Office-Based Labs: Getting Started

An in-depth look at the development and key issues related to office-based labs (OBLs) from the perspective of a physician who made the OBL leap and can offer valuable lessons learned.

The movement of doctors and patients away from hospital settings to outpatient venues such as office-based labs (OBLs) and ambulatory surgery centers (ASCs) is expected to increase 18% by 2019. Trend underpinnings include improved patient outcomes, greater autonomy for doctors and staff, and reduced costs for the overall health care industry. Patients are increasingly seeking care closer to home, without having to wait long hours to see a physician, and in a more comfortable, patient-focused environment with friendly, familiar staff. On the provider side, OBLs offer physicians greater control (and accountability) over the entire medical procedure from the initial office greeting to post-op instructions and follow-up. Health care savings accrue from reduced overhead rates, no overnight stays, increased flexibility and productivity by owning the full process, and eliminating inherent inefficiencies related to inpatient procedures.

Improvements in medical technology have also played a significant role in furthering this trend. New technologies offer enhanced capabilities in smaller packages and footprints, making it easier and cost-effective to treat increasingly complex maladies on an outpatient basis.

Varieties of clinical outpatient models exist, ranging from a singularly focused OBL to multidisciplinary OBLs to hybrid models that combine both the OBL and ASC.

This migration away from large hospitals began almost 20 years ago with the formation of renal dialysis centers, followed shortly by cath labs and endovascular lab services. Today, even some cardiac interventions are safely completed in ASCs.

TRANSITION TO A HYBRID OBL/ASC MODEL

Having recently transitioned to a hybrid model, can you tell us about your original OBL?

Dr. Cross: We started our OBL, Waco Cardiology Cath Lab and ASC, almost 5 years ago. We partnered with the National Cardiovascular Partnership, a management group that executes the day-to-day operations, administrative, and business concerns of the practice. Our physician group, which includes 10 doctors, is focused almost exclusively on the clinical and patient care side. This structure has been very enabling, freeing up the doctors to concentrate on the patients and facilitating our management group to do what it does best—running the business end. Initially, we started somewhat slow in regard to the types of procedures, but quickened the pace as we became more comfortable. Our emphasis has always been on cardiac and peripheral disease.

When did you make the transition to a hybrid OBL/ASC?

Dr. Cross: We launched our ASC 1 year ago and now operate as a cath lab OBL 4 days a week and as an ASC 1 day a week. Similar to OBL benefits, the ASC enables us to improve work efficiency and quality by removing many of the variables hampering hospital schedules, such as case turnover, wait times, unavailability of rooms, unexpected delays, etc. In addition, we can increase our practice income by recovering more of the technical and facility fees through ASC work.

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Can you tell us about the transition from an OBL to a hybrid model?

Dr. Cross: Frankly, our management partner recognized the benefits and opportunities that would accrue by incorporating an ASC along with our OBL.

The ASC provides a higher level of care and, accordingly, we have had to institute enhanced safeguards and procedures surrounding infection control and the use of anesthesia. We quickly realized that we could continue to deliver optimal patient care in the outpatient setting. It was valuable for our patients and professionally satisfying for the physicians, so we transitioned with the leadership and counsel of our management partner.

What are the benefits of partnering with a management group in the launch and operation of an OBL/ASC?

Dr. Cross: The partnership enabled us to spread financial risk and move forward quickly. The management group was eminently skilled on the business end of the practice, enabling the doctors to do what they do best—taking care of the patients. The management group was also instrumental in helping with the state regulations, which can be tricky to navigate. Additionally, they assisted with site selection, building design, equipment selection and payment options, staff recruitment, supply purchasing, medical and management information systems, and then they largely managed the daily operations.

What have been the benefits of the hybrid model?

Dr. Cross: The biggest benefit is that it has allowed us to increase the types of patients and the number of patients for whom we can provide care. Our patients really enjoy and appreciate the ability to have their surgical procedures in an outpatient setting with consistent and compassionate staff.

Another good thing in having our own lab is that we work closer with our staff. We are more engaged in making sure that there is collaboration, good communication, and that they are on top of their game. The physicians and staff represent the Waco Cardiology Cath Lab and ASC brand.

Have you seen any changes in the practice over the last 5 years?

Dr. Cross: Mostly routine changes. We have had some turnover in partners as three of our senior colleagues have retired over that period. However, the opportunity to hire new physicians with new ideas has been beneficial in keeping abreast of contemporary technology and procedures.

The types of patients we have taken care of over the years probably have not significantly changed. The prevalence of peripheral artery disease (PAD) has increased, but we have stayed ahead of the curve by offering a comprehensive line of service to care for those patients.

Technologies have changed, and there are different things we are doing now that we did not do 10 years ago in the peripheral and cardiac realms. For example, we recently adopted the Philips Atherectomy device to assist in treating our PAD patients. We have embraced innovation over the years, as many of the new devices and equipment were developed with an eye toward suitability in the outpatient arena.

How have you worked with industry to introduce new technology into your facility?

