From Red to Black

Strengthening Program Performance for Patients and the Future

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Objective: Demonstrate the specific operational and financial interventions used to rapidly improve program margin and how to replicate.

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Background

- Mercy St. Vincent
  - 1st hospital in Toledo, OH – established in 1855
  - Urban acute care hospital; Level 1 trauma center; 568 beds
  - Structural Heart program established in 2016
  - ACGME-accredited cardiovascular fellowship program
- Initiative to reset the SH program began in July, 2025
  - Negative margins threatened administrative support and the ability to resource the program for growth
  - Program now enjoys positive margins and significant growth



Creating Physician/Administrator Alignment

ONE TABLE, ONE PLAN

- **Start with leadership.** Physician and administrative leaders own the change jointly before anything is redesigned.
- **Bring relevant stakeholders to the table.** Administration, CDI and billing, cardiology, surgery, anesthesia, and nursing.
- **Share the same numbers.** Open clinical and economic data, with a shared plan for cost, documentation, and workflow.
- **Make it durable.** A quarterly structural governance committee keeps workflow, quality, and margin on one agenda.

Alignment bridges clinical care and organizational sustainability — it is the first intervention, not a byproduct of the others.



Two Primary Levers: Revenue and Resources

REVENUE Capture what the work is worth

- Standardized H&P template so MCC is stated at admission
- Objective evidence supporting each diagnosis, congruent from H&P through discharge summary
- Intraprocedural hemodynamic assessment documented
- MS-DRG 266 with MCC $52,498 vs MS-DRG 267 without MCC $40,724

Estimated
+$4,710 per case at a 50% MCC blended rate
(vs. 10% baseline)

RESOURCES Spend less to deliver it

- Structural cases moved from hybrid room to cath lab
- Nurse-led sedation reduces cost, facilitates patient recovery, and allows for reduced room time
- Reducing procedure staff, including eliminating perfusionist in the room
- Telemetry admission instead of ICU, 90% discharged next day

Estimated
-$6,264 per case: $4,770 room, $1,494 recovery

Source: DRG estimates from CMS published payment rates; Estimated cost savings based on FY2024 MedPar, Med Econ, 2019 Oct; 22 (10); 1022-1024: CPI inflation adjusted for Oct 2024; Butala et al. Economics of Minimalist TAVR: Results from the 3M – TAVR Economic Study, 2022. Circulation: Cardiovascular Interventions

What To Do When You Get Back

- **First create alignment.** Bring administrators, surgeons, anesthesia, and nursing to one table before changing anything.
- **Sit down with CDI and billing.** Standardize the H&P template so MCC is documented and captured appropriately.
- **Get the room right.** Move suitable structural cases out of the hybrid room and into the cath lab.
- **Change the anesthesia model.** Adopt nurse-led conscious sedation and right-size the procedural team.
- **Trim the workup.** Drop non-essential pre-procedure testing to shorten time from heart team to treatment.
- **Move recovery downstream.** Admit to telemetry rather than ICU and target next-day discharge in appropriate patients.
- **Make it durable.** Set up a quarterly structural governance committee to track workflow, quality, and margin.