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FREE SUMMARY REPORT

MARCH 2014

Cardio Services: Keeping Pace With the Pulse of Population Health

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NEW
HealthLeaders Media Intelligence Report

Cardio Services: Keeping Pace With the Pulse of Population Health

This report highlights the strategies healthcare providers are pursuing to grow their cardio services while addressing margin pressures.

- Discover which cardiovascular services are expected to drive the most revenue growth
- Learn how one Mercy Health System hospital cut its readmission rate for chronic heart failure from 31% to 19% through message standardization and telehealth
- Find out how United Hospital cut its readmission rate for chronic heart failure from 21% to 12.9% by identifying at-risk patients and organizing care across the continuum
- Discover how John Ochsner Heart & Vascular Institute saved $250,000 over 18 months by collaborating with physicians on purchasing

PLUS! Get actionable strategies and analysis, segmented peer data, and a meeting guide for your organization.

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About the Premium and Buying Power Editions

This is a summary of the Premium edition of the March 2014 HealthLeaders Media Intelligence Report, ***Cardio Services: Keeping Pace With the Pulse of Population Health.*** In the full report, you'll find a wealth of additional information, including the results of all the survey questions. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Christopher J. White, MD, System Chairman for Cardiovascular Diseases and Medical Director of the John Ochsner Heart & Vascular Institute, Ochsner Medical Institutions, New Orleans, and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Mercy Health System in Conshohocken, Pa.; United Hospital in St. Paul, Minn.; and John Ochsner Heart & Vascular Institute in New Orleans
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Methodology

The *2014 Cardiovascular Service Line Study* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In December 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 257 completed surveys are included in the analysis. Respondents are from organizations that currently operate a cardiovascular service line or plan to within three years. The bases for the individual questions range from 216 to 257 depending on whether the respondent had the knowledge to provide an answer to a given question. The margin of error for a sample size of 257 is +/-6.1% at the 95% confidence interval.

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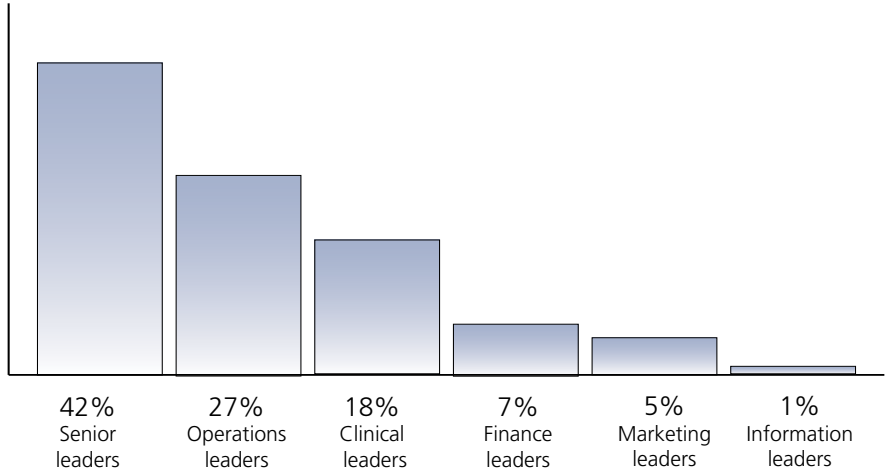
Respondent Profile

Respondents represent titles from across the various functions at at hospitals, health systems, and physician organizations.

Title

Base = 257



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Type of organization

Base = 257

Hospital	53%
Health system	37%
Physician org.	9%

Number of beds

Base = 137 (Hospitals)

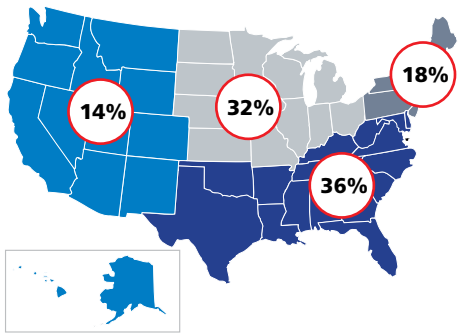
1–199	34%
200–499	47%
500+	20%

Number of sites

Base =96 (Health systems)

1–5	29%
6–20	30%
21+	41%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Margins Strong, But Some Bottom-Line Pressure Possible

MICHAEL ZEIS

Operating margins for cardiovascular specialties remain strong, but many leaders anticipate changes and challenges to their revenue streams that could mean bottom-line pressure. As a result, provider efficiency and cost containment rise in importance as levers to help cardiovascular service executives reach operating margin objectives.