Dr. Cross: We are always open to new technologies that improve patient care in our market space. I know that Philips has modified their strategy recently to provide a more full-service OBL offering. This could be beneficial to newcomers contemplating an OBL or hybrid.

What advice do you have for other physicians considering an OBL?

Dr. Cross: I would tell them that it’s a great idea. It is an opportunity for physicians to remain independent and grow their practice. To be more involved in the decision-making process in terms of patient care and selecting what type of technology should be used is something most doctors would relish. And of course, there are a variety of models you can adopt depending on your risk profile and predilections. Our model was to partner with a management group that helped us set up the OBL and ASC and then provide the administrative support. That allowed our physicians to concentrate on their specialty—providing quality care to patients with cardiac and peripheral disease. Again, companies like Philips can also help with menu support with capital equipment, devices, consumables, financing, and lab build-out consulting. For those physicians who want the full experience of owning, running, and providing direct patient care—that is certainly an option as well.
heart catheterizations and peripheral angiograms/interventions. Something we’ve started to do more of is intervening through radial artery access. Although not new to us, we decided to increase our use of this technique versus the femoral approach. While it is technically challenging, we are more experienced now, and the benefits to our patient—including less discomfort, improved time to ambulation, reduced costs, and a reduction in potentially life-threatening complications—are too compelling to pass up. It was purely a patient satisfaction decision.

Our patient profile is pretty similar on both sides of our model, with the ASC enabling us to treat patients who require slightly more complex therapies than the OBL (but less complex than the hospital) and with general anesthesia when required. On the ASC side of our hybrid lab, we primarily perform the device cases, such as pacemaker and defibrillator implantations.

In fact, patients oftentimes need a procedure in the OBL and subsequently need a device implantation in the ASC. Additionally, there are times that we’ll perform peripheral procedures in the ASC because a patient’s insurance will authorize a peripheral procedure in the ASC but not in the OBL. By in large, the ASC has really enabled us to capture a larger percentage of procedures outside of the hospital.

What were the biggest changes required for your ASC?

Dr. Cross: We did go through a fairly major design change and reconstruction. To receive licensing for an ASC, you have to meet higher standards. Things such as the width of doorways, the number of preoperative and postoperative beds, emergency backup power, and a 1-hour–rated firewall were some of the additional requirements we had to meet to become certified. Unfortunately, we could not merely expand our OBL into an ASC; we had to start a new construction site in a different but proximal location. It was a pretty large evolution with its attendant costs.

Do you have any lessons learned to share with our readers regarding getting started?

Dr. Cross: I wish we had planned for a larger location to accommodate growth or opened up as a hybrid from the start. My advice is if a physician or group practice is capable of performing the various therapies performed in an ASC, then jump straight to the hybrid. By planning ahead and at least preparing to be an ASC, you can avoid having to pay for construction twice.

Another lesson I recall from our first discussion involved our alliance with National Cardiovascular Partnership, the management group that does most of the day-to-day business operations. For us, this was the way to go—an equity partner that helped spread financial risk, got us up and operating quickly, and remained involved substantially in running the business end. However, some OBLs might want to team with a full-service provider, such as Philips, who can provide entrepreneurial physicians with a fully integrated solution. Specific capabilities include outfitting OBLs and ASCs with capital equipment, medical devices, and related disposables; offering financing options; and delivering physician-assisted training and other advisory services. Of course, it all boils down to physician preference, experience, and the specific business model you want to execute.

Do you use Philips capital equipment or medical devices to support your therapies?

Dr. Cross: We use digital intravascular ultrasound (IVUS) and the Phoenix atherectomy system. Frankly, the innovation and technologic advances from companies like Philips and other health care companies have facilitated this current outpatient trend, and they will likely contribute to further therapy migration away from the big hospitals in the future.

The role of digital IVUS in our office has been key to increasing our diagnostic accuracy of stenotic areas within the vascular system. With IVUS, you can better assess how occluded an area of the vessel is when angiography is inconclusive. IVUS complements angiography, ensuring we intervene when necessary and don’t when it’s not.

We also use IVUS to evaluate the density or plaque burden, help guide the balloon or stent into position and, after intervention, get a good sense of how well our devices are improving the luminal area and whether anything else needs to be done. With recent technologic enhancements like the bioresorbable scaffold, precise sizing and placement of the stent can lessen the chances of malapposition, edge dissection, and other postimplantation problems.

The Phoenix 2.4-mm atherectomy device is nice because it provides a rotational process to help cut and clear the plaque, and it is also a directional device; so you can change the direction of the head in cases where the vessel is larger than the diameter of the cutting blade. In addition, Phoenix’s capability to capture and clear matter while you’re working is helpful. This feature helps me to work more confidently...
with a reduced concern of distal embolism or other problems. Although there is no single atherectomy tool for all situations, the Phoenix device performs well in many settings and I use it frequently.

BUSINESS OPERATIONS AND GROWTH STRATEGIES
How did you establish business processes and procedures in your OBL/ASC?

