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OPINION

The Evolution of the Program Coordinator: From One Valve to the Whole Heart

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At the center of every Structural Heart Program is a Program Coordinator (PC). To successfully perform the job, this person has to be organized, diligent, detail-oriented, personable, intuitive, calm, and motivated. The PC is to a Structural Heart Program what air traffic control is for the skies. Each patient is a fast moving jet, with their pilots (the Interventional Cardiologist and CardioThoracic [CT] Surgeon) maneuvering them quickly to their destinations. The PC has to have sight of every part—where everyone is, who lands first, and in what order the rest will follow. I had the privilege of working closely with Kelsey Johnson during my time as a Structural Fellow. I learned so much from Kelsey in terms of what I should consider, incorporate, and need in order to not only start but to also direct and grow a successful and full-bodied Structural Heart Program at my now current institution, the Medical College of Georgia at Augusta University. She understands that the key to running a successful program is consistent and clear communication, and always remembering that the patient comes first. With her skillset and air traffic controller mindset, Kelsey currently continues to create a robust, vibrant, and growing program at the University of Washington in Seattle, WA. Because of her experience and the importance of the PC position, I reached out to Kelsey to provide her insight and perspective on her pivotal structural heart role. Her knowledge is beneficial not only for other program coordinators, but also for structural fellows, for early career structuralists such as myself, and for seasoned structuralists who strive to grow and cultivate their programs.

As the field of Structural Heart continues its trajectory of seemingly nonstop growth, the role of the Program Coordinator on the Heart Team has naturally evolved to keep up with this progression. While the details of the roles and the actual titles may vary from institution to institution, within each heart team is an individual, often a team of dedicated people, responsible for keeping the patients and the program in motion. Though factors such as volume, resources, and services offered may create some role variability, trends are emerging across the field that are expanding the role of the coordinator significantly.

Where we were

Just a few years ago, the Structural Heart Coordinator was a near foreign concept. While other services such as Heart failure and Transplant could provide some direction, there has been no clear guide to the establishment of the coordinator role. Few resources existed, so the majority of the roles and processes within the programs were independently developed. With time and networking, the coordinator role from program to program started to take on some universal characteristics. In general, the early days of coordinating primarily involved overseeing and participating in the day-to-day tasks of maneuvering patients from their initial referral across to their transcatheter aortic valve replacement (TAVR) procedure and through their subsequent follow-up clinic visits. The early role of the coordinator involved navigating communication between Interventional Cardiology, CT Surgery, and core systems in the hospital such as the cath lab and the OR. The role back then was still very fast paced and intense. Days were consumed by making many phone calls, scheduling (and often rescheduling) many appointments, and obtaining insurance authorization. Additionally, the workload often included data collection pertaining to registry requirements. Volumes were considerably lower and, in general, easier to manage, which meant that these day-to-day job tasks were fairly linear and truthfully, a bit easier to define.

Where we are

Today, the role in many institutions has undergone a dramatic transformation as the world of Structural Heart has exponentially grown. With the addition of mitral and tricuspid clipping, transcatheter mitral valve replacement (TMVR), left atrial appendage occlusion, other catheter-based procedures, and an abundance of clinical trials and research studies, we are no longer just TAVR coordinators, we are Program Coordinators. As structural treatment options continue to be developed and expand, and as volumes continue to increase, there has been a shift in focus from those earlier day-to-day tasks to programmatic initiatives, process improvement, and optimization of current practice. As coordinators, we are constantly looking for ways to build, grow, expand, and above all improve our programs, rather than just sustain them. Coordinators are now much more integrated members of the heart team and certainly now hold a uniquely specialized role in the field.