Providers along the care continuum—in the form of outpatient services, clinics, private practices, skilled nursing facilities and home care agencies, and so on—now are allies in enhancing acute care efficiency, as well as important partners in addressing population health management. In fact, the broader care team may hold the keys to sustained profitability, and those in the care continuum represent important elements in delivering on the promise of healthcare reform.

Highly profitable for most, but some signs of margin pressure.

Interventional cardiology provides a financial foundation. As one might expect, the broad category of interventional cardiology remains a top revenue generator for cardiovascular service lines.

More than one-third of healthcare organizations (37%) pick interventional cardiology as their top-ranked moneymaker in terms of net patient

WHAT HEALTHCARE LEADERS ARE SAYING

"Cardiologists who are not aligned with our hospital are the challenge. We have begun to recruit and employ cardiologists."
—CEO at a large hospital

"Cath lab volumes are the challenge. We will increase PCP referrals and offer new procedures and technology such as a valve program."
—Vice president of operations at a medium hospital

"The challenge: maintaining physician compensation levels. We will address this by greater interdependence and risk contracting."
—President of a large health system

"The challenge is the declines in interventional and cardiovascular surgery volumes. We are reducing the amount of capacity in each area and focusing on increasing general cardiology."
—CEO at a physician organization

"The challenge is declining cardiovascular procedures, which we will address by trying to expand our geographic market."
—COO at a medium health system

"Maintaining or increasing access to cardiology services in a population health model is the challenge. We are investigating investing in comanagement opportunities with our providers."
—Service line director at a medium health system

"Appropriate utilization, procedures, and providers are the greatest clinical challenge. There is a lot of competition among specialists. We are starting to use peer review and case studies to improve appropriateness."
—Medical director at a small hospital

Analysis (continued)

revenue. Hospitals (40%) and health systems (37%) pick interventional cardiology as their top revenue generator in nearly equal proportions.

Looking at the other two-thirds—those who earn top revenue from a specialty other than interventional cardiology—we see a sharp distinction between hospitals and health systems. Nearly one-third of hospitals (30%) say that medical cardiology is their top revenue generator, while just 11% of health systems place that in the top spot. Similarly, we see variation when it comes to cardiac surgery, where 34% of health systems earn their highest net patient revenue compared to just 19% among hospitals.

For most organizations (80%), cardiovascular services produce a positive contribution margin. Only 4% report a negative contribution margin. The remaining 16% say their CV service line breaks even. And for more than one-quarter of respondents (28%), the contribution margin is 20% or more, with nearly equal percentages of hospitals (29%) and health systems (28%) experiencing such high contribution margins.

Because health systems generally offer a broader range of services than hospitals (and the cardio services at many health systems include leading-edge, high-priced treatments such as transcatheter aortic valve replacement), one might not expect to see nearly equal percentages of hospitals and health systems with contribution margins at 20% or more.

But Bill Kenney—vice president of the cardiovascular service line for the United Heart and Vascular Clinic located at United Hospital in St. Paul, Minn., which is part of Allina Health, operator of 12 hospitals in Minnesota and western Wisconsin—suggests that acquisitions of cardiology practices by health systems may be adding some low-margin revenue to their mix. "There's been a shift from independent groups to system-owned cardiology practices," he says. "With buyouts, factors such as physician compensation and practice valuation may in the short term reduce profit margins for health systems."

"There's been a shift from independent groups to system-owned cardiology practices. With buyouts, factors such as physician compensation and practice valuation may in the short term reduce profit margins for health systems."

—Bill Kenney, vice president of the cardiovascular service line for the United Heart and Vascular Clinic at United Hospital in St. Paul, Minn.

