APC

Association of Professors of Cardiology

August 2022 APC Panel Discussion

Service Line: Department or Division?

Hosted by the Association of Professors of Cardiology

Type	Moderator	Moderator	Panelist	Panelist	Panelist	Panelist	Participant	Participant	Participant
Name/Title	Dr. James Fang Chief, Cardiovascular Medicine Director, Cardiovascular Service Line	Dr. Tom Cappola	Dr. Mike Acker Chief, Division of Cardiovascular Surgery Director, Heart and Vascular Service Line	John Oldenquist MS, MBA Vice President, Cardiovascular Services	Dr. Prem Shekar, FRCSEd, MBA Chair of Cardiac and Thoracic Surgery	Dr. Ravi Ramini Chief Quality Officer Clinical Chief of Cardiology	Dr. Christine Albert, MPH Chair, Department of Cardiology	Dr. James Udelson Chief, Division of Cardiology Director, Nuclear Cardiology Laboratory	Dr. Clyde Yancy Vice Dean for Diversity and Inclusion Chief of Cardiology, Department of Medicine
Organization	University of Utah Health Care	Penn Heart and Vascular Center	University of Pennsylvania Health System	Smidt Heart Institute	Lahey Hospital & Medical Center	University Hospitals, Cleveland	Cedars-Sinai	Tufts Medical Center	Northwestern Medical Group
How would you best describe your governance structure?									
		• Service line is a health system wide catalytic structure that helps execute things across divisions and departments. • Given the scale of these enterprises, and how complex and how, how big they're becoming, you do need matrix shared leadership to do things quickly enough and to stay on top of all these niche areas where you don't fully understand all the details. • Reports directly to corporate. • Gets its budget from corporate outside of the departments • Budget is smaller relative to departmental budgets	• Service line comprises of cardiac surgery and cardiology and vascular surgery in Penn-owned hospital • Two committees: (1) network committee where we try to have one voice that spans all the hospitals as far as hires go (2) operational committee that tries to work on efficiencies • Just an advisory • Not every cardiologist is part of service line • Historically an old-fashioned departmentally-driven medical school • Few employed administrators	• Developing divisions right now • Currently set up underneath the Executive Director of Institute • Role is to work with Chairs of different departments • Team of Associate Directors report up to John (operations, academics, research school)	• Have a service line, but function primarily through the old departmental structure • Single executive director who intersects between all three specialties • Executive director reports up into the administrative structure, including to the department chairs • Not a very robust stress structure for our service line, but at this time works for us • Meet periodically and discuss issues that are pertinent to the intersection of specialties.	• Somewhat matrixed • A network of hospitals • Service line consists of cardiology, cardiac surgery, and vascular surgery; academic division lives here at some hospitals • Service line Institute is headed by service line president • Chair of cardiology has dual reporting structure to the president and to the Department of Medicine	• Good relationship between department of cardiology and department of medicine	• Cardiovascular Center • Essentially a department • A financial entity • Needed a more nimble structure • Took a bunch of years to get it completely financially separated from medicine and surgery • Has worked very well over the years	• Cardiovascular Institute • Philanthropic contributions to develop world class services • Divisions are part of departments, with a lot of accountability • A fair amount of intimacy between departments • Matrix management

	Fang	Cappola	Acker	Oldenquist	Shekar	Rami	Albert	Udelson	Yancy
What do you like about this structure?		• An incredibly useful structure	• What unifies us is commitment to disease teams, quality teams set up in each vertical space of cardiovascular disease, valvular, disease, cardiac disease, EP, etc • Common goals and common metrics	• Love that there's a department • Working with Chairs because they know a lot more about what's going on. So they're actually a fantastic partner • Having the chairs help with big changes to make sure that we are meeting the needs of the patients was was incredibly important. • Better oversight • Move faster • Move on fires more quickly	• Camaraderie. Always people jumping in and out of offices and asking questions, etc. So I think that makes for a lot of collegiality over here • There's a lot of positives that are associated with having a CV service line, and something that I'm trying to advocate	• The ability to bring the entire service line to bear to serve academic mission • Brings the service lines as three separate departments, together		• More nimble than we might otherwise in a traditional structure • Work in an integrated way	
What do you dislike or wish to see improvements on the structure?		• It is complicated when it comes time to execute something • Very matrixed, so can be slow. The upside is, once you do something, no one wants to undo it because it's such a pain in the tail, but they just want to move on to the next thing and leave it alone	• Antiquated concept • No ability to hire/fire • Many different types of reporting structures	• Prefer to have more hands-on oversight of finances • We should be able to take more responsibility, even though we do end up being ultimately financially responsible, but, there's an approval process that seems to kind of slow things up a little bit • Would like better, quicker, more defined access to funding	• Funds flow	• More financial alignment between the academic side and clinical side operational side of things. • Tend to get a little too matrixed • Unclear what it's a little unclear what a particular cost item line item really falls under and how that is assigned and where you actually go for money and things like that. So I think some great alignment would be better than			

