When Is Opening an Outpatient Access Center a Bad Decision?

Jeffrey G. Hoggard, MD, discusses what it takes to prevent an outpatient facility from failing and how providing quality care leads to success and more patient referrals.

What kind of individual/physician is ill-suited to work in an outpatient facility?

The physician who does not place safety first is ill-suited. Possessing excellent technical skills for the particular procedures may not be enough. The physician should be up to date on Basic Life Support and Advanced Cardiovascular Life Support certification, as there is not a hospital code team down the hall. He or she should be able to direct the team in an emergency. Elective procedures should not be performed in unstable patients; an experienced clinician should recognize subtle instabilities in the patient's presentation and postpone any procedures until the patient is more stable.

Ignoring the economics of the facility can also be problematic. If one ignores these cost issues, the center may fail financially and in serving its patients.

I believe the desire to be an exceptional communicator and to act as a team leader is an important quality. The willingness to provide excellent medical documentation in a timely manner enhances the quality of care and follow-up for the patient. Many of the staff will be cross-trained to perform various jobs in the outpatient center. The ability to accommodate a broader range of technical experience in the staff and a willingness to teach are desirable qualities for the operator in an outpatient setting. These qualities tend to engender an enjoyable and rewarding working atmosphere and cause less staff turnover.

What factors would make it unsafe to perform outpatient procedures?

As previously mentioned, unstable patients should not undergo elective procedures in an outpatient center. Obviously, a center must have all of the necessary equipment and drugs in case of an emergency. Understanding the risks of each procedure can help one be prepared for such an emergency, and an emergency response protocol should be in place. A transfer agreement with a local hospital should also be mandatory.

What types of startup costs might make it prohibitive?

One should carefully review a pro forma of the procedures, the anticipated volume of procedures, and reimbursement scenarios before committing to the facility, personnel, and equipment costs. Certain states have Certificate of Need laws, and these administrative costs and legal fees can certainly negatively affect startup costs.

What is the minimum amount of structure needed, below which a center will fail (ie, nurses, techs, administrators, PACS, EMR, marketing, quality, patient prep, and monitoring)?

One has to follow the state laws that govern outpatient medical facilities. A registered nurse will be required to administer and monitor moderate sedation through recovery. Monitoring equipment will also be required. Some states allow the physician to operate the radiology equipment, whereas others require a radiology tech. A radiation safety program is a must. Some states will specify certain space obligations for the parking lot, waiting room, and patient evaluation areas. I would first check state regulations to determine the minimum amount of "structure." EMR and PACS are not crucial but are highly recommended. Marketing may or may not be part of the "minimum" startup structure, but this depends on the presence of local competition providing the same service.

What are some of the mistakes made in trying to develop patient referrals?

I believe that traditional methods of marketing are the wrong way to go, but I am "old school" and not an MBA. I think that the physician-patient relationship is key. Satisfied patients will tell other patients about their positive experience at the outpatient interventional center, and that will lead to more referrals.

To expand my concept of "good" versus "bad" marketing, let me give an example. Marketing to a clinical nurse manager or medical director of a hemodialysis unit to send all of their access business to a particular outpatient facility makes little sense to me if there is no other competition. A coffee mug with your access center's name and phone number may be helpful if there are five different competing access centers, but is this really how you want to obtain your referrals?

If there is competition, the marketing should be aimed at patient service and convenience. This means extra communication with the patient and family to help with transportation, adjusting schedules to accommodate urgent thrombectomies, seeing the patient in a timely manner, arranging for makeup hemodialysis sessions, and providing personalized education about his or her dialysis access and cannulation strategies. The patient will recognize the compassion and concern that differentiate you from any other health provider services he or she receives. For me, this is just providing good medical care for my patients, but you can call it marketing, if you want.

The MBAs running the large health care companies haven't figured out a marketing strategy that solves the large number of "no-show" patients in this business. That is because they haven't walked in the shoes of a hemodialysis patient. I think my center has a low no-show rate because we understand their plight. Most of my staff has past experience working with dialysis patients, and we genuinely try to make any experience at our interventional center the best possible.

Are there minimum daily volume and/or case mix factors that could cause an outpatient center to fail?

It is probably best to consider yearly volume. For dialysis access procedures, reimbursement has trended downward, and a recent study suggested that an outpatient center needs to serve a minimum of 450 patients to avoid financial stress. Case mix will always be a factor in reimbursement and therefore affect a minimum volume requirement.

Can a center be successful if it isn't partnered with a much larger organization such as a national dialysis company or an organization that helps start outpatient facilities?

An independent center can be successful, particularly if it serves a large number of patients and performs a high volume of procedures. The large organizations can bring economies of scale to the business and might be a smart partnership for a center with a marginal volume of procedures.

Does the Affordable Care Act have any specific impact on starting a new outpatient center?

I am not aware of any direct impact. United States citizens who develop end-stage renal disease will receive Medicare coverage, and the Centers for Medicare & Medicaid Services remains the main source of reimbursement for interventional access care in this patient population. Future cuts in reimbursement in our field will likely lead to the closure of some outpatient centers.

Not being able to predict these future cuts in reimbursement is a difficult part of the risk assessment in opening a new center. Accountable Care Organizations are on the horizon. One would predict that these organizations would preferentially direct interventional access care to the outpatient centers because they have demonstrated excellent outcomes in a more cost-effective manner than inpatient or outpatient hospital care.

If you were to start your outpatient practice over today, what is one thing you would absolutely change? What would you be sure to keep in place?

Change: I would spend more time interviewing and selecting staff. Identifying those persons with the right skill sets and who will work together as a team in an outpatient center is important. Preventing staff turnover is a major issue in a small business with limited ability to buffer the workload of employees who leave.

Keep: For dialysis access interventions, I believe an access coordinator is essential; this person not only drives the referrals but is a key factor to quality care in my interventional program. ■

Jeffrey G. Hoggard, MD, is an interventional nephrologist at Capital Nephrology Associates in Raleigh, North Carolina. He has disclosed that Fresenius Vascular Care owns controlling interests in Raleigh Access Care, for which he is Medical Director. Dr. Hoggard may be reached at (919) 747-7820; jhoggard@capneph.com.