

Figure 5. The broad and expansive scope of cardiovascular services.

health care is complex in its scope, with myriad pressures from within and without the traditional industry. However, regardless of the business, an effective leadership and governance structure provides a framework on which to create and implement an organizational vision. Cardiovascular services are no exception, and given the pace of change in our industry, getting the service line right improves the chances for success. ■

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2. Hendriks, J, de Wit R, Crijins H, et al. Nurse-led care vs usual care for patients with atrial fibrillation: results of a randomized trial of integrated chronic care vs routine clinical care in ambulatory patients with atrial fibrillation. European Heart J. 2012;33:2692-2699.

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