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As data continues to support the efficacy of the technology, the population that we are treating has become more extensive. With an increase in inpatient transfers and often urgent/emergent procedures, the role of the coordinator spans more between inpatient and outpatient services than ever before. Working with the entire Structural Heart team to triage these patients and develop treatment strategies requires a great collaborative effort. These collaborative needs, as well the addition of more catheter-based treatment options, have led to the inclusion of more disciplines on the heart team. Facilitating teamwork and communication between multidisciplinary care providers in various departments such as Electrophysiology, Heart Failure, Advanced Cardiovascular Imaging, Radiology, Cardiac Anesthesiology, Adult Congenital Heart Disease, and Vascular Surgery is essential to program success and to improve patient outcomes.

In my own experience as a Program Coordinator, I have found a great deal of satisfaction in adapting my role to the growing needs of the program. Treatment options have expanded and program volumes have increased creating opportunities to improve processes around patient access, outreach, and communication. Creating care pathways to standardize processes has helped with program automation, efficiency, and ensuring continuity of care for all patients. Tracking referral volume, generating timeline goals, and identifying program deficiencies, has helped to increase patient access and to recognize areas to target for improvement. Strategizing accommodating inpatient transfers as well as urgent/emergent cases without disrupting the flow of electively planned cases has become an important consideration when evaluating access needs as well. Improving communication not only to the patients but also to the physicians has become an increasingly important program need. As referral volumes continue to climb, systematically updating referring physicians on the status of their patients throughout the entire process has been an important part of the coordinator role and ensures continuity of care for these shared patients.

While many of these initiatives seem directed at process improvement, the ultimate goal of each and every task that I do as a Program Coordinator is to ensure the delivery of early responsive, exceptionally efficient, high quality patient care. Having a patient centered care model drive the system facilitates improvement across the program while simultaneously prioritizing the patient above everything else. Though my direct patient interactions aren't as prevalent on a day-to-day basis as they once were, program initiatives around improving patient communication, education, and outcome review processes have allowed me to nonetheless directly impact patients in a way that continues to feel meaningful.

My role as the Structural Heart Program Coordinator would not be sustainable or even possible without an incredibly talented and passionate team around me. The resource intensive care that these patients require demands that appropriate staffing and adequate infrastructure exist to support a program's needs. Though it seems obvious, there is no way for a program to grow without eventually adding the staff to support it. Since my specific role is now greatly made up of some of the afore-mentioned initiatives, many of the daily coordinating duties are now executed by other members of the team. In reality, there is no longer a single coordinator, rather multiple coordinators participating in the program. Many of these staff members have also seen a transformation in their specific positions as structural heart programs grow and really take on their own identity. Outpatient schedulers work between the inpatient and outpatient worlds, facilitating all of the necessary appointments and serving as the front door to the program. Structural heart nurses have emerged to educate, triage, and assist patients along their journey from referral to treatment and follow-up clinic visits. Structural heart nurses serve as subject matter experts who are heavily relied upon by patients to translate complicated ideas and proposals into patient friendly language. Structural heart medical assistants are now specifically trained to not only complete and capture data for registry specific needs but to also assist the rest of the Structural Heart Team by providing specific education to patients. As attending structural physicians become more occupied with the increased demands of the program, advanced practice providers (APPs) and structural heart fellows function as crucial resources for staff and as instrumental care providers to patients; therefore, preventing delays in communication and treatment. All of these personnel, individually and combined, serve as critical facilitators of the entire process.

Where we are going

Although Structural Heart programs and our roles within them have grown by leaps and bounds, the Structural Heart Program Coordinator role will continue to be ever evolving. Continuous efforts to look for process improvement and ways to incorporate concierge style services will be important areas of focus. As more implanting centers emerge across the country, I believe that we can anticipate that more experienced and higher volume centers will continue to see an increase in urgent and emergent cases, a growth in cases with alternative access needs, and a higher acuity patient population. Research and emerging data will continue to drive best practice, molding and further developing our processes and guidelines along the way. The field of Structural Heart will continue to be innovative, challenging, at times chaotic, but above all brilliant, and the Program Coordinator will proudly continue to lead amongst others from the front line.

Disclosure statement

No potential conflict of interest was reported by the author.