Dr. Cross: Launching an OBL and/or ASC can be a daunting task. As doctors, our expertise and desires lie with the medical specialties and providing outstanding patient care. However, some physicians are drawn to the challenge of setting up and running both the medical and business sides of an OBL, affording them complete control over the entirety of the operation. Our group opted to go with a business partner that had expertise in all areas of starting and operating an OBL/ASC to help us get started. They remain our partner today and are responsible for all aspects of running the operations. Another option is to partner with a large manufacturer, such as Philips, that can provide the full suite of capital equipment, disposables, and equipment services. If your practice does not have the expertise in launching an OBL, these last two options may be the faster path to take. They can help you navigate through the various stages of launching your OBL.

How do you evaluate and improve processes?

Dr. Cross: Our ASC is accredited through the Joint Commission and must be maintained to the highest standards. Like any business, we develop and track metrics to help assess how we are doing. For example, when our measures for hospital transfers, infections, and/or patient satisfaction, vary from the norm, we can identify the issue and implement a course of action to bring the metrics back in line. This enables us to meet or exceed expectations. So far, for 2017, our overall patient satisfaction rate is 97.5%. Additionally, 98.2% of patients would recommend our facility to their family and friends.

As medical director of the OBL, I meet monthly with the staff to review issues and measure variances pertaining to patient care. Our leadership also meets to focus on the business. We discuss a variety of topics, including patient flow, patient satisfaction, and processes that we can improve. We consider acquiring new equipment or devices at that time, particularly if it would result in improved quality and care. Last, we stay current on industry practices and clinical skills through continuous education.

How does the hybrid model affect utilization and growth?

Dr. Cross: The addition of the ASC was a business decision that enabled us to capture more cases. We perform between 95 to 110 cases per month in our hybrid lab, which has an approximate utilization rate of 80%. In the OBL, we mostly perform heart catheterizations and peripheral interventions. On the ASC side, we perform about 12 to 18 cases monthly, mostly device implantations (eg, defibrillators, pacemakers) and interventions that we cannot perform in the OBL due to insurance company guidelines. The ASC has really helped increase our overall utilization.

What else have you done to grow your practice?

Dr. Cross: Beyond the ASC, the key to growing a practice is having good communication with the doctors who refer patients to you and good communication with their patients. Educating primary care physicians on what you do and how you can help their patients can have a huge effect on growth. Occasionally, we’ll invite physicians to special events. These are usually smaller, more intimate gatherings where we’ll give a talk on one of our therapies followed by a Q&A session. We have done that on a larger scale as well.

Patient-centered events include free screenings for PAD or venous disease. We’ve been thinking about putting together courses that our nurse practitioners can teach to a group of patients with specific ailments that we can treat. Our top referral sources are from wound care clinics, including wound care specialists and podiatrists. It is often difficult to diagnose PAD, so we convey the importance of considering PAD as a diagnosis, treatment options, and our capabilities to these specialists. These types of conversations often result in a significant number of heart-related referral patients as consults from primary care physicians or following discharge from the hospital emergency department.

PREDICTIONS FOR OFFICE-BASED LABS
What major trends are driving the health care industry in the next 5 years?

Dr. Cross: Despite a lot of congressional posturing and hyperbole, I do not anticipate much change. Top issues include whether Obamacare is repealed in whole or part and the extent to which Medicare Access and CHIP Reauthorization Act (MACRA) is implemented. MACRA is the Medicare payment reform framework that rewards physicians for providing higher-quality
The biggest unknown in today’s environment is the unknown. We cannot predict its precise direction, but our hope is that insurance companies and the government continue to value the product they are getting from OBLs and ASCs in terms of quality and affordability.

What changes do you anticipate in the patient journey?

Dr. Cross: How physicians take care of patients in the United States differs depending on location of the practice. In most places, a primary care physician (PCP) refers a patient to a specialist, a consult ensues, the problem is fixed, and the patient goes back to the PCP. Here in Texas, when we diagnose a patient with coronary disease or peripheral vascular disease, we will see that patient in follow-up and become more involved with the PCP and the patient moving forward. I’m not sure which scenario is better in the long term. It’s complicated by factors such as PCP workload, patients with several maladies, and patient preference. Interestingly, I do not believe it’s driven by insurance. To my knowledge, there have not been any CMS guidelines on how often a patient should be seen based on type and severity of an illness.

Looking ahead, what types of procedures do you see transitioning out of the hospital and into an OBL/ASC?

Dr. Cross: Building on past success, I believe we will continue to see procedures transitioning from the hospital and into the outpatient setting. Our record of safety and patient outcomes represents a harbinger of increased migration away from the hospitals, facilitated in large part by improved medical devices and techniques. For example, some insurance companies already reimburse for coronary stenting in the outpatient setting. Other potential outpatient procedures I envision include transcatheter aortic valve replacement (now indicated for high- and moderate-risk surgical patients) and mitral valve replacement or repair.

Improvements in medical technology continue to play a significant role in furthering the outpatient trend. New technologies offer enhanced capabilities in smaller packages and footprints, enabling ever smaller patient access points with quicker recovery times. Combined, these advancements make it easier and cost-effective to treat increasingly complex maladies on an outpatient basis.

1. Advisory Board’s Cardiovascular Roundtable, 2015–2016 National Meeting

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