rationalizing resources
a framework and a process

To meet the demands of population health and value-based care, healthcare organizations may soon be compelled to take steps to rationalize their service and resource offerings.

Imagine what would happen if the nation’s health systems were to set about rebuilding their organizations from scratch. In response to today’s healthcare environment, with the increasing focus on value, a redesigned health system would likely have fewer hospitals and more outpatient sites and virtual encounter capabilities, being built around an ambulatory model that treats hospital beds as an ancillary service. Similar types of care services would be congregated into single, comprehensive sites to minimize duplication and take advantage of economies of scale.

Without the benefit of a clean slate, however, today’s complex health systems must adapt their existing organizations to the changes that are sweeping the nation’s healthcare system. They are compelled to find financially responsible ways to ensure the services they deliver and the resources they provide are well-aligned with the needs of their communities. Short of rebuilding from scratch, health systems must focus on rationalizing service and resource offerings.

What does it mean to rationalize? In this context, borrowing from Merriam-Webster, it means “to apply the principles of scientific management to (as an industry or its operations) for a desired result (as increased efficiency).” Based on this definition, rationalizing healthcare service and resource offerings may involve, for example, consolidating or scaling back on healthcare offerings in one area while expanding or adding to offerings in another, as community needs dictate.

Rationalization is an important objective for health care given the continuing decline in utilization. It also constitutes a change in mindset from the traditional focus on expanding capacity to optimize performance under volume-based payment to a focus on enhancing value through

AT A GLANCE
To be able to effectively rationalize their service and resource offerings, health systems must first have a solid framework in place to support such an initiative. Creating such a framework requires four steps:

> Building cultural readiness
> Applying a transparent, collaborative process
> Prioritizing key opportunities
> Adhering to a well-developed implementation plan
Given its sheer scope, a rationalization initiative requires, first and foremost, cultural readiness in the form of systemwide receptivity to the goals of the initiative.

improved quality and reduced cost of care. Indeed, organizations have much more reason to consider rationalization as a consequence of the healthcare industry’s shift in focus to population health.

Creating a Rationalization Framework
For most health systems, a rationalization process will focus primarily on centralizing or co-locating similar service offerings within a given market with the goals of containing costs, optimizing resource utilization, and delivering high-quality care as efficiently as possible. Achieving these goals requires effective leadership and change management supported by financial stewardship. The role of a health system senior finance leader in supporting this function should be to challenge capital investment decisions by asking how the investments can position the health system to avoid duplication of services, provide services in the optimal setting, and reduce the overall cost of care.

Rationalizing services can be a complex and potentially contentious exercise, and it therefore requires careful analysis, a well-defined strategy, and the ability to cultivate influential champions for change. To set the stage for effective rationalization of services and resources, health systems must first establish a framework based on the following five factors:

- Cultural readiness
- A transparent, collaborative process
- Physician support
- Clearly defined priorities
- A thorough implementation plan

Building cultural readiness. Given its sheer scope, a rationalization initiative—like any large-scale transformational effort—requires, first and foremost, cultural readiness in the form of systemwide receptivity to the goals of the initiative. Yet as it attempts to foster such receptivity, a health system may face a challenge in persuading many of its employees to shift their inherent loyalties. Employees often identify with and feel a sense of commitment to the organization, campus, or building in which they work, and such loyalty generally should be encouraged. But if that commitment is limited to only a piece of the health system, it can become an obstacle to the health system’s ability to optimally serve its communities.

Motivating leaders, providers, and staff to think beyond their separate facilities and adopt a systemwide perspective is arguably the most difficult undertaking within this framework. Effective strategies for promoting such a change in perspective can include:

- Linking rationalization to other strategies that are less controversial, such as population health and improved outcomes
- Rallying staff to work together to address inconsistencies and shortcomings in the health system’s overall performance (for example, pointing to a significant variance in readmission rates across facilities)
- Making a compelling case for why service redistribution is clinically beneficial and necessary for success at both system and facility levels (a particularly important message for communities that may object to a perceived loss of service offerings in their localities)
Establishing a service line governance model that encourages stakeholder leadership and influence across multiple organizations within the system

> Focusing more on system or regional performance than on hospital performance as a primary factor influencing executive compensation

Far too many hospitals within the same health system compete just as aggressively against each other as they do against hospitals outside the health system. In such an environment, rationalization efforts have virtually no chance of being successful.

Applying a transparent, collaborative process. Before delving into specific initiatives, it is important to obtain long-term buy-in to allow for the development of a clear set of unbiased, objective criteria for service rationalization decisions. Defining guiding principles at the outset will make clear to all stakeholders what issues or factors drive decision making as opportunities are evaluated. Chief among the decision-making objectives for any organization is the opportunity to enhance value—if an initiative can reduce costs, improve quality, or both, then it ought to be considered.