Looking to the future, more hospitals (29%) than health systems (14%) expect to see a major increase in operating margin for their CV service line over the next three years. Top-end surgeries performed at CV centers,

Analysis (continued)

such as TAVR, may carry high price tags, but such procedures can be burdened by high prices for implants and some limited reimbursement opportunities. "That device today costs $33,000," says Christopher White, MD, FACC, FAHA, FSCAI, FESC, system chairman of the Department of Cardiovascular Diseases and medical director of the John Ochsner Heart & Vascular Institute in New Orleans. "It's very hard to make a profit when you use a device that costs you that much money." But that is expected to change.

"That device will become cheaper over time as more products come onto the marketplace, and we will earn more money five years from today than we do today, so we are investing," White says. "Community hospitals don't have the weight of those expenses or costs, so they simply can look for more profitable procedures to perform. Stents are becoming much more of a commodity. The price of the disposables is dropping significantly, and so hospitals' profit margins or contribution margins would tend to increase, even if their volume is staying relatively flat, which is what I think most people are seeing. They're getting the cost out. They're getting the waste out."

Targeted growth prospects. Within the cardiovascular service line, opportunity for growth varies based on the specialty.

Interventional cardiology. Interventional cardiology is picked as the No. 1 specialty for growth in net patient revenue by 31% of respondents, with nearly equal proportions for hospitals and health systems. That is unexpected, according to Dan Bair, FACHE, administrative director of cardiovascular and radiology services at Mercy Health System in Conshohocken, Pa., which operates four acute care hospitals in the Philadelphia area. "I'm surprised that interventional cardiology is ranked first by so many, given that the market in interventional cardiology seems to be in decline."

"The price of the disposables is dropping significantly, and so hospitals' profit margins or contribution margins would tend to increase, even if their volume is staying relatively flat, which is what I think most people are seeing."

—Christopher White, MD, FACC, FAHA, FSCAI, FESC, system chairman for cardiovascular diseases and medical director of the John Ochsner Heart & Vascular Institute, Ochsner Medical Institutions, New Orleans

Bair identifies three dynamics that may be softening the demand for interventional acute care cardiology services. First, interventional cardiology has not escaped the industrywide push toward practicing medicine more efficiently. "I think there's a lot more thought now about which patients are treated with stents and angioplasty, for one," he says. "Second, we've come

Analysis (continued)

a long way in terms of pharmaceuticals and medical management. Perhaps in the past there was more stenting done on a prophylaxis basis. Now people are more aware of cardiovascular disease and the preventive things associated with staying healthier." Third, Bair notes, "more interventional cardiology procedures are done on an outpatient basis. But the reimbursement that we get through the outpatient interventional procedure is a lot less than what we saw if the patient was treated in the hospital."

Despite such forces, nearly one-third of respondents rank interventional cardiovascular services first in net patient revenue growth in the three-year time frame, which is a testament to the pervasiveness of the service and the expectation that, important as they are, the time frame for preventive and outpatient programs to yield results may be quite long.

Vascular services. One-fifth of respondents (19%) expect vascular services to be their top specialty in net patient revenue growth over the next three years, including more than one-quarter (26%) of health systems. Better screening may be prompting some of the optimism. Says Bair, an advisor to this Intelligence Report, "I'm not sure we've done an adequate job of screening for vascular disease in the past."

Medical cardiology. Nearly one-quarter of hospitals (23%) expect medical cardiology services to be their No. 1 CV specialty in net patient revenue growth over the next three years. The expectation seems especially strong among small hospitals, cited by 40%. White, who served as lead advisor to this report, reminds us that revenue in medical cardiology is weighted toward imaging services such as MRIs, stress testing, PET, echocardiograms, and other diagnostic activities, rather than physician services.

> "More interventional cardiology procedures are done on an outpatient basis. But the reimbursement that we get through the outpatient interventional procedure is a lot less than what we saw if the patient was treated in the hospital."
>
> —Dan Bair, FACHE, administrative director of cardiovascular and radiology services at Mercy Health System in Conshohocken, Pa.

Cardiac surgery. Within the vast field of cardiac surgery, Bair sees good prospects for both CABG and valve cases. "It's the valve segment of the cardiac surgery market that's expected to grow more than the CABG segment," he says. Seventeen percent of respondents cite this specialty as the No. 1 prospect for net patient revenue growth.

