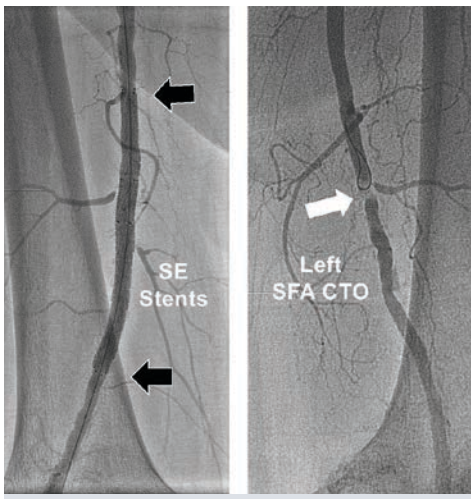
Cath Lab Digest

A product, news & clinical update for the cardiac catheterization laboratory specialist



PERIPHERAL INTERVENTION

Radial to Peripheral in Women With Small Radial Arteries: 5 French Access for Endovascular Therapy in Femoral, Iliac, Renal, Subclavian and Carotid Artery Disease

Robert L. Minor, Jr, MD

Transradial access (TRA) with same-day discharge for coronary interventions can save over $3000 per case, as compared to femoral access with overnight hospital stay. In addition, it improves safety, reduces patient discomfort, and is strongly preferred by patients and nursing staff. TRA for endovascular interventions also allows same-day discharge and may provide similar benefits.[1]

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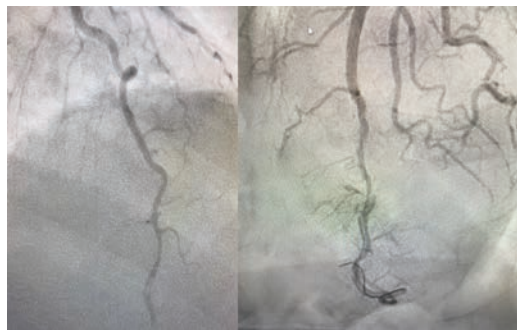
In This Issue

CARDIOLOGY CARE

Coronary Artery Disease in Women: A Review

Julie Billingsley, Richard J. Merschen, EdS, RT(R)(CV), RCIS



Cardiovascular disease (CVD) is the leading cause of death in women and men in the United States. Coronary artery disease (CAD), heart failure, and stroke cause around 500,000 deaths in U.S. women every year, with the most deaths caused by CAD.[1] While CAD is the leading cause of death in both sexes, the etiology, recognition, management, and outcomes of CAD differ between men and women. Many of the common risk factors associated with CAD also have different clinical presentations and chronology in women. Additionally, women may have pregnancy-, ovarian-, and estrogen-related complications that increase their risk for developing CAD.[2]

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OUT-OF-HOSPITAL CARE

How One Healthcare System Creates and Partners Around Cardiovascular Ambulatory Surgical Centers

CLD talks with Kristi McShay, Associate Vice President, Cardiovascular Service Line, Banner Health.

Can you tell us about your role and how you are involved with cardiovascular ambulatory surgical centers (ASCs)?

I am the associate vice president for cardiovascular services at Banner Health, and in our organization, it is a corporate-level position. I report up through the vp of service lines to our chief strategy officer. Banner Health's service line executives are very firmly housed within the strategy side of the organization versus operations, meaning I am not "in the weeds" as an operational person.

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How One Healthcare System Creates and Partners Around Cardiovascular Ambulatory Surgical Centers

CLD talks with Kristi McShay, Associate Vice President, Cardiovascular Service Line, Banner Health.

We are focused on developing and championing innovation and strategies that support growth and improved performance within the service line. Growth means increasing market share and expanding into new markets. Performance improvement encompasses our focus on enhanced quality, value-based care, and efficiency. I have been more involved in the ASC world with the idea that ASCs can be both an innovation and value-based care tool. It is a way for us to enter new markets and align with desirable cardiologists, both employed and independent.

How did ASCs become an important part of your work?

About five years ago, Banner developed a partnership with Atlas Healthcare Partners, which has had a lot of in-depth experience in the ASC space across all service lines. We originally did not contemplate the cardiovascular (CV) service line — at least not the cardiac part of it — as being a participant in this space. Over time, we saw a proliferation of ASCs in our market. Arizona is not a certificate of need state, and these ASCs were exclusively developed, built, and operated by independent cardiology groups.

Banner has a significant footprint in the health plan payer space, and our payers continually ask us to demonstrate value and efficiency in how we provide care. We were seeing these independent labs spring up and had the chance to learn more about the business model in terms of revenue and cost efficiency margin. We could see it as a way for us to take a bigger leap into that space. Also, at the same time, we were all going through the pandemic, and the related issues it brought around capacity and throughput. When we chose to enter the ASC space, we knew that there would be an out-migration of cases from our acute care facilities, but we tried to look at the larger picture. We thought ASCs improved patient care, improved patient access, and even could create capacity in our hospitals for other services. In those ways, working with ASCs has helped us grow. We did a lot of analysis with Atlas and decided to take that leap.

