THE HEART TEAM MODEL

The benefit of a patient-centered multidisciplinary approach

Interventional cardiology • Cardiac surgery • One shared standard

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BACKGROUND

How the Heart Team became the standard.

Two decades of new therapy, trial evidence, and coverage policy built the model we use today.



01 ORIGINS

Cardiac surgery and cardiology as separate referral cultures

Before 2002

02 FIRST TAVR

Cribier's first-in-human case opens a transcatheter option

2002

03 TRIALS NAME IT

PARTNER trial and SYNTAX formalize joint patient selection

2009 – 2011

04 POLICY LOCKS IT IN

CMS NCD 20.32 makes the Heart Team a coverage condition

2012, revised 2019 and again in 2026

05 LIFETIME MANAGEMENT

Low-risk approvals shift the question to lifetime strategy

2019 – today

Background synthesized from valve guideline history, TAVR trial programs, and CMS NCD 20.32.

HEART TEAM IMPORTANCE

Expert team vs team of experts.

How frequent should meetings be held and who should attend?

INTERVENTIONAL CARDIOLOGIST

CARDIAC SURGEON



EXTENDED HEART TEAM

- Anesthesiologist
- Cath lab/OR staff
- Nurses

IMAGING

- Echocardiographer
- CT specialist
- Radiologist

VALVE CLINIC COORDINATOR

HEART TEAM CHALLENGES

What gets harder after the NCD.

The 2026 revision keeps the Heart Team but removes most of the mandates previously used to enforce it.

01

SINGLE EVALUATION

One in-person operator exam replaces two independent evaluations

Keeping both voices

02

OPERATOR FLEXIBILITY

Joint IC and surgeon participation is permitted but no longer required

Who scrubs in

03

QUALITY IS THE BAR

Ongoing quality monitoring replaces volume as the standard to meet

Build it, staff it, report it

04

MISALIGNED INCENTIVES

A single operator captures the full RVU; co-operators split the case

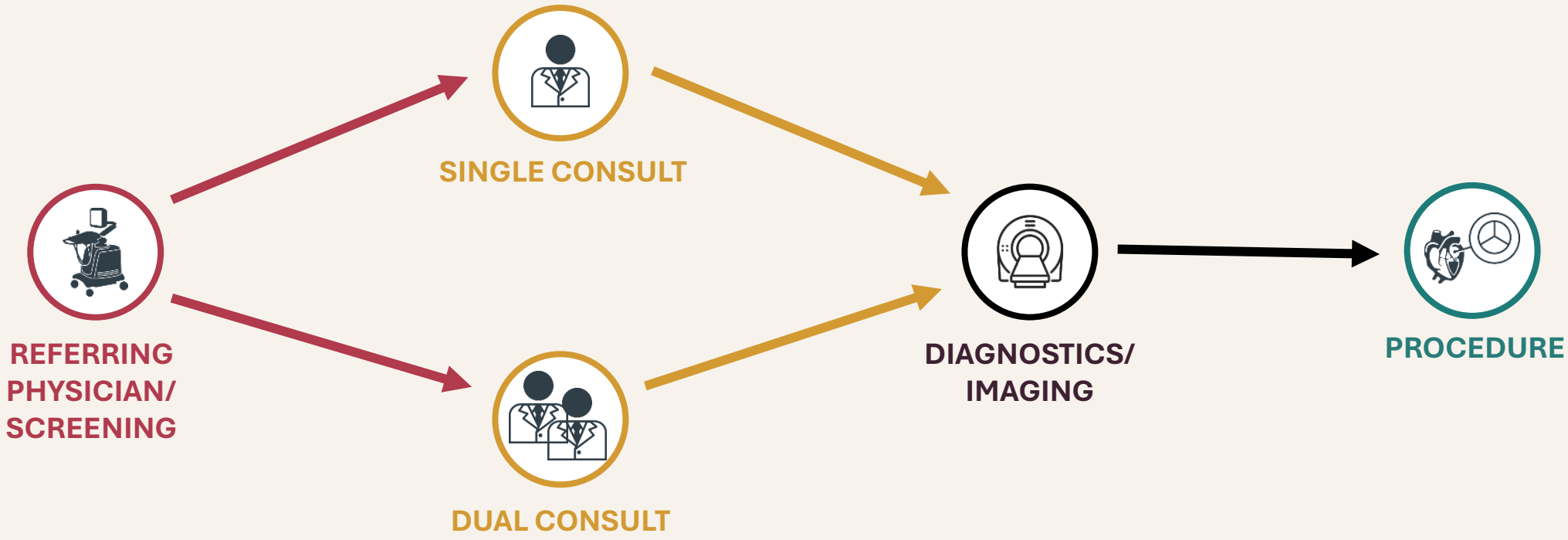
Patient care at the center

Synthesized from the CMS NCD 9/10/2026 revision, ACC/SCAI/STS comment letters, and the EVOLVE multicenter Heart Team survey.