Electrophysiology. Relatively few respondents (6%) pick electrophysiology as their top current revenue generator, and just 14% expect that

Analysis (continued)

electrophysiology will be No. 1 in revenue growth over the next three years. Nonetheless, those who offer electrophysiology probably do pretty well. Says White, "Profitability-wise, our EP guys are as profitable as our interventionists. But they won't have the same growth in revenue, because there are fewer of them."

Extending into new cardio subspecialties. Transcatheter aortic valve replacement has earned considerable attention in the industry. The qualifications to perform the procedure are stringent, and one needs staff expertise, specialized equipment, implants that carry high price tags, and a patient population of sufficient size to support the effort. Another damper on growth is that today TAVR is reimbursed by CMS only for patients who cannot be treated with surgical aortic valve replacement. (The FDA approved the first TAVR device for marketing in the United States in November 2011. The Centers for Medicare & Medicaid Services announced reimbursement conditions in May 2012.) Nonetheless, more than one-third of respondents (37%) say they now include TAVR among their subspecialties, and an additional 18% expect to add TAVR within three years, including 23% of health systems.

Survey results reinforce a high degree of interest, although as White notes, "CMS requirements limit expansion. One requirement is total number of valve operations done. You've got to do something like 25 aortic valve surgeries to even qualify, and a lot of hospitals don't come close to 25 aortic valve surgeries a year." Nonetheless, White says, "TAVR is going to grow. TAVR will expand. It's going to become safer and easier and more available."

> "TAVR is going to grow. TAVR will expand. It's going to become safer and easier and more available."
>
> —Christopher White, MD, FACC, FAHA, FSCAI, FESC, system chairman for cardiovascular diseases and medical director of the John Ochsner Heart & Vascular Institute, Ochsner Medical Institutions, New Orleans

Although only 6% of those who do not now perform peripheral interventions say they expect to add the procedure to their cardiovascular offerings, White sees plenty of potential in the treatment. "There's a lot of peripheral arterial disease among our patients," he says, "which means opportunity to improve patient health with peripheral vascular interventions."

Nearly half of respondents (45%) have no plans to expand into new specialty areas, which is an indication of a degree of stability in the industry. In addition, the high number without expansion plans underscores the challenges of expanding services in a highly competitive and relatively mature marketplace.

Analysis (continued)

A bigger footprint. Expanding geographic reach is included as a revenue growth factor by more health systems (71%) than any other item; the item mentioned second most often—partnerships—is pretty far down the list, with 49% saying partnerships will help increase revenue for cardiovascular services. Although it occupies the top of the chart for health systems, geographic expansion by methods other than acquisitions or partnerships may be difficult.

"There just are not any unserved communities with any [patient] population at all, so the opportunity to go to a market that's underserved is extremely limited," says White. Both competition in specific specialties and competition for patients thwart geographic expansion efforts. "Even in medium-sized cities, we've got two or three hospitals competing hard with multiple bypass programs. Plus, if you set up a clinic 50 miles from your hospital, you won't find a lot of patients waiting to come into your clinic, because they're already going to somebody else's clinic."

Via in-system and out-of-system referrals, partnerships make the classic hub-and-spoke care delivery system work. But with more emphasis on coordinated care, relationships today involve much more than mere referrals. More than half of all respondents (51%) say that partnerships are expected to be factors that will prompt revenue growth in the next three years. And 24% say shared-risk strategies will support revenue growth.

Coordinating care. White explains that care coordination helps both patients and the cardiovascular service. "We think the patient with routine heart failure should be cared for in a community hospital, but the patient who has been readmitted or has complex heart failure or has other issues going on should be transferred to a higher level of expertise in order to get more definitive care. And as we establish relationships between not only the hospitals, but also the providers in those hospitals, there's continuity of care, and the patients then feel like their doctors are talking to each other. They know what they're doing. It makes a lot of sense to have such familiar relationships. These are ways that you can grow your business by having more referrals

> "Handoffs outside of the organization are more challenging because there might be a lack of integration of the medical record; it's not necessarily clean."
>
> —Bill Kenney, vice president of the cardiovascular service line for the United Heart and Vascular Clinic located at United Hospital in St. Paul, Minn.