Although it is not necessary, or even prudent, to involve all stakeholders in initial discussions, it is important to work with a broad set of representatives once an organization decides to pursue a rationalization strategy. The core team will typically involve the system leadership team and the chief executive of each region or hospital. This team will transition to operational leaders once the impacted service areas are defined. The level of each team member’s involvement ultimately will depend on the magnitude of the system’s rationalization efforts. Expanding the stakeholder team will not only promote accountability and systematic rigor throughout the decision-making process, but also provide a communication platform to make this process more inclusive.

If a decision is made to consolidate a particular service at the system level, it is important to ensure that local stakeholders retain avenues for systemwide guidance and feedback. Implementing regional, multi-organizational committees for service line programs, for example, can provide a strong means to coordinate care pathways across the system and, in the process, help promote provider support at the local level.

Gaining physician support. Cultural readiness and a collaborative process will help to reduce obstacles from hospital executives, board members, community members, and many other stakeholders. But no other constituency is in a better position to derail a rationalization initiative than affected members of the medical staff. Rationalization may result in changes that have a drastic impact on the day-to-day activities of physicians and the way in which they intend to operate their practice. The business case used to gain the support of hospital executives will be somewhat helpful when meeting with physicians, but a whole new perspective needs to be considered to get physicians on board. A clear strategy to engage physicians in the decision-making process is needed to facilitate their acceptance and support.

The process of engaging physicians to evaluate options should consist of meeting individually with affected physicians to get their viewpoints and educating them one-on-one on the situation the organization is facing and the need for change. Then, smaller meetings with a group of physician leaders can take place to identify
A Case Study on Rationalization

Two neighboring hospitals (Hospital A and Hospital B)—both within the same health system—were considering merging their cardiovascular (CV) surgical programs. Each organization had its own cadre of high-quality CV surgeons, but on average, the volumes per physician were low and did not justify the fixed costs associated with operating two CV surgery programs. The health system also wanted its CV service line to encompass some of the new, more minimally invasive technologies already adopted within its structural heart program, because these technologies require a minimum volume threshold to qualify for Medicare payment and even greater volumes to be considered "top tier.”

Despite being in close proximity to each other geographically, the two hospitals were separated by a body of water that the patient and physician community generally considered a divide within their service area. Even though CV surgeons from these hospitals were employed by the same overarching system, they did not generally practice together, and some surgeons in each group harbored concerns about the quality of the other group’s work. As a result, the overall service line comprised, in essence, two camps that were distinct from each other in all aspects—strategic, financial, and operational.

The health system’s leaders acknowledged this challenge, but they also understood that there are significant fixed costs associated with any CV surgical program, which can be offset to some degree through greater coordination. Organizations also can achieve certain variable-expense “economies of scale” (e.g., supplies) through operational integration and the support of higher volumes. So despite stakeholder preferences, there clearly was an opportunity for rationalization that the health system wanted to pursue.

Despite the perceived benefits, a number of discussions were initiated with limited support. Indeed, from the start, the overall discussion was a struggle as the health system encountered significant political concerns about merging the CV programs. A decision therefore was made to put the entire service line rationalization initiative on hold for a year to give the organizations time to speak with the various stakeholders, explain the rationale, and begin outlining a future model.

Eventually, when the health system was able to move forward again with the initiative, its first major challenge was to decide which program ultimately would provide the best basis for the service line. This decision was informed by an in-depth analysis of key aspects of each CV surgery program to determine which one made the strongest case for being selected as the future site of care.

After much discussion, system and hospital leadership identified Hospital A as their preferred choice, particularly given recent upgrades to its facilities and equipment. It helped that Hospital A also was aligned with a set of newly trained, highly qualified physicians who were interested in pursuing cutting-edge initiatives (e.g., transcatheter aortic valve replacement). Nonetheless, the decision had significant ramifications, because Hospital B had been the longer-standing site of care, its physicians were deeply embedded within the hospital organization and hospital board, and substantial internal pushback remained to the idea of consolidating programs.

In the end, the entire CV surgical program was transported to Hospital A, progressing in stages. At the initial stage, only select, high-acuity surgical cases were consolidated to Hospital A. A governance structure for the CV service line also was developed that included physician representatives from both programs. This structure proved to be instrumental in winning support for the initiative from the Hospital B surgeons who had initially objected to it. The strategy gave all stakeholders time to process the change, witness the outcomes, and begin to understand their physician counterparts. The initiative’s success was attributed, in particular, to the way the governance structure encouraged physicians from both hospitals to meet regularly, discuss strategic initiatives, and—perhaps most important—view outcome reports from physicians across both hospitals to dispel the belief that one program was better than the other.

