FROM CONSTRAINT TO TAVR EFFICIENCY STORY



The Longview Regional Medical Center story

Efficiency was not the goal. Timely local access was the obligation.

A resource-constrained East Texas program redesigned the work so more patients could receive advanced valve care close to home.

Aspiration

Use this case as a practical challenge to better-resourced programs: remove bottlenecks now, not after the next capital request.

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WHY LONGVIEW HAD TO BUILD DIFFERENTLY

Access pressure

Patients in the region often would not travel to Dallas for advanced cardiac care.

Resource constraint

The program operated with limited space and a scaled team, yet demand continued to grow.

Leadership choice

The team built a reliable local TAVR pathway instead of accepting friction as unavoidable.

Executive message:

Longview's credibility comes from scarcity. The story gives hospital administrators permission to start with process changes before waiting for more rooms, more staff, or more perfect conditions.

Challenge: if a smaller program can create capacity through discipline, larger programs can act immediately on preventable delays.

Sources: CLD_Germanwala_1125.pdf; LRMC profile_450702_2026-07-17.pdf

DESIGN PRINCIPLE 1: COMPRESS THE PRE-PROCEDURE JOURNEY

The fastest procedure still fails patients if the front end is fragmented.

1. One coordinated visit

CT, echo, surgery consult, and labs are bundled to reduce repeat travel.

2. Single source of truth

A physical binder carries labs, echo, CT, and planned approach.

3. Pre-case alignment

A brief timeout aligns the surgeon, interventionalist, anesthesiology, and coordinator.

4. Cardiac holding flow

Dedicated holding capacity supports predictable prep and recovery.

Key takeaway:

Start where delay enters the system: referral, workup, imaging, surgical evaluation, and scheduling. Room efficiency is the visible result; upstream reliability is the foundation.

Source: CLD_Germanwala_1125.pdf

DESIGN PRINCIPLE 2: MINIMALIST CARE, STANDARDIZED BY DEFAULT

~90%

local anesthesia with minimal sedation

1 + 1

single-groin access plus radial angiography

No ICU

telemetry disposition for most patients

Early

sit-up / ambulation pathway

Keeping it real:

Minimalism is not “less care.” It is fewer unnecessary lines, fewer handoffs, less variation, and faster recovery for the right patient.

Speaker cue

“We stopped asking how many resources a TAVR case could consume and started asking which steps this patient actually needed.”

Source: CLD_Germanwala_1125.pdf

DESIGN PRINCIPLE 3: STANDARD WORK CREATES CAPACITY

Custom TAVR kit

One standardized opening sequence; fewer sterile items handled one-by-one.

Pre-pulled meds

Medication set arrives ready for the day rather than interrupting the room.

Parallel valve prep

Valve preparation occurs while the access team proceeds.

Consistent small team

Repeated roles build rhythm, communication, and accountability.

Leadership translation:

Standardization turns individual heroics into an operating system that survives busy days, new staff, and growing demand.

Source: CLD_Germanwala_1125.pdf

THE ROOM RUNS LIKE A SYSTEM, NOT A SERIES OF CASES

Block scheduling, sequential time slots, and a consistent room team create a predictable operating rhythm.



5/day	7/day	7–8 min	20–30 min
average TAVR day	occasional peak day	average turnover	most procedure times

The Provocative Truth:

If room idle time is accepted as normal, latent capacity stays invisible.

Sources: CLD_Germanwala_1125.pdf; internal summary email

A TYPICAL CASE DAY: ONE LOGGED SEVEN-CASE TAVR SCHEDULE

Seven valve replacements from first anesthesia to final room exit in 5 hours 42 minutes. Patient identifiers removed.

Case	Anesthesia ready	Patient in room	Femoral access	Procedure finish	Out of room	Access to finish	Total room time	Turnover to next case
Case 1	06:50	07:02	07:11	07:24	07:33	13 min	31 min	20 min
Case 2	07:40	07:53	08:02	08:21	08:28	19 min	35 min	9 min
Case 3	07:52	08:37	08:50	09:07	09:19	17 min	42 min	8 min
Case 4	08:35	09:27	09:38	09:50	10:03	12 min	36 min	6 min
Case 5	10:02	10:09	10:20	10:35	10:43	15 min	34 min	4 min
Case 6	10:30	10:47	11:00	11:12	11:23	12 min	36 min	16 min
Case 7	11:31	11:39	11:57	12:24	12:32	27 min	53 min	—

7
cases completed by 12:32

38 min
average total room time

11 min
average room turnover

5h 42m
first anesthesia to last exit

The next patient is induced while the current case is still underway, so the room never waits.

Source: handwritten Cath Lab case log, single TAVR day, 3-19-2025. Derived intervals calculated from logged times. Patient names redacted.

EFFICIENCY ONLY WORKS WHEN OUTCOMES EARN TRUST

105 → 25
average room time reduced, minutes

2.2 → 1.1
length of stay reduced, days

8–9%
reported pacemaker rate

<1%
reported mortality across 700+ cases

Our message:

The Longview story should not land as “go faster.” It should land as “remove waste without compromising patient safety, staff sustainability, or clinical discipline.”

Program scale note

The CV references 800+ TAVR, 200+ TEER, and approximately 1,100 annual procedures.

Sources: CLD_Germanwala_1125.pdf; Dr_Samir_Germanwala_Prettier_CV 7-13-26.docx

WHAT ADMINISTRATORS SHOULD DO MONDAY MORNING

1. Pick one bottleneck

Referral-to-workup, imaging access, anesthesia default, room idle time, ICU use, discharge time, or follow-up compliance.

2. Name one owner

Assign a clinical-operational dyad rather than diffuse accountability.

3. Choose one metric

Track time, variation, and missed handoffs visibly every week.

4. Make one small change

Protocol, schedule block, kit, medication staging, daily huddle, or discharge trigger.

5. Report back in 30 days

Prove progress with data, then expand the standard work.

Sources: CLD_Germanwala_1125.pdf; HLS Agenda 2026 DRAFT+objectives 6.29.26.docx

CLOSING MESSAGE: ANSWER THE CALL OF DUTY WITH THE RESOURCES YOU HAVE

Patients cannot benefit from capacity that exists only on paper.

Longview's lesson is not that every program should copy every step. The lesson is that leaders can create access by removing friction, standardizing work, and holding the system accountable for time.

Close with urgency

"Your patients are already waiting. What will your program change next Monday?"

Sources: CLD_Germanwala_1125.pdf; HLS Agenda 2026 DRAFT+objectives 6.29.26.docx