Analysis (continued)

coming into the hub than before because of these relationships."

Nearly two-thirds of respondents (61%) say that aligning with primary care practices is one of their tactics for accommodating at-risk payments and taking responsibility for full episodes of care. As mentioned above, many such relationships go beyond conventional referrals. White continues, "I think the front door is important, but I would argue that even primary care physicians are too expensive for their yield. I would be looking very seriously at what we call advanced practice clinicians, the mid-levels, the nurse practitioners, the PAs. At Ochsner we're making huge investments in that workforce as extenders and members of 'providing pods,' run by a primary care physician with three, four, or five mid-level providers. The idea is to get much more bang for our buck in terms of touching patients, but not by hiring more expensive physicians."

Approaching the future. Healthcare leaders are taking a variety of approaches regarding their investments in cardiovascular service lines.

Population health management. Two-thirds of health systems (66%) expect to make cardiovascular-focused population health investments over the next three years. Half of hospitals (50%) expect to make such investments. Allina's Kenney suggests that the difference in emphasis on population health may be related to the organizations' preparation to take on risk.

"Some health systems probably have risk already, and others may be anticipating risk," Kenney says. "And managing across the continuum is an important strategy when managing risk." Today at Allina, care coordination via case management is a principal technique for population health management. "There is the opportunity for our organization to care better for the chronically ill and to prevent readmissions that are unnecessary [principally by] following our patients postdischarge. Within our primary care clinics, we've got case management for the vulnerable chronically ill population," Kenney says.

> "There's a lot of peripheral arterial disease among our patients, which means opportunity to improve patient health with peripheral vascular interventions."
>
> —Christopher White, MD, FACC, FAHA, FSCAI, FESC, system chairman for cardiovascular diseases and medical director of the John Ochsner Heart & Vascular Institute, Ochsner Medical Institutions, New Orleans

Analysis (continued)

White says he would have expected a higher degree of investment in population health. "You can't possibly hope to be profitable and grow in the future if you don't do population-based management."

IT integration to reach outside of the acute care setting. More than half of healthcare leaders (54%) expect to invest in IT integration in support of their cardiovascular service lines. Among large health systems, IT integration is the investment mentioned most often, cited by 67%.

For some, investments in IT infrastructure are also investments in population health management. At Allina, thanks to an IT boost, notifying the heart failure nurses about a patient to be added to their caseload for care management no longer happens the day of discharge. Kenney says, "We're moving further upstream. That helps facilitate the discharge because the heart failure nurses visit the patient and the family in advance to talk about what the discharge and follow-up plan of care is going to be."

Kenney acknowledges that care coordination with organizations that are part of the Allina system is simpler than with those that are not in the system, partly due to difficulties with data integration. "Handoffs outside of the organization are more challenging because there might be a lack of integration of the medical record; it's not necessarily clean. Following our patients is much easier in the integrated network; we can take a view of a medical record and see what home care has done and what other activities have taken place on the outpatient side. All of that is more challenging for patients who are not fully utilizing our services within our system."

Ochsner's White sees IT integration supporting patient-physician interaction in the future. "Information integration is absolutely necessary. You need to be able to see and touch people at multiple locations and in their homes," he says. "Nontraditional healthcare sites are going to be very important. None of us has enough money to put physicians in front of all these people, and so we have to find other ways to interact with patients. To me that's what information technology integration means."

> "Short of significant changes in plan of care for the patient, nurse practitioners may be more appropriate for follow-up visits with patients."
>
> —Bill Kenney, vice president of the cardiovascular service line for the United Heart and Vascular Clinic located at United Hospital in St. Paul, Minn.

Care coordination and partnerships help reduce readmissions. Nearly two-thirds of respondents (65%) have an outpatient program now or expect to add one within the next three years. At Allina, cardiovascular admissions

Analysis (continued)

are down and office visits are up. For Allina, as with Ochsner, nonphysicians play an important role in increasing the efficiency of cardiovascular care delivery.

According to Kenney, "We've increased our office visits significantly and we're more diligent at managing patients in the outpatient setting. In the past, we weren't using our nurse practitioners in our clinic to the extent that we're using them now. We've been able to fill their practices. Short of significant changes in plan of care for the patient, nurse practitioners may be more appropriate for follow-up visits with patients. Allina sees this as an investment.

