Changing Paradigm of Cardiovascular Care- Service Line vs Departmental

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Large Academic Multispecialty Departments of Medicine and Surgery

- Based on 19th Century German model
- Historical distinction of cognitive vs surgical approach to patient
- Promotes financial partnership between disparate specialties with no day to day interaction around patient care
- Creates competition between clinical partners around the same patient or same patient disease
- Potential for promoting conflict of interest in interpretation of best practices between competing /overlapping interdepartmental care givers--
- Promotes competition of expensive hospital resources around emerging technologies ie hybrid OR
- Not ideal for optimizing quality and efficiency around patient care across the continuum of in-patient to out- patient transitions
- Not ideal for population management of specific disease
- Fractured/Siloed/misalignment of Network development—whats profitable for the health system is not necessarily profitable for individual departments
- Decreased transparency around hospital financial support (IET) for purposes of promoting multidisciplinary patient centered programs
Transformational Idea: Diseased Focused Centers Provide Superior Care than Multispecialty Departments (Porter and Olmsted: Redefining Health Care)

- Each center will be patient-centric and results-driven recognizing the importance of multidisciplinary approach to diagnosis, treatment and disease management.

- These Centers will distinguish itself from other regional and national systems by implementing personalized, evidence-based medical therapies and developing cutting-edge new technologies.

- Critical to the success of the Center are financial and accounting platforms that will ensure aligned transparent incentives within the Center and between the Center and other components of the Health System.

- Each Center will require leadership with sufficient authority and autonomy to drive the Center toward common goals, supported by the resources necessary to achieve those goals and to allow accountability for outcomes and financial performance.
Diseased Focused Center (CV)

- The Diseased Focused Center will provide a multidisciplinary approach to patient disease with the goal of creating the ideal patient experience through an integrated practice unit (IPU).

- This IPU or interdisciplinary care team will be patient centric and will comprise all elements that care for a patient including: medical specialist; surgeons, critical care intensivists and anesthesiologists, nursing, social services, and administrative support services.

- Ideally one shared transparent bottom line between hospital and physician practices
Penn Disease Focus Center:

- Develop a team approach dedicated to patient care
- Share common inpatient and outpatient space
- Share and cross-train staff in the inpatient and outpatient settings
- Allow patients to be followed longitudinally for life
- Develop a common outcomes infrastructure
- Facilitate clinical and translational research across divisional and departmental boundaries
- Optimize and facilitate communication with referring physicians
- Organize a regional Penn Patient Care Network around that particular disease
- Develop unified leadership with authority, accountability and resourcing.
- Focus marketing around this patient centered approach, when combined with superior outcomes and unique services, will position the Center as a national leader.
Diseased Focused Centers

- Optimal for current goal of Patient Centered Care
- Aligns hospital resources and promotes multidisciplinary clinical partnership approach to a specific patient disease
- Creates financial partners of doctors providing the critical care to the patient; removing potential financial conflicts
- Easily Aligns joint incentive programs around patient focused areas of quality improvement and growth
- Eliminates competition for expensive hospital resources
- Penn Centers would unify care across all hospital entities
- Best way to model new bundle reimbursement models
- Best method to managed disease populations across the continuum of care
Information Technology

- Informational technology will be the foundation of the center for collecting, compiling, and utilizing information on patients, activities, methods, costs and results for each patient across the cycle of care and across time.

- This will become ever more essential as care moves from discrete interventions to care cycles and from traditional structures to integrated teams.
Centered Based Life Time Care

- The delivery of best practices of disease management for life of patient

- Collection of demographic, clinical and imaging results serially throughout the patient’s life. Such an approach is essential for clinical research that will tie the phenotype of the natural history of the disease to a specific intervention and to the genomics of a given patient.

- Data for maximization of results based reimbursement

- Maintenance of relationships with patients and families to enhance development

- Communication with referring physicians in the community
Center Leadership

- Center leadership will be responsible for the entire care cycle incorporating referring physicians, rehabilitation and disease management.
- Leadership will also have the authority and be held accountable for financial performance, effective supply chain management, quality of care, patient satisfaction, and hospital throughput.
The Penn Disease Focus Center requires a financial structure that is unique to the Center, yet still within the purview of CPUP, the hospital and the health system.