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In your current position, please describe your up-stream- and down-stream reporting structure.									
			• Some few employed administrators that work with me, we report to an executive board that is the divisions of that make this up	• Do not report to Chair of Medicine	• Service line director reports into administrative structure	• Vascular surgery, vascular and cardiac surgery, cardiology goes up under the Department of Medicine		• I report to the Chair of Medicine for academic things and promotions. • We work cooperatively on how staff and resident things and promotions, etc. But it's, you know, very financially independent	
Who in your enterprise has hiring/firing medical staff responsibilities?									
			• No personal ability to hire/fire • Department Chair hires/fires					• Me • Get permission from chief physician, executive of the Cardiovascular Center • Work with the hospital to find find funds if staff looking for more money	
Who in your enterprise has hiring/firing nursing staff responsibilities?									
						• Separate CNO for the HPI • All nursing is actually controlled by the service line leadership		• Senior nurse VP, who reports to the CNO • Work cooperatively	

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Does your department have P/L responsibilities?									
		• Service line get budget from corporate outside departments	• No • No real process • Not expected to make money or lose money • Departments pay taxes		• No tax structure as no deliverables from division of cardiac, cardiothoracic surgery to department of surgery			• Yes • P/L is integrated with the hospital P/L	• Yes, funds flow • Role in leadership is to make sure that the “”L”” is as little as possible • Manage so everyone is generating that portion of their income as expected from the research or from the clinical enterprise or from supporting the service lines • Cardiology carries wages for APBs, but does not participate in assessment, hiring, or dismissal • Significant expenses extracted pre-tax for compensation

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How does your work unit receive funding?									
			• Funds flow • Hospitals and doctors all owned by Board of Trustees • Problem is when it comes to hiring, leaders are forced to justify he hire by what it will make the hospital • Then leader must go do departments to fill in wage gaps to propose competitive wage	• Professional fees to into account • Not net, just billing numbers • Not actual tax as service line is in academic side • Have CFO or contributing financial obligation of 80% for cardiology and cardiac surgery • Pay 10% from professional fees to offset tax for incentive bonuses					• Philanthropic contributions • Substantial amount of capital for recruitment, or creating more physical space for outpatient and inpatient services, and similarly for new product lines • Both the division of cardiothoracic surgery and the Division of Cardiology will yield the financial analysis to the institute • Surgery, cardiology, and vascular surgery all see each other's performances and financials • Benefit from a competitive patient payer mix

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What about research and educational budgets?									
	• Exploring integrating with the hospital so division and department are responsible for not only the clinical costs, but also the research and educational costs. And that the revenues generated from grants, state monies, as well as clinical care all go to all those missions. • Difficult to calculate ROI on academic side and hospital administration finds it hard to understand a certain investment is going to give you in the clinical enterprise • We actually came up with a conceptcalled LOI, leverage on investment. No direct money, but investment leverage for recruiting, raising stature, advancing science, etc.			• Research and educational budgets are all strictly indirect cost					• As much as we think about contribution to margins, we think about scholarship and academic productivity • A very well developed performance matrix and 25% of performance assessment is based on teaching; 25% is based on scholarship; 25% is based on citizenship; 25% is based on productivity.

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How does your enterprise align medical/surgical with research and education?									
	• We have the Cardio-vascular Research and Training Institute • Agnostic to department • Although it's the Cardio-vascular Research and Training Institute, people have appointments and surgery, medicine, bioengineering, pharma-cy, in the argument there is that your phenotype doesn't matter as much as what you're trying to do. • Great collaborations between cardiologists, bioengineers, cardiac surgeons, etc. So that's one model, but that grew organically. And that institute for us actually sits outside of the School of Medicine	• I think to have these independent Institute's that sit in between everything else, whether it's a CVI or others, we have a whole alphabet soup of them that we can leverage. So I think that's a good model, and it probably exists in many of centers	• Service line has zero mission around research or teaching • All grants are in the department"			• Research tends to be si-loed within departments			