The ground is shifting in cardiovascular services. Historically, cardiac surgery has been the economic engine of many hospitals. Six or seven years ago, cardiac services made up 25% to 40% of hospitals’ margins. Then along came drug-eluting stents, and coronary artery bypass graft (CABG) volumes started shrinking. A hospital that counted on heart surgery for 25% of its margin might have seen that fall to 15% to 20%.

The response isn’t just to ask, “How can we get more CABGs?” Instead, hospitals need to retool their business, advises Todd Burchill of the Tiber Group, Chicago-based consultants. Tiber was acquired by Navigant Consulting this spring.

“We want to get people thinking not only about new ways of attracting business but also transitioning from a surgical, CABG-based program to a cardiology-based program,” he says. That will likely mean doing a larger number of smaller-revenue procedures.

Also, as outpatient volumes grow, hospitals are being left with sicker patients. Some could have difficulty generating enough business to care for their cardiovascular inpatients effectively and efficiently. That’s likely to lead to a consolidation of cardiac surgery programs.

Burchill outlined some planning assumptions for hospitals to consider.

**Cardiac volumes are shifting**

Cardiac volumes as a whole will continue to increase, but growth is expected to be in areas such as left-ventricular assist devices (LVADs), automatic implantable cardioverter-defibrillators (AICDs), and congestive heart failure where hospitals haven’t had much of a margin.

“A lot of the volume now is focused around new devices, which are expensive,” Burchill observes. “Reimbursement hasn’t caught up with the cost of the device, let alone the cost of the care that’s needed. A lot of our clients want to be early adopters and are investing in these new technologies and services but without the strong economic base they had in the past.”

**CABG no longer cash cow**

CABG surgery, hospitals’ historic cash cow, is diminishing. In a study with OhioHealth, Tiber found the system’s cardiac surgery volumes fell 24% from 2000 to 2004.

At the same time, indications are increasing for expensive new devices like LVADs, meaning more patients qualify.

“We need to get a better handle on how to integrate these technologies in our pro-
grams in an economically viable way,” he says.

A major challenge is the lack of alignment between hospital and physician incentives. A cardiologist may want to put in a $20,000 AICD without understanding the economic consequences to the hospital.

“These decisions have to be addressed at the senior level to set policies and rules of engagement so you can get on the same page with your physicians,” Burchill says.

CT/MRI may replace some invasive caths

As CT and magnetic resonance imaging progress, they will begin replacing some invasive diagnostic cardiac catheterizations. Diagnostic caths are fairly profitable, but noninvasive scans will not be as well reimbursed. How rapidly this shift occurs will be market-specific. Some physicians will be enthusiastic and others more conservative.

“Organizations really have to think about how they are going to integrate this into their overall cardiovascular programs,” Burchill says.

Eventually, the advanced scans will enable more patients to have their cardiac disease detected early so it can be treated without surgery. A patient who might once have had a $25,000 CABG would instead have a $500 CT or MRI scan with a $5,000 balloon.

Drug-eluting stents will see growth

Drug-eluting stents, which already have had a dramatic impact on surgery, will continue to spur evolutionary change.

“This technology is pretty much where it is going to be, though you probably will see different sizes of stents implanted in smaller arteries and for bifurcated lesions,” expanding the indications, Burchill comments.

Hospitals need to work with their cardiologists on protocols and standards to manage stent utilization. Medicare reimbursement currently is based on 1.5 stents per patient. “If you look at your data and see you are using an average of 2.1 per patient, you will be losing money,” he points out.

Quality measures will steer patients

Talked about for years, quality measurement is starting to see some action. Medicare has pilot projects to reward hospitals for better performance on quality indicators, and where Medicare goes, private payers tend to follow.

“Going forward, you might see special designations for facilities to treat certain types of patients and do certain types of procedures,” says Burchill. “Why not be proactive and lead some of that effort in reporting your outcomes?”

Patients will be more involved in facility selection. As more decisions and financial consequences are pushed down to consumers, patients will be “getting online to compare hospitals the same way they buy a car or new piece of furniture,” Burchill says. “The days when the patient said, ‘I’ll go wherever the doctor tells me to go,’ are starting to erode.”

Stand-alone angioplasty centers will proliferate

Some states now allow primary and even elective angioplasty without on-site surgical backup.

Currently, a lot of hospitals may have cardiac surgery programs so they can do interventional cardiology procedures. With stand-alone angioplasty programs, that will no longer be necessary in some areas.

“We’re going to see a huge proliferation of stand-alone angioplasty, and as a result, we might start to see consolidation of open-heart surgery programs.”

Say you’re in a market with 1 or 2 other hospitals, you’re in a certificate-of-need (CON) state, and you have the only angioplasty program with surgery backup. Consider the impact if your competitors move into stand-alone angioplasty.

“I think this will have a big impact on well-established programs that have a franchise in those services,” Burchill says.

Cardiac surgery programs will consolidate

As drug-eluting stents allow more patients to be treated in the cath lab, smaller
cardiac surgery programs may have trouble sustaining themselves. As a result, a community-based program that performed 150 to 200 CABGs a year might see its volume dwindle to 100 or so.

“We might see some of these programs consolidate because they can’t economically support stepping up to become a more complex surgical program,” he says.

**Will statins reduce acute myocardial infarctions?**

Treatment of acute MIs has been a predictor of cardiac business for a hospital. With many patients taking statins, there may be a long-term impact on cardiovascular disease.

This is yet another factor that could mean less surgery and interventional treatments, with less revenue from those services.

**Shift will affect facility planning**

The shift in cardiac services has huge implications for facility design, Burchill notes. Will your facility need fewer ORs and more interventional rooms? Who will occupy those rooms? Will it be interventional radiologists, who don’t bring patients? Or will it be the cardiologists who are big revenue producers?

“You need to work through these turf battles,” Burchill advises. Can you have one type of universal procedure room rather than doing these procedures in the OR, the cath lab, and the radiology department?

Multiple locations can create a “free-for-all with no standardized credentialing, protocols, or billing,” Burchill notes.

“The economics of cardiac services are changing quickly, and organizations need to be planning for how to make the transition,” he notes.

*More information on the Tiber Group is at www.tiber.com.*