The Center will be incentivized by volume, efficiency and quality metrics—joint incentive shared by cardiologists; cardiac and vascular surgeons

- QA targets will be established to maximize quality of care, patient satisfaction, and reimbursement. Examples include: supply chain initiatives, compliance with MS-DRG documentation requirements, decreased length of stay, decreased infections, decreased readmissions and increased patient satisfaction.
10. Creating a clinically-integrated care model that coordinates care, creates accountability and empowers leaders across multiple hospitals and non-acute settings even when there is not a direct reporting structure to the service line leader.
9. Partnering with a physician leaders to effectively manage strategic planning and the delivery of high-quality, low-cost patient care and ensure a positive “system” patient experience, in acute and non-acute settings.
8. Aligning independent and employed physician incentives across the system.
Current Priorities in CV Care

7. *Optimizing care across multiple hospitals.* Remember to factor in:
   - Unique cultures
   - Different degrees and models of physician alignment
   - Practice of care variances
   - Opposing data platforms
   - Competing and duplication of services.
Current Priorities in CV Care

6. Securing a data platform (the one source of trusted information) to provide meaningful clinical, operational and financial comparisons as well as identify leading practices and variances. A platform that serves:

- Each system hospital
- Across all physicians
- With external comparison groups.
5. *Decreasing cost-per-case by effectively managing supply price and “utilization.”* This means:

- Participating in a value analysis process that includes physicians and makes decisions based on evidence
- Contracting at the system level
- Integrating clinical and supply analytics to gain the critical insights required to identify new opportunities
- Gaining physician buy-in
- Implementing appropriateness criteria.
4. Managing resources effectively with acute case volumes that are decreasing due to shifts to outpatient settings and transitioning to an environment where the question is asked, “Should the procedure or surgery be performed at all?”
3. Growing a health system through an aggregation strategy that is forcing decisions about the duplication of services and what services will be provided at what location.
Current Priorities in CV Care

2. Extending the service line across the entire continuum of care: acute and non-acute.
Current Priorities in CV Care

1. Balancing the challenges of delivering high quality, low-cost care today while implementing strategies that minimize the financial risks of tomorrow.
Advancing Penn Medicine Heart and Vascular Care Through the Service Line Approach
Timeline of UPHS HV Service Line Formation

Pre - 2006
• Service lines primarily for marketing activity

2006 - 2008
• Formation of Perelman Center for Advanced Medicine
• Organized outpatient care around the patient by service line

2011 - 2012
• Formation of the HUP CV Contribution Margin Incentive Funding Program
• Hired dedicated Chief Administrative Officer for Heart Vascular
• Fully implemented service line governance model for heart vascular

2013 – 2014
• UPHS Service Line Governance Model created and approved
• Named formal Physician Service Line Director for heart vascular services across the system
• Partnered with CEQI for dedicated Director of Quality and Safety for the service line
• Launched Disease Teams (Heart Failure was first)
• Began CMS Bundle Payment Pilot project for Heart Failure and CABG and one hospital

2015
• Began work to centralize the clinical databases and registries across the system under the service line
• Expanded HUP CV contribution margin incentive to a system-wide service line incentive
• Beginning discussions to organize nursing model by service line
Heart And Vascular Vision

1. The Penn Medicine Heart & Vascular Center will be a preeminent international center of cardiac and vascular patient care integrated with the Departments and CVI in the overall academic mission of research and education.

2. To improve quality, grow services that treat more people, drive cost efficiency, improve margin and be research, technology, and innovation leaders in the presence of intense local, regional and national competition.
Partnership with CVI Around Common Academic Mission

CV Center

CVI

CV clinical care

Clinical research

CV research
Aligning Clinical and Business Functions….

Around the Heart Vascular Patient

Quality of the Clinical Professionals and Work
Provider Behaviors
Provider Production
Clinical Innovation
Compliance
Patient Care Standards
Clinical Pathway / Model Management
Referring Physician Relations
Provider “Leverage”

Operations
Revenue Management
Operating Expense Management
Capital Planning and Application
Staffing Models
Performance Reporting
Supply Chain
Support Systems and Services

MISSION
VISION
VALUES
CULTURE
OVERALL PERFORMANCE
INTERNAL ORGANIZATION STRATEGY
Service Line Objectives

- Adapt to a climate of decreasing reimbursement and increasing competitiveness
- Grow clinical programs and improve integration with existing physician practice sites
- Partner with owned hospitals, employed physicians, and independent physicians at affiliated and owned hospitals to grow the Penn Medicine HVC
- Improve quality and maximize efficiency and profitability
- Engender engagement and alignment using professional and financial common incentives for physicians and advanced practitioners
- Recruit, train and retain outstanding nursing, technical and support staff for providing and managing advanced specialty services.
- Develop a long-term Database on all CV patients for Life to better align with CVI and the Academic Mission of being able to follow phenotype of all CV patients for life.

Adapted from CCA White Paper, “Developing and Managing a Successful CV Service Line.”
HVC Strategy

- Explore innovative ways to partner with owned, affiliated and independent hospital and physician entities to achieve programmatic HVC growth

- Employ and/or partner with existing cardiologists to increase Penn HVC market share

- Ensure access and care coordination for an exceptional patient care experience

- Build physician-led disease centers of excellence that provide quality and value to patients and insurers

- Provide value-based service to Penn affiliated hospital and physician entities

- Build downstream referrals to all Penn Medicine entities
Service Line Governance Model

**HVSL Executive Committee**

- Purpose: Establishes “Guiding Principles” and oversight for Service Line and working committees
- Chaired by Physician Leader: Michael A. Acker, MD
- Chief Administrative Officer: LuAnn Brady, MSPH