Although the transition was slow, this consolidation spurred improved outcomes because the health system was able to dedicate more resources to the consolidated CV surgery program, and because its CV surgical group became much more collaborative. Additional benefits were gleaned from increased economies of scale and cost efficiencies that allowed the health system to invest in facility upgrades and new technologies. Although such an approach will not work for every organization, this health system’s experience exemplifies the types of challenges an organization might face in pursuing a service line rationalization strategy, and the types of decisions it can make to meet those challenges.
guiding principles, evaluate available options, and reach consensus on the preferred path.

When evaluating options with physicians, the case for rationalization must be supported with credible clinical and financial data. To be effective, the data must be presented in a way to overcome the typical objections of “our patients are sicker,” “the cost allocations are arbitrary,” and “your data are old.” The data should be converted into graphs that are digestible and help the physicians reach appropriate conclusions. A picture is worth a thousand words.

Even after these steps—involving physicians in a thoughtful process and providing them with data that supports the health system’s plan—the question remains, what is in it for them? Plans for the new, rationalized service must be accompanied by a structure that somehow delivers clear advantages for the physicians—both collectively and, in the best of circumstances, individually. Benefits to physicians may take the form of more money, greater control, improved efficiency and convenience, enhanced patient outcomes, or new gadgets. Ideally, a key component of enhanced alignment is an enhanced shared leadership model that will position physicians to be able to maintain the highest standards of quality and safety, achieve efficiency goals, pursue service line development opportunities, and foster relationships throughout the medical staff.

Prioritizing key opportunities. Finance executives have a critical role to play in helping the organization prioritize rationalization opportunities. However, the opportunity with the highest ROI is rarely the best place to start. In most rationalization efforts, it is best to look for low-hanging fruit in service lines that are not high-profile to obtain an easy and early win. More politically charged opportunities that provide greater value to the organization can come later, after the system has gained momentum and the culture is more supportive of the rationalization effort.

Some hospital systems opt to transition services in phases. For example, if a health system has two cardiovascular programs in close proximity to one another that it wants to consolidate into one facility, it may initially choose to transition only high-acuity, low-volume procedures (e.g., complex aortic valve replacements) to one facility over another. Although the objectives achieved through this approach may be only near-term, providers have an opportunity to experience day-to-day changes on a smaller scale and to work together more closely and develop a trusted relationship. This approach also can benefit from a common consensus among cardiovascular clinicians and other stakeholders that the outcomes of these high-acuity procedures benefit from higher volumes.

Other health systems may opt for a more aggressive approach, but they typically do so only if some level of stakeholder support exists from the start of the process, and there already have been positive discussions revolving around how best to effectively transition services. In some instances, in particular, the benefits of combining resources to produce an enhanced program overall (e.g., a comprehensive cancer institute) may be apparent to all stakeholders, resulting in a win–win mentality in which everyone has a positive stake in the outcome.

Regardless of an organization’s preferred approach, making changes on a smaller scale where success is highly likely can be an effective way to show the benefits of rationalization and gather enough support and trust to then broaden the scope.

It also is important not to lose sight of the opportunities that generate the greatest
long-term value. As opportunities are vetted and prioritized with the stakeholder team, it will be important for all parties to understand the relative ROI of each of these initiatives and how it enhances quality. If these points are explained correctly, stakeholders should be able to understand the relative trade-offs required for each initiative and how it ultimately will benefit every organization in the system.

**Adhering to a well-developed implementation plan.** Rationalization is a transition that requires a substantial time commitment; it cannot be managed periodically or during spare time. Firm timelines and high levels of accountability are critical factors. The work plan should define who, what, when, and how to ensure all stakeholders have a common understanding of the process and timeline. Without a commitment to a schedule, the pressures of competing interests will take hold and delay a rationalization effort, putting its success at risk.

Organizations often adopt a risk management process to provide a mechanism for identifying and quickly resolving problems that could jeopardize a project’s success. Incorporating such a process can help the team identify risks early and prepare contingency plans to mitigate their effects. Under most rationalization efforts, the risks are numerous. Examples of areas where risks will need to be managed include:

- Inability to gain stakeholder support
- Licensing, legal, and political concerns
- Competitive responses

These areas all deserve attention from the start to assess their probability of occurring, their potential severity if they occur, steps required to mitigate their occurrence, and the contingency plan that will be used if they do occur. Ongoing monitoring of risks as the initiative moves forward will improve the likelihood of success and facilitate effective communication.

There is no such thing as over-planning or over-communicating a rationalization initiative. In fact, when undertaking a transformative process like rationalization, having frequent, open communication with staff and stakeholders can dispel rumors and uncertainty about the system’s position. A communication strategy and action plan create awareness, understanding, and commitment to the rationalization initiative.

