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Rationalizing Cardiology Care in an Era of Hospital Consolidation

The health care landscape has dramatically changed during the past few years—and will continue to do so—as hospitals consolidate into larger entities. For many organizations, mergers and acquisitions present opportunities for greater geographic reach, enhanced clinical capacity, increased care coordination, and economies of scale. When it comes to the cardiovascular (CV) service line, consolidation can enable greater subspecialization for services (e.g., congenital heart disease, TAVR, transplant) that typically have limited volume but are critical to comprehensive patient care. However, consolidation can also create a crowded clinical environment in which newly consolidated hospitals provide overlapping services; and while subspecialty care and patient access are key priorities of the CV service line, redundancies are not.

Enter *rationalization*, the third installment in our series on the five key attributes of a thriving value-based enterprise. To mitigate the potential clutter of consolidation, systems are evaluating the (re)distribution of cardiology services and centralizing or colocating similar service offerings within a particular market. The intent is to contain costs and optimize resource utilization while also providing high-quality care. Yet the decision to rationalize services, although increasingly necessary, can be highly complex. This article highlights the common challenges organizations may face and offers guidance for determining the appropriate level of rationalization.

YES, RATIONALIZATION IS COMPLICATED

I am currently working with several hospital systems that are managing multiple CV surgery programs within close proximity to each other. While volumes may have justified this service duplication 5 or 10 years ago, the practicality and benefits of having two programs are now much more difficult to explain. Most agree that clinical cardiology services (e.g., clinical consults, routine testing) need to be readily available and in close proximity to where people live and work. Conversely, heart transplantation and VAD implants should be centralized on a regional or multiregional basis.

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The ideal distribution of subspecialty and surgical services generally lies somewhere in between these two options. Questions regarding the number and location of open-heart programs are obviously important and need to be addressed. From a quality perspective, having a high-volume open-heart program is more advantageous than one with a lower case volume; however, many patients and providers are hesitant to remove on-site surgical backup from their local facilities. Similarly, some systems opt to limit the number of cath labs available for diagnostic interventional procedures and instead, focus on enhancing their processes for transferring STEMI cases from local facilities to a regional cath lab facility. While there are a number of benefits to these rationalization efforts, many health care systems are reluctant to venture down this path for fear of the strategic, financial, operational, and cultural and political considerations that accompany such endeavors.

Even though challenges exist and can be difficult to overcome, systems cannot afford to tip-toe around tough discussions given the steadily growing emphasis on value-based care—particularly for CV services—that continues to be at the forefront of CMS' reimbursement initiatives. Successfully managing the complexities of rationalization strategies requires systems to establish a carefully constructed framework for identifying, evaluating, and prioritizing their options. More importantly, it requires a collaborative process that brings both physicians and administrators to the table to ask the important questions and engage in a logical, unprejudiced assessment of the benefits and risks.

RATIONALIZATION FRAMEWORK

Rationalizing services requires careful analysis, a

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TABLE Example Considerations for CV Service Line Rationalization

Strategic	Operational	Financial	Cultural and Political
• Patient/provider loyalty and retention when services are relocated • Degree of competitive response and potential local market shifts • Anticipated on-site CV offerings in the long term (that might necessitate a short-term service)	• Potential to improve outcomes through volume consolidation of high-risk procedures • Downstream implications (e.g., impact on cardiac imaging studies, lab tests) • Proximity to related services (e.g., cardiac rehab, SNFs) • Equipment/space under- or over-capacity	• Impact of lost revenue streams and associated contribution margin • Implications of value-based reimbursement and other cost/financial factors • Hospital and CEO performance incentive structures • Capital initiative funding at the local level	• Reactions of medical staff and hospital leadership • Shift in mind-set from silo to system orientation • Previous promises/agreements made to boards, communities, local governments, and donors regarding the types and level of services provided by the facility

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well-defined strategy, and the ability to cultivate influential champions for change. There should ultimately be a compelling case for why service redistribution is necessary, as well as how services will be distributed to best support the strategic and financial success of the system.

Regardless of how services are redistributed, there are several other critical elements that need to be factored into a framework for rationalization.

» ***Establish clear ground rules and transparent decision-making criteria.*** Providing a clear decision-making path and precise criteria to be followed helps organizations communicate an unbiased, stakeholder-inclusive, and transparent approach to service distribution.

» ***Engage stakeholders throughout the decision-making process.*** Reactions to rationalization efforts vary and often depend on whether a community perceives it will be losing or gaining services. Engaging stakeholders in the discussion increases the opportunity to address questions and concerns early on while creating win-win scenarios for those who are directly impacted.

» ***Enlist local and/or regional provider input into system initiatives.*** If a decision is made to consolidate a particular service at the system level, ensure that local stakeholders still have venues to provide system-wide guidance and feedback. For example, the implementation of regional, multi-organizational committees for programs like TAVR can provide a strong means to coordinate care pathways across the system and, in the process, secure broad provider support at the local level.

» ***Start with services that have the greatest potential for improving quality and cost.*** Take manage-

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able steps toward rationalization by focusing on initiatives that will improve overall patient care as well as the system's bottom line. For example, begin by transitioning low-volume and/or high-acuity cases to a particular hospital as a way to monitor and garner trust in the new arrangement before incorporating more sweeping changes.

DIFFICULT BUT OFTEN NECESSARY

Rationalization approaches are often met by internal—and sometimes external (e.g., boards, patient community)—resistance, and thus are utilized infrequently. Yet with the continued trend toward consolidation, systems are facing overlapping CV services, diminishing volumes, overcapacity, and increasing costs. Though difficult to work through, a thoughtful strategy for rationalizing services can represent the means to better manage costs and care delivery in the wake of value-based reform. ■

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