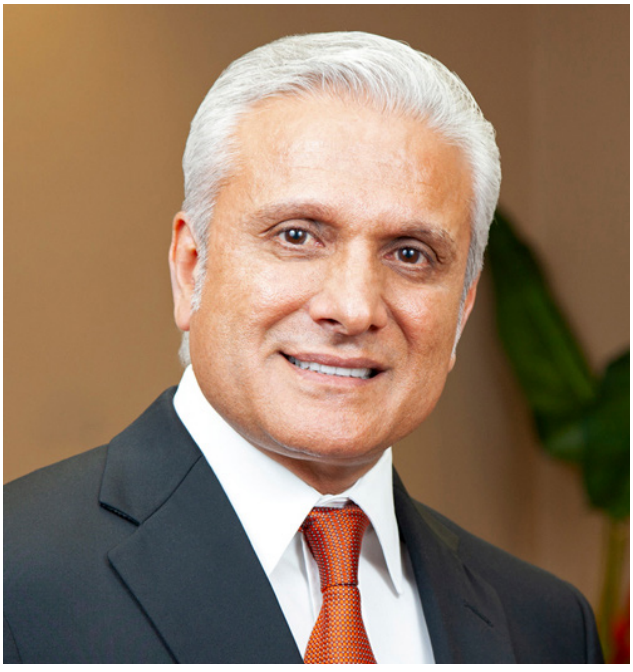
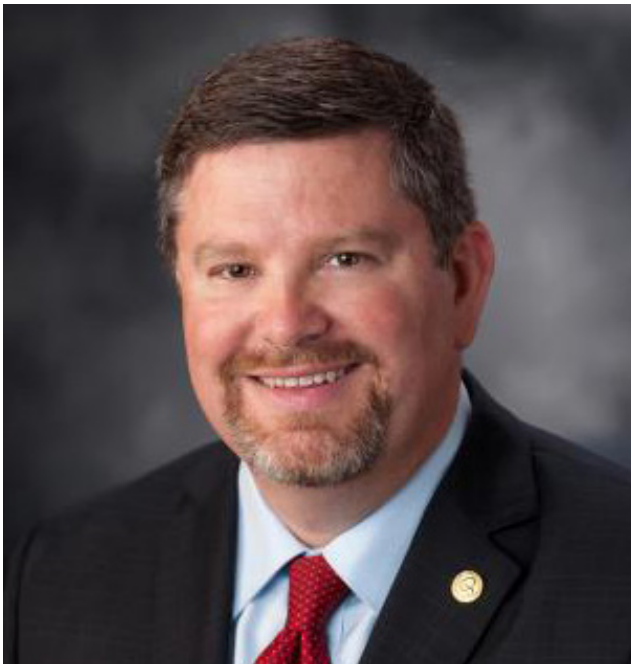
# The Collaboration Between Outpatient-based Labs and Hospitals Working together improves patient care.

*By Valerie Neff Newitt*



Laiq M. Raja, MD, FACC, FSCAI



David Konur, FACHE

As outpatient-based labs and ambulatory surgery centers (OBLs/ASCs) are becoming more prominent in the health industry, how do they work alongside hospitals? Outpatient and ambulatory centers can complement hospitals by expanding access to care in communities while helping hospitals grow their own programs. Two prominent health-care professionals, one clinical and the other administrative, reach similar conclusions from disparate perspectives: OBLs/ASCs and hospitals can form working partnerships that benefit each other to improve patient outcomes.

## THE CLINICAL VIEW

In 2001, Laiq M. Raja, MD, FACC, FSCAI, interventional cardiologist, joined El Paso Cardiology Associates working with The Hospitals of Providence – Memorial Campus in El Paso, Texas. He quickly realized many patients with vascular pathology were undergoing limb amputation. "Patients showed up in the emergency department with gangrene to the toe, had an ultrasound, a consultation, and an amputation below the knee. That was the gold standard," laments Dr. Raja. "There were limited treatment options for peripheral arterial disease, especially critical limb ischemia. Some patients were rejected by vascular surgeons because they were considered high risk – too old, too many comorbidities. They had nowhere to go, and physicians had no place to refer them. It was a black hole, and it wasn't acceptable."

In short order, Dr. Raja decided to train in endovascular work with Craig Walker, MD, in Houma, Louisiana. Once back in El Paso, he began a rigorous outreach to surgeons, podiatrists, wound care specialists, and family physicians to educate them about the specialized endovascular work he could perform. Referrals followed, and so did an unsurpassed reputation.

Realizing the complexity of CLI was best served by collaborative treatment from interdisciplinary physicians, Dr. Raja approached the hospital with an idea. "I said, 'Let's create a team of physicians to help patients at every stage of vascular disease, with true continuity of care,'" he recalls. It opened the door to his development of a robust CLI program of which he remains medical director.

Today, the hospital has one of the lowest amputation rates in the city.

About 10 years ago, Dr. Raja's team of 8 cardiologists hung their shingles on their own OBL, which also employs nurse practitioners, nurses, and a patient navigator. "Many patients just didn't need to go to the hospital," he says, noting the OBL provides easier access to care, more efficient scheduling, same-day interventions for critical cases, and patient convenience and satisