Dear <redacted>,

Just thought I would write and give you a quick update on our situation, not that you asked. As you recall, a few years ago we spent many hours discussing and planning the Heart and Vascular Service Line that you encouraged us to set up in our new hospital. These conversations were filled with the greatest hits of health care administrators. “Institutional silos,” “layers of integration,” and “financial dashboards” were crowd favorites. Personally, I enjoyed the endless timelines, flow charts to nowhere, and of course the countless hours spent crafting a vision statement. It’s a wonder we got any work done! At least one of us was getting paid by the hour.

When I asked you to provide concrete examples of fully integrated, functional Heart and Vascular Service Lines you initially deferred. Finally, you listed three examples. Of course, when I reached out to them, two had disbanded, and the third had no idea what I was talking about. Nevertheless, I pressed on. I tried to figure out how this would all work. What keeps the service line synchronous? My research kept turning up lines like: “alignment across departments and specialists is imperative for addressing the care delivery and business challenges facing cardiovascular providers.” OK sure, but huh?

The purpose of a Heart and Vascular Service Line is purportedly to improve the quality of care of cardiovascular patients. The concept of the service line has been in place for over 20 years, so where is the literature demonstrating the quality benefits? The improved outcomes? As far as I can tell it does not exist. So maybe that was never really the primary goal. Based on the vigor and financial capital hospitals pour into the creation of these lines, there must be a different game afoot. Looking deeper into the health care administration literature it seems the true benefit of a service line is that it keeps patients within the system. Once a patient is brought in by one specialty, the other specialties can converge to offer their services. It soon becomes an assembly line of atherosclerotic delights. The patient enjoys the theoretical advantage of having all of his or her specialists together, and the hospital enjoys the profits.

I would have been comfortable fighting the concept of the service line on the basis of access, practicality, or quality. The truth is, it isn’t about any of these things. If the service line were really about patient convenience, we would have put a vascular lab in the clinic as I requested. But that wouldn’t have been convenient for radiology or cardiology. In your model, which specialty does the work doesn’t matter because the hospital profits regardless. So without a financial map to describe how this all plays out, you just threw us into the same cage Thunderdome-style. Two specialists enter, one specialist leaves. The problem is that CMS is already looking at the volume of diagnostic studies
as a factor in total cost. You helped us build a system that enables and encourages more testing. Cue Tina Turner, “We don’t need another ECHO…”

The turning point in our relationship should have come when you sent me the list of CPT codes for the procedures expected to be performed by vascular surgery. You got a few right. Lower extremity bypass, amputations, and even aneurysms were there. You seemed surprised, though, that we would be doing other leg interventions and thought the carotid endarterectomies would be done by neurosurgery. Here the problem was laid out. You were describing in detail the mechanisms for our new service line, but you didn’t really know what a vascular surgeon was. It’s a little late, but let me help you.

When I sent back the CPT list, even I forgot a few. Like 35251 (repair of intra-abdominal blood vessel), 27364 (radical resection of thigh sarcoma), or 35141 (repair of femoral pseudoaneurysm). You see, vascular surgeons are the great facilitators. Our expertise enables other specialties to perform at their highest levels. Comprehensive programs in orthopedics, neurosurgery, cardiology, cardiac surgery, surgical oncology, trauma, and urology would be essentially impossible without vascular surgery. A study conducted at Northwestern showed that 7% of their total volume of vascular surgeries were cases providing intraoperative assistance to other specialties. And this excluded trauma. While the hospital greatly benefits from this relationship, the vascular surgeons often do not. Emergently helping other physicians requires canceling our responsibilities, both at work and at home. CPT codes often severely undervalue our time spent assisting with large resections or waiting “on standby.”

The overall financial contributions of vascular surgeons to hospital systems are often overlooked. In a study performed at a tertiary care hospital in New Jersey, vascular surgeons were found to have the leading gross margin per FTE of any specialty, 66% more than cardiology. (And these were academic vascular surgeons, a famously lazy breed!) In 2002, Merritt, Hawkins & Associates found that the average vascular surgeon provides over $2 million in revenue to his or her hospital, third highest of any specialty. With the widespread adoption of endovascular procedures, this number is likely to be higher today.

So now, an update on our great experiment. Run by cardiology our service line treats heart disease, heart attacks, heart failure, and high blood pressure. At least according to the website. If you want to find vascular surgery, it is listed last, under “other services.” And no, sadly the list is not alphabetical. Around the country, there is a great shortage of vascular surgeons. There are two to three job openings for every graduate annually. Remarkably, our service line boasts 10 board-certified vascular surgeons. But people always seem to want what they don’t have. In our service line director’s case, that was a TAVR program. So there was great effort and expense in creating one. When it came time to start our FEVAR program, I simply took my friend Andy Schanzer out to dinner and asked him how he did it at UMass. Then we just started doing cases. No fanfare, no press releases. No expensive hires. The dinner cost about $100 (Andy is a cheap date, but I ordered multiple apps).

Today, our service line is disintegrating. There is no animosity. It just didn’t work out. It never really made sense. Yes, our patients have heart disease. They also have lung cancer, diabetes, prostate disease, and spinal stenosis. They would benefit from wound care, smoking cessation, and certainly a comprehensive vascular lab. None of which were offered in our service line. We didn’t belong in the same silo as cardiology, and I certainly never believed they should be in one that treats PVD. I guess it is quaint to expect that a specialty’s scope of practice matches their ACGME and ABMS training requirements. Maybe I’m old-fashioned.

So <redacted>, looking back on our meetings you often took the tone of an adult explaining a difficult, but necessary thing to a child. Maybe the biggest lie we tell children is that adults know what they’re doing. Vascular surgery is an incredibly valuable asset to a health care system: one threatened by physician scarcity and one deserving of promotion and growth. It seems remarkably shortsighted to bury this asset on a service line under the direction of cardiology.

In the end, I have only one request. The next time you are in a meeting with a vascular surgeon who asks for an example of a successful Heart and Vascular Service Line don’t use us. It didn’t work. I don’t think it ever truly works.

References
From the Editor: An open letter to our hospital consultants
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