"Cardiovascular conditions are the No. 1 reason for readmissions, so we're on the line for some risk in some of our contracts and with Medicare," Kenney says. "Readmissions for heart failure are at risk for payment. And, if we're going to end up getting X amount of dollars to manage patients and the switch is flipped at that point, with these care coordination programs we will have had the opportunity to develop and have in place a program that will have a direct effect on financial return."

Cardiovascular services have long been a source of steady revenue and high operating margins for acute care facilities, big and small. With the industry's emphasis on providing better healthcare more efficiently, this top-performing specialty often takes the pivotal role in implementing efficiency improvements, cost containment, and waste reduction.

Healthcare leaders are working many fronts to accomplish efficient care delivery, such as establishing solid working relationships with in-system and out-of-system care collaborators to optimize patient transfers; augmenting outpatient teams with RNs, physician assistants, nurse practitioners, mid-levels, and other allied healthcare professionals to improve the efficiency of outpatient physicians; instituting wellness programs; using screening and other techniques to target patients at risk and addressing heart-health issues before they reach critical stages; and investing in data integration so that the broader set of care collaborators can be informed about patient health status and treatment activity.

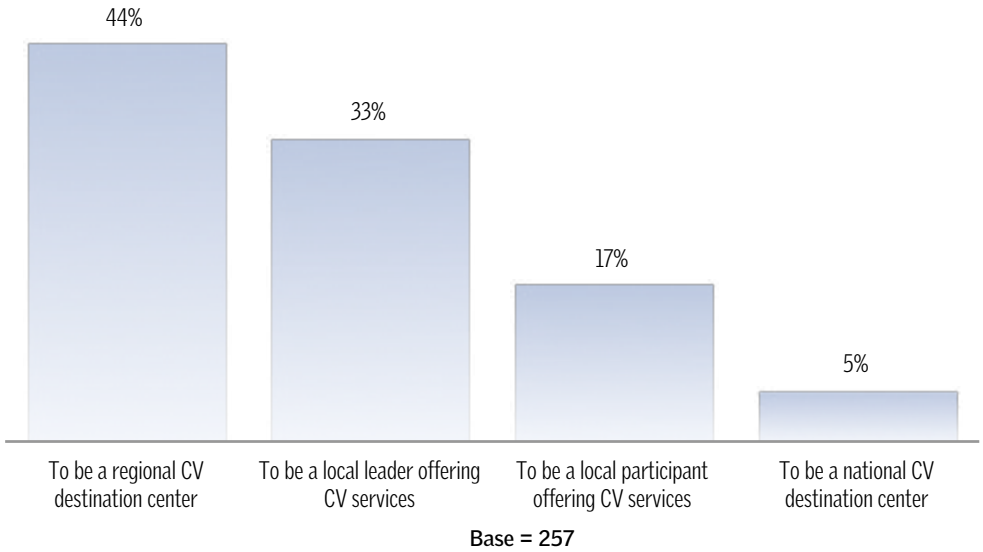
Leadership is approaching cardiovascular service line decisions with an understanding that they will be working with an expanded set of care collaborators, while at the same time will be working in an environment of shrinking admissions and challenges to the revenue stream.

Michael Zeis is research analyst for HealthLeaders Media. He may be contacted at mzeis@healthleadersmedia.com.

FIGURE 1 | Strategic Purpose of Cardiovascular Service Line

Q | What will be the principal strategic purpose of your cardiovascular service line over the next three years?

Total responses



TAKEAWAYS

- As one would expect, almost two-thirds of health systems (60%) are now or expect to be a regional destination center for cardiovascular services.
- Not quite half of hospitals (42%) will position themselves as a local leader offering CV services.
- More than one-third of hospitals (35%), including 44% of large hospitals, say they are or expect to be a regional CV destination center.

WHAT DOES IT MEAN?