It sounds like Banner viewed ASCs as a possibility, rather than something negative.

Exactly, I think that is important to say. We thought that if ASCs provide quality care, if patients like the experience they get, if it is easier to schedule, easier to park, easier to navigate, and if payers like them because ASCs are more cost-effective, it is absolutely where we want to be as a healthcare system. We wanted to align it with our overall strategy direction for the service line.

What have ASCs focused on prior to cardiovascular procedures?

In the vascular world, ASCs are more of a community standard and have been in place for a long time. Certainly, in orthopedics and specialties like interventional radiology, ASCs are the community standard. ENT and ophthalmology have a long-standing track record of procedural work done in the ASC setting. Nationally, it is very new in cardiac care. It might be that the Phoenix market is a little ahead of the rest of the country in that respect, because I would say our area has a couple examples of well-established cardiovascular ASCs that have been in business for 10 years.

The Centers for Medicare & Medicaid Services (CMS) allowing percutaneous transluminal coronary angioplasty (PTCA) in an ASC is a more recent development — although for commercial payers, the procedure is fairly common in this setting in our market and has been for many years. Again, I believe the most critical thing is to work closely with center physicians to develop patient access and other standardized clinical protocols that support safety and high quality.

Banner has felt comfortable working with interventional cardiologists doing these kinds of procedures in an ASC. Can you talk about how you took those steps forward?

We did approach this with a lot of appropriate caution, in terms of making sure that we worked very closely with our internal and external physician partners around developing access standards and patient selection standards. We understood what we were prepared to support versus not support in this setting, which included both the initial ramp-up period when things are new and the entity is maturing, and a staging of those procedures. Our caution, research, and collaboration with our key physician partners around safety and protocols has been a key factor in the success of our ASC.

Has this been a situation where you are working with already established partners, or is this a way that you have reached out to more physicians?

Both. We have taken a level playing field approach and said, "We want partners who are aligned with us around values of improved access, improved care, and improved efficiency." We have found partners in the independent community and also within our employed physician group. We have really wonderful cardiology practice partners who have been aligned with our organization for many years, and employed physicians, so our employed community cardiologists are able to invest as well.

Can you talk more about the financial aspect?

Our model is a joint venture model and our ASC entity is a 51% Banner/Atlas fund. It is a partnership and 49% is owned by physician investors. That Banner share allows us to bring a lot of resources and support as an organization to the ASC. Then, the physician piece does the same in terms of incentivizing physicians to support the center, so it truly is a partnership. A joint governance board model manages the center, its direction, and operations. We have one ASC that has been open about 24 months and two more recently operational cardiovascular ASCs. Two additional ASCs are now in the development stage. It is still a newer initiative for us, so I want to point out that I am speaking about our ASCs that are open and now mature.

The model has proven very successful from a patient care perspective, operationally and financially. I think a lot of that, if not almost all of it, has to do with the things that health systems always talk about when we want to align with physicians. We want to be on the same page around developing patient care pathways and protocols. We want to be on the same page when thinking about where we should deploy our resources in terms of services for interventional cardiology, electrophysiology, vascular care, etc. We also want to be aligned financially so that we are efficient in terms of staffing and operational support — everything from supplies, the cost of those supplies, how we develop our usage protocols, to the building itself and the equipment that we buy. From that overall perspective, our ASC has been a huge success.

Can you talk more about the relationships the ASC partnership has with payers?

In our market, because overall there are many of these facilities, meaning cardiovascular ASCs specifically, there might be more of a standard operating procedure in place to contract with payers than in a market where there aren't any cardiovascular ASCs yet or an entity might be the first. Our ASCs are all accredited and appropriately licensed, and we have contracted rates and a contracted pricing schematic we follow that have served us very well.

How does Banner evaluate for location and the range of procedures offered in an ASC?

One of the advantages of these facilities is that we can be more nimble in our choice around where we place them. It is obviously a much smaller investment than building a brand new acute care hospital, which healthcare systems are very cautious about. Because

The big gap is that there is no, as of yet, specific registry to support the collection of data to monitor quality. There are groups such as MedAxiom discussing the creation of a registry, and Atlas and Banner are partnering in that endeavor.

ASCs are a joint venture, our partner participates in their share of the financing and the ramp-up costs. That flexibility allows us to put an ASC in areas and regions where we see demand and an opportunity to grow and improve patient access. We want to be careful that the ASC is within an appropriate distance to an acute care facility should a patient need to be transferred. We have a rigorous clinical protocol developed by our physicians to manage patient transfers, should that be necessary. That has worked very well for our physicians and patients, which I think is a testament to our selection criteria and the rigor around its development and our adherence to it. When we look for a new location, we are looking at areas where although close to a hospital, a location can still provide an entry into a new region and allow us to continue to grow.

Can you tell us more about how you work with physicians?