PATIENT PATHWAY

Simplify the patient journey.

Route by risk, anatomy, and disease state. Reduce patient visits and time to treat



PATHWAY VARIATION

Heart Team essential with added flexibility where appropriate.

Age, disease trajectory, comorbidity burden, and access anatomy steer each patient differently.

Expedited Pathway

YOUNGER, LOW RISK

Under 65, isolated AS, decades of valve life ahead

Surgery first; plan the second valve now

OLDER, HIGH RISK

Over 80, frailty, renal or pulmonary disease

Transfemoral TAVR; expedited pathway

Heart Team Discussion

STEADY PROGRESSION

65 – 80, gradual symptoms, limited comorbidity

TAVR or SAVR by anatomy and goals

CONCOMITANT DISEASE

Multivessel CAD, mitral or aortic pathology

Surgery with combined repair; staged PCI

HOSTILE ANATOMY

Prior sternotomy, poor access, bicuspid or small annulus

Alternative access or redo strategy



BALANCING THE PATHWAY Simplify what is routine • standardize what is variable • remove barriers that delay treatment

Illustrative pathway archetypes; individualize with imaging, risk scoring, and patient goals.

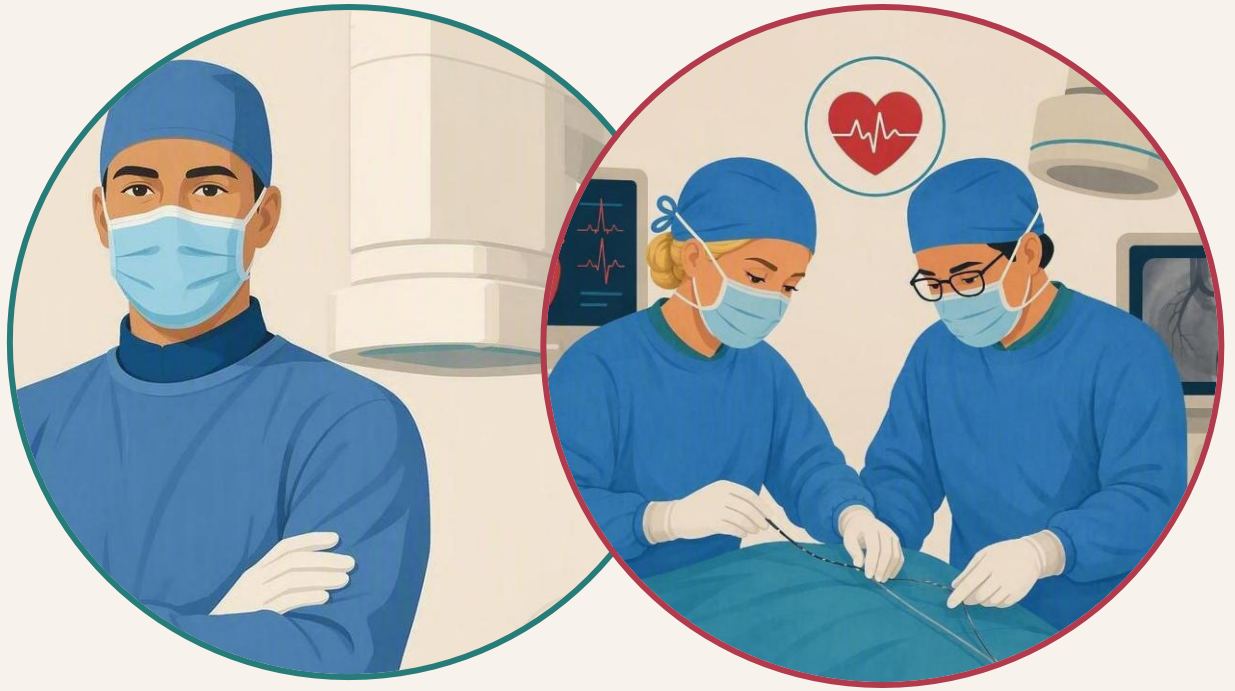
PROCEDURE OPERATOR MODEL

One operator or two working together.

Multiple models resourced for specific needs of individual patients.

SINGLE OPERATOR

Routine anatomy, a clear indication, and standards set by the Heart Team.



CO-OPERATORS

Complex or combined anatomy, alternative access, or a case where rescue must be immediate.

KEY OPERATIONAL CONSIDERATIONS **Protect time for dual operator cases. Procedural coordination and communication.**

Illustrative staffing framework; align with local credentialing, protocol, and current CMS requirements.

LEADERSHIP AGENDA

Key take away: Build a Heart Team of the future.

Evolving the heart team at your institution- what are best practices.



Multiple specialties. One program.

Closing framework synthesized from CMS requirements, valve guidelines, and user-provided Heart Team materials.