

# Care in Congenital Interventional Cardiology is Regionalized

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## Introduction

For each SCAI clinical practice area, collaborative think tanks consisting of interventional cardiologists, administrative partners, and industry members meet annually at the SCAI Annual Scientific Sessions meeting to discuss topics of particular interest to the group. The proceedings of the congenital session in 2022, which focused on regionalization of care, are presented in this document. Regionalization of cardiovascular consideration has been a much-discussed theme concerning careful results. It has been argued that regional centers with higher volumes can lower mortality and produce better outcomes. According to the IMproving Pediatric and Adult Congenital Treatments (IMPACT) registry of the National Cardiovascular Data Registry (NCDR), between 27,000 and 30,000 diagnostic procedures are carried out across the country each year [1].

Atrial septic defect closures, coarctation procedures, valvuloplasties, patent ductus arteriosus closures, pulmonary artery procedures, and trans catheter pulmonary valves are among the additional 11,000 interventional cases that the NCDR reports annually. These cases are not equally distributed, and there is a wide range of volume in centers. When only high-risk procedures are regionalized in models based on US data, this beneficial effect is not observed, despite the fact that a significant portion of these data on regionalization come from outside the United States. Regarding the regionalization of complex congenital cardiology care, several strengths were identified. In other areas, like single-ventricle outcomes, standardization of processes and procedures has been shown to increase survival in high-risk situations. Improved communication with a dedicated and specialized team that is well-versed in caring for these patients and increased volumes leading to increased experience may be the advantages of centralized care for high-risk diseases [1].

## Description

The concentration of specialists in a single area may result in improved postoperative care and shorter stays overall. However, it is unclear how surgical mortality directly relates to interventional cardiology outcomes. Some studies indicate improved surgical mortality rates in particular case types 2. The outcomes of salvage and rescue procedures demonstrate value, but it is difficult to quantify this value. Because the overall mortality rate in congenital interventional cardiology is so low (ranging from 0.08% to 7.2%), it is difficult to find value as an outcome measure. However, if a center can successfully negotiate with a potential payer with proof of improved outcomes and reduced morbidity, centralized care may potentially increase revenue. Centralization of training efforts may standardize education and improve outcomes. Due to the absence of a standardized curriculum or board certification, congenital interventional cardiology training does not currently have a regulated standardization. Having fewer centers, on the other hand, could speed up the industry's distribution of device training [1].

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The group looked at a proposal for regionalization's flaws and found several of them. It's possible that a surgical specialty's improved mortality outcome potential cannot be measured. The overall mortality rate of interventional procedures is very low, and the direct measures of success presented in support of surgical regionalization would not be directly applicable. Additionally, the proceduralist's skill is required to achieve the claimed reduction in surgical mortality. Precision care is made possible by the regionalization of skilled physicians who handle the majority of difficult cases; however, neither the identification nor distribution of these individuals is understood. It is possible to recruit experienced interventionists from large programs to take on more administrative responsibilities in smaller programs. As a result, some smaller programs may actually have excellent operator talent and do not require a centralized institution to be referred for local complex and challenging procedures. The program's volume or size may not necessarily indicate true proceduralist talent, but rather opportunity. Results may suffer as a result of less competition and acceptance of the institutional status quo. The training of medical students, residents, and fellows, as well as their exposure to the field, would be compromised, resulting in only regional centers recruiting specialists [2].

The junior interventional faculty's development and training would undoubtedly be compromised. Community care providers and centralized hospitals' communication would be compromised. The conversation of distance from the middle is maybe one of the main contemplations as this might prompt expanded variations in view of financial class. Families might not have enough money for travel or lodging. Additionally, the current insurance infrastructure with a non-single-payer system might make it possible for multiple payers to allow travel to a regionalized area that public payers might not. In addition, families with lower levels of health care literacy may not be aware of the specifics of when a patient needs to be transferred, and those with lower socioeconomic status may not have the means to travel long distances or take time off from work to get care. All of these factors, taken together, could lead to an increase in disparities in outcomes based on the type of insurance or socioeconomic status [3].

Opportunities exist to enhance the infrastructure of congenital interventional cardiology, in addition to its strengths and weaknesses. The current model of centralized heart transplantation, in which best practice is promoted by government regulatory guidance, has been quite successful. The improvement and regulation of specialized care could take inspiration from this kind of regionalization. One more model for regionalized care is that seen with grown-up inborn coronary illness license as a way to work on unified care. Official license, while not expected to give grown-up intrinsic coronary illness care, gives normalization and accreditation of care. A regionalized care model may make it easier to identify and process high-risk procedures, and this risk assessment may improve overall care by optimizing preparation and planning [4].

There may also be a number of threats to this idea. Regionalization would put the health care system at risk because medicine is currently a for-profit industry. Innate interventional cardiology, as a substance, upholds different fortes in pediatric institutions. Regionalization of such consideration would definitely think twice about care gave beyond the essential community. Additionally, the identified center might be underutilized, overwhelmed, or simply unable to handle the increased number of complex patients. Institutions outside of the regionalization may choose more invasive procedures because less invasive (interventional) procedures may not be available, thereby limiting treatment options. Last but not least, interventionalists' job satisfaction may significantly deteriorate, reducing the number of specialists in the field [5].

## Conclusion

Despite the fact that regionalization of interventional care may have a number

of potential benefits, including improved care quality and potential cost savings, the disadvantages and threats outweigh these benefits. Regionalization of congenital interventional cardiology is neither feasible nor proven to be beneficial in the current state of public and private insurance providers. This topic will need to be revisited frequently as anticipated changes in health care reimbursement occur. The expert opinion of the SCAI Congenital Think Tank Group is that it is still the interventionalist's responsibility to seek the best center for the patient to optimize care at this time, rather than mandated regionalization of care.

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