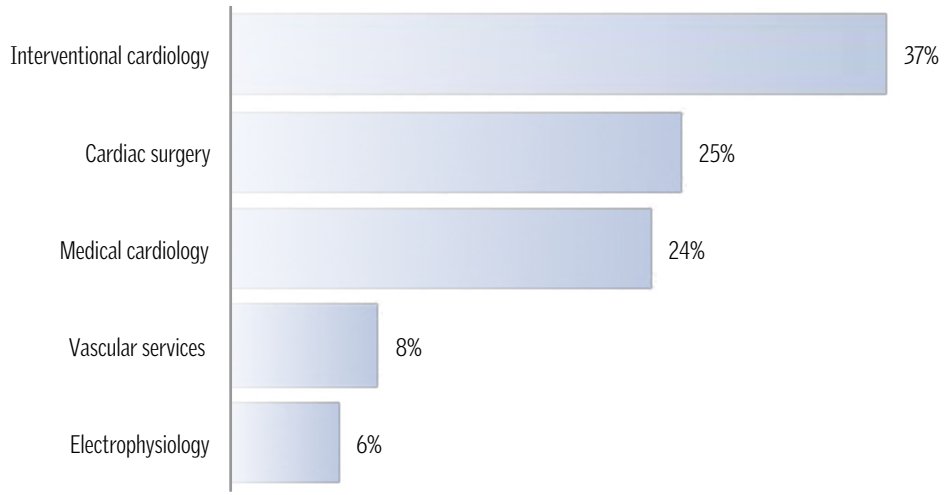
Two related parameters help define the position one's cardiovascular service line will occupy in the market. First is the level of service offered; second is the patient population a CV service can draw from. A patient with what might be called "routine" heart failure could be cared for at a stand-alone or community hospital. One-third of respondents (33%), including 42% of hospitals, are positioned as local leaders. Offering a higher level of care are regional centers. Sixty percent of health systems indicate the strategic purpose of their CV service line is to be a regional designation center, and they are likely to offer tertiary services that may include heart surgery and other procedures such as treating peripheral vascular disease. Tertiary services are not just for health systems: 35% of hospitals are positioning themselves as regional CV destination centers. The market is competitive, which complicates the decision to add services—in other words, it is difficult to change position.

DATA SEGMENTATION TOOL
Click on these icons to dig deeper
VIEW BY SETTING
VIEW BY NUMBER OF BEDS
VIEW BY NUMBER OF SITES
VIEW BY NET PATIENT REVENUE
VIEW BY REGION
MAIN CHART AND TAKEAWAYS

FIGURE 4 | Top Cardiovascular Specialties This Year

Q | Please rank your top three cardiovascular specialties by net patient revenue for the most recent fiscal year.
(First ranked)

Total responses



TAKEAWAYS

- Nearly equal percentages of hospitals (40%) and health systems (37%) say that interventional cardiology is their No. 1 specialty in net patient revenue for the most recent fiscal year.
- The more complex cardiac surgery is ranked first in net patient revenue by 34% of health systems, nearly as many as pick interventional cardiology as their No. 1 revenue generator. Fewer hospitals (19%) than health systems say cardiac surgery is No. 1 in net patient revenue.
- Some 30% of hospitals identify medical cardiology as their top-ranked cardiovascular specialty by net patient revenue.

WHAT DOES IT MEAN?

Interventional cardiology is equally important to hospitals and health systems. While it can be a stand-alone service, it also provides the infrastructure for a wide array of procedures and treatments, including cardiac surgery and medical cardiology. Especially in health systems, cardiac surgery includes advanced heart failure procedures that are well reimbursed. Medical cardiology is mentioned as the No. 1 revenue producer by a higher percentage of hospitals than health systems. Hospitals, especially small ones, seem to depend on the diagnosis and treatment of conditions such as coronary heart disease and congestive heart failure that are part of medical cardiology. As new payment models, prevention, and population health management move to the forefront, expect many hospitals to rethink their procedure-driven strategies.