The objectives of a communication strategy should be to:

- Provide stakeholders with a clear vision of the benefits to patients, the community, and the organization
- Keep stakeholders informed about the process
- Foster commitment among the leadership team, ensuring team members truly understand and are ready to do what is required to support change
- Overcome staff resistance and reduce anxiety and fear by clarifying plans and their objectives
- Promote involvement in the change process

**Key Considerations**

Successfully rationalizing the delivery of services requires a system to overcome a variety of strategic, financial, operational, and cultural obstacles. Examples of such considerations are detailed in the exhibit on page 7.

Strategically, many health systems are reluctant to venture down this path for fear of disrupting care and alienating important constituencies. Relocating services tests patients’ loyalty and willingness to accept change, opening up a potential opportunity for competitors to capture disenchanted patients and unhappy physicians.
COVER STORY

Financially, rationalization necessitates a thorough examination of the costs associated with the services in question as well as the direct and indirect impact on related offerings. Rationalizing service lines may trigger a cascading economic effect on related services throughout individual organizations and entire systems, testing understanding of complex cost and revenue dynamics. For example, if a health system invests in Hospital A’s obstetrics program, will it also need to expand the neonatal intensive care unit? Will OB/GYNs start performing more of their surgeries at Hospital A, too? Should the health system target a closer relationship with the independent OB/GYN group or recruit into its medical group?

Operationally, the health system will need to address the following questions:

- What are the opportunities to improve outcomes through service-line redistribution and integration?
- Where are services located today, and how can distribution be optimized?
- Where are our bottlenecks? Does our intensive care unit fill up before other areas of the hospital, for example?
- How should we adjust capacity to account for declining utilization?

As noted previously, one of the chief considerations from a cultural standpoint is the strong tendency, especially in recently formed systems, for staff and leadership in specific hospital facilities to fight to preserve the services and relevance of their facilities without regard for a larger system strategy. This mindset can be overcome only if senior leadership is steadfast in communicating and disseminating a vision for the health system with a focus that looks beyond the walls of their hospital and toward what is best for the region, system, and population.

### A Rationale for Rationalization

There is a common perception in health care that rationalization is a code word for service reduction. In reality, however, rationalization is an approach that can help a health system optimize its resources and enhance patient access across the entire organization. In an ideal world, hospitals would be able to spontaneously

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<th><strong>Strategic</strong></th>
<th><strong>Operational</strong></th>
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<tr>
<td>Patient and provider loyalty and retention when services are relocated or consolidated</td>
<td>Potential to improve outcomes through volume consolidation of high-risk procedures</td>
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<td>The potential extent of competitive response and potential local market shifts</td>
<td>Downstream implications, such as opportunities for ancillary services and complementary clinical services</td>
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<th><strong>Financial</strong></th>
<th><strong>Cultural</strong></th>
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<td>Impact of lost revenue streams and associated contribution</td>
<td>Reactions of medical staff and hospital leadership</td>
</tr>
<tr>
<td>Implications of value-based payment and other financial and cost-related factors</td>
<td>Shift in mind-set from silo to system orientation</td>
</tr>
<tr>
<td>Hospital and CEO performance incentive structures</td>
<td>Previous promises and agreements made to boards, communities, and donors</td>
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**KEY CONSIDERATIONS FOR SERVICE-LINE RATIONALIZATION**

- Patient and provider loyalty and retention when services are relocated or consolidated
- The potential extent of competitive response and potential local market shifts
- Opportunities for clinical service affiliations to focus on service lines where the organization has superior capabilities
- Potential to improve outcomes through volume consolidation of high-risk procedures
- Downstream implications, such as opportunities for ancillary services and complementary clinical services
- Reactions of medical staff and hospital leadership
- Shift in mind-set from silo to system orientation
- Previous promises and agreements made to boards, communities, and donors

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hfma.org DECEMBER 2016 7
transform their service line structures to address the shift from inpatient services to ambulatory and virtual encounters. But the reality is not so simple, and rationalization decisions can have significant political ramifications. Even if most stakeholders support the change, the competing financial incentives among individual healthcare entities within the system don’t always lend themselves to a rationalized structure.

Yet as healthcare organizations continue their quest for more-efficient care models, many communities still seek a “one-stop shop,” despite the risk of service duplication, overcapacity, and increased costs. Such demands from consumers and communities cause health system leaders to feel limited in their ability to execute change within their organizations, even as they recognize the benefits of a more rationalized strategy.

If approached thoughtfully, thoroughly, and inclusively, however, rationalization can rid an organization of wastefulness and cost-ineffectiveness and transform it into an exemplar of value-based care.

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