**Network and Market Strategy Committee**

- Purpose: Ensures system-wide alignment and input for strategic growth and marketing plans
- Chaired by Physician Leader: Harvey Waxman, MD
- Director of Affiliate Network: Meriem Aberra, MBA
- Focus has been: Aligning Penn Cardiology practice growth and referral development to sub-specialty services

**Quality Oversight Committee**

- Purpose: Ownership and management of quality initiatives across the service line (IP, OP, transitions) in coordination with operations and the entities
- Quality and Safety initiatives led by Joanne Fante-Gallagher in conjunction with Disease Team physician leaders
- Have not created a single quality oversight committee as yet

**Operations and Program Committee**

- Purpose: Ownership and management of operations issues and opportunities across service line (IP, OP, Satellites)
- HUP examples for IP and OP transitions
- Formed a system-wide Cardiology Practice Operations Committee to share best practices and optimize access across the cardiology network

Integrated within each disease team
Penn Medicine CAD Disease Team

- **Established September 2014**

- **Multi-Disciplinary Representation:**
  - Physician leadership: Cardiology and CT Surgery
  - Performance Improvement Specialists
  - Clinical Nursing
  - Heart and Vascular Service Line Support
  - Marketing Support

- **Representation:**
  - HUP, PPMC, PAH, CCH
**An example: Heart Failure**

- **At risk**
- **Asymptomatic Early Disease**
- **Advancing Disease**
- **Advanced Disease**
- **Advanced Treatment**

### Increasing severity of disease
- **Primary care**
- **Pathology**
- **Vascular**
- **Anesthesiology**
- **Gastroenterology (GI)**
- **Consultative cardiology**
- **Radiology**
- **Heart Failure cardiology**
- **Interventional/Arrhythmia cardiology**
- **CT Surgeons**

### Increasing complexity of treatment
- **Exercise**
- **Diet**
- **Drugs**
- • Diagnostic testing
- • Pacemakers
- • Right heart cath
- • CRT
- • Ablation
- • ICD
- • Anti-coag
- • VAD
- • Transplant
- • Palliative Care
How do we get there?

Success on delivering a Penn Medicine way of care for the Heart and Vascular patients will be through developing a **structure** that supports the expertise to define the care, an **execution** arm for process improvement and a reliable way of **tracking meaningful outcomes** that will drive value and growth.

**Penn Medicine Heart & Vascular Continuity in Care Delivery**

**Strategy / Structure**
- UPHS Blue Print for Quality & Safety
- SL Governance Model
- HVSL Disease Teams

**Execution / Process**
- Alignment of the UBCL / PBCL and entity quality service line committees
- Incorporate innovation and ongoing PI work
- Bundles/Accountable Care

**Measure / Outcome**
- Clinical registries & databases
- National benchmarks - UHC, US News & World Report
- Market Share
- Cost of Care
How do we ensure sustainability?

System wide sustainability for the disease specific work requires coordination and alignment across the continuum and amongst the entities.
## Imperative to Achieve the Vision:

<table>
<thead>
<tr>
<th><strong>Barrier</strong></th>
<th><strong>Future</strong></th>
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<tbody>
<tr>
<td>Entities each seek a solution that is optimal for that unit;</td>
<td>All components of the HVC working to achieve a common set of goals with shared incentives</td>
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<tr>
<td>Individual divisional/departmental, group &amp; entity budgets</td>
<td>Common HVC budgeting principles across all entities</td>
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<tr>
<td>Perceived quality differentials</td>
<td>Same clear &amp; consistent quality metrics and performance standards are achieved</td>
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<tr>
<td>Fragmented referral network</td>
<td>Integrated network through improved partnership among all Penn employed physicians, Penn entities, affiliated hospitals and independent physician practices</td>
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<tr>
<td>Entity management inefficiencies</td>
<td>Comprehensive effective &amp; efficient HVC mgmt process</td>
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What success will look like

❖ For the Health System:
  • A model of integrated Surgery and Medicine through disease-based programs

❖ For Clinicians
  • Decisions are collaborative and information-based with a focus is on long-term results and Penn Medicine results
    – Quantitative data on CV market – what comes down to Penn and what does not
    – Incentives are aligned throughout the Entities, Departments, Divisions and practices associated with the Center
    – Decisions based on All in budgeting and P and L— downstream and practice
  • All CV physicians are integrated with common identity around the patient with the common disease; driving improvement, quality and efficiency initiatives and successfully launching new services
  • Program development decisions are determined on the basis of quality

❖ For Patients
  • In addition to its world-class clinical care, Penn Medicine HVC addresses every aspect of my encounter, including physical, educational, emotional and spiritual needs.
It is About the Patient!!

If you do not change direction, you may end up where you are heading

- Lao Tzu

Coming together is a beginning; keeping together is progress; working together is success

- Henry Ford

We’re all working together; that’s the secret

- Sam Walton