FIGURE 4 *(continued)* | Top Cardiovascular Specialties This Year

Q | Please rank your top three cardiovascular specialties by net patient revenue for the most recent fiscal year.
(First ranked)

Click on these icons to dig deeper

BUYING POWER Who controls the money? Click on the icons to learn how they think

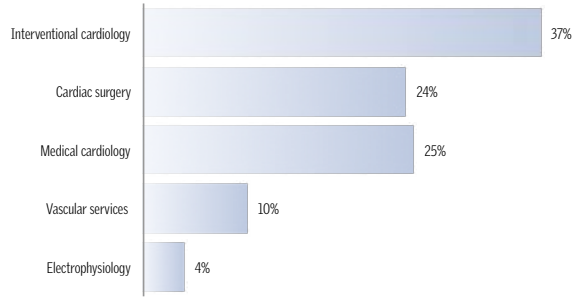
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

PRODUCTS/SERVICES

Clinical products



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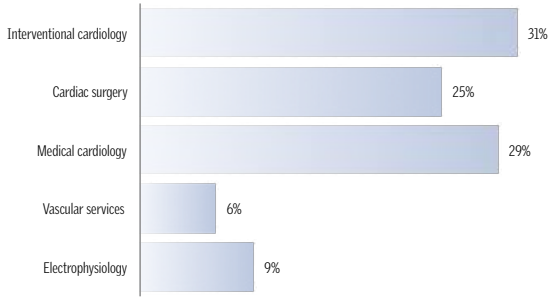
Financial services



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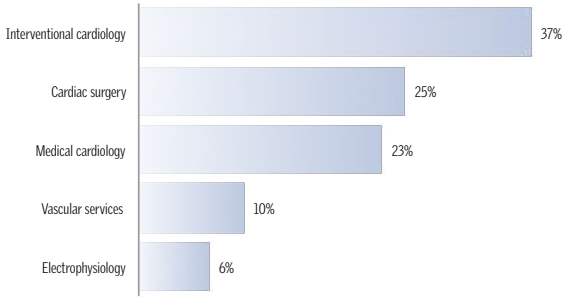
Executive search



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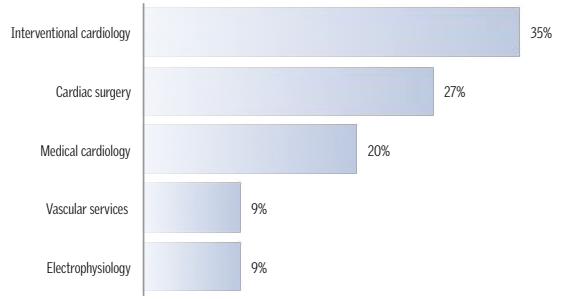
Consulting services



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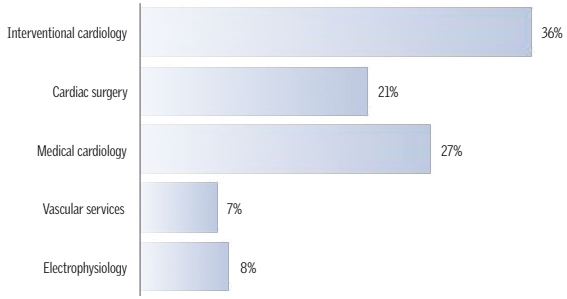
Outsourcing services



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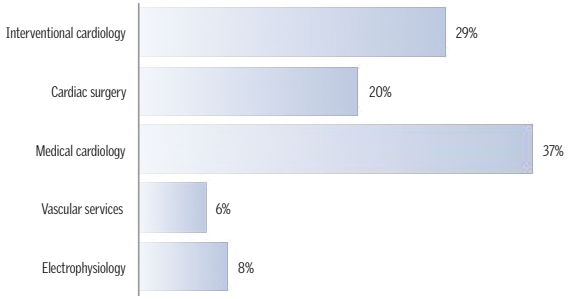
Legal services



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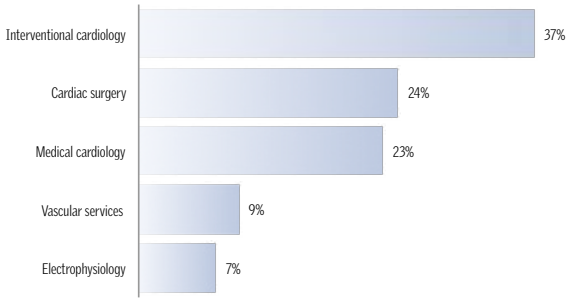
Information technology



Base = 141

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