We have a robust physician leadership team within our physician division, and on our partner side, Atlas participated in developing standards for us. We rely heavily on our physician partners because they are the ones who are actually scheduling and bringing cases to the facility, and they have to buy in as well. We have been fortunate to partner with a high-quality group that believes in our standards, developing them, and supporting them. We evaluate data that you would expect, such as comorbidities and frailty, patient age and history, and the appropriateness of the procedure in terms of the capability of the center. It has been gratifying and successful thus far.

It is important to make sure that we develop good communication and collaboration with our physician partners, because we both approach the center from different perspectives. We need to be on the same page around operational initiatives, staffing, physician scheduling, and around adding new partners. All those things require consensus, which requires a lot of discussion and spending time together to make sure that we are aligned. The procedural flow has gone smoothly, which is a tribute to our leadership team and our physician partners.

The big gap in this whole industry, if you want to think of it as an industry, is that there is no, as of yet, specific registry to support the collection of data to monitor quality. There are groups such as MedAxiom discussing the creation of a registry, and Atlas and Banner are partnering in that endeavor to develop something more formal. I think it is important to support a registry, because as ASCs proliferate, and I believe they will nationally, we should be accountable for outcomes and quality in these centers versus in a hospital setting.

It is interesting that you bring up the idea of adding new partners. As ASCs grow, physicians who maybe weren't part of the initial build out might want to join the ASC.

Yes, exactly. You need a mechanism to support that, that everybody buys into, because at the end of the day, you are all working together in a fairly small space, and you need that partnership and collaboration for everyone to be successful.

What have been some of the challenges that you have seen?

A lot of challenge is in the development stage. ASCs take a long time from conception through build out, including equipping, staffing, and accreditation. That cycle can be 18 months or more. I think that there are some of the same operational challenges that we all face in our hospital settings — finding appropriate staff and not cannibalizing our existing hospital staff, because we would not want to do that. ASCs are attractive in the sense that the hours are typically Monday through Friday business hours versus the hospital setting where there is call, but it is hard in our market to find clinical staff in general, and that includes ASCs.

There has been discussion about the peril rural hospitals are facing. Do you see an ASC as something that might help?

We have thought that, and we do not yet have an ASC in a rural area. We have a few rural areas that are under consideration, both as a way to bring physician talent to a rural area, but also as a lower-cost way to add services. Since it looks like the CMS horizon will continue to expand the procedures that can be done in an ASC, it does seem to make sense in a rural area. It is much more cost-effective, for example, to put a new cath or electrophysiology lab in an ASC setting than to have to build it out in a hospital, especially if it is an older facility. Interestingly, however, the challenge I mentioned earlier around staffing is actually even more of a challenge in a rural area, for all the reasons you might imagine. We are working through that aspect right now.

Can you tell us more about Banner's ambulatory division?

Banner has an ambulatory division and within our organization, the ASCs fall under that division. Banner Atlas, our partnership, is accountable through that division. Our non-physician, non-hospital outpatient services also fall into that ambulatory division, including our diagnostic imaging centers and urgent care centers. Incorporating ASCs might be a challenge for some systems and it has come up with other systems I have spoken to. I think because of our Atlas partnership and the expertise that they had from the very beginning of our evaluation, we were able to see it as a separate care delivery system, rather than a subset of acute care for the hospital outpatient department. It is an important point, because the expertise needed to manage the ramp up, everything from the size of the rooms to the staffing model to the pre and post patient care pathways, is unique and specific to an ASC environment, as is the revenue and expense profile. I would say it is crucial to understand that the ASC is a completely separate entity with a very distinct business model that is not a subset of the hospital outpatient department.

Do you have any other recommendations if a hospital system is looking to move ahead and partner with a group specializing in ASCs?

The first thing I would say is that for us, Atlas brought expertise that I did not appreciate until I had worked with them for a long time, but I am not here to endorse Atlas specifically. Even from an agnostic perspective, sourcing that expertise is critical because the ASC is a very unique environment with a very different set of parameters for success. Probably the second thing, coming from conversations I've had with some of my colleagues in other markets, is that you need to understand the ideal physician profile for your partner. Be ready to make a commitment to those physicians, because unlike the hospital setting we are used to in cardiology, in the ASC setting you are partners in every sense of the word: clinical, operational, and financial. There has to be a high level of clarity and understanding on both sides. If you are offering the ASC as an investment vehicle to employ physicians, you want to make sure you do that in the absolute best, most compliant, above-board way, obviously, but also that the expectations on both sides are crystal clear. One thing that has been an eye-opener for us, both from recruitment efforts that we have internally and in relation to our independent partners, is that the ASC is an incredibly powerful recruitment tool. We didn't really enter the ASC space thinking about recruitment. Our independent partner told us about this aspect, as they go out and recruit nationally and obviously want to attract the very best talent they can. ASC partnerships have proven to be a powerful tool for them, and we have seen the same thing in recruiting community physicians to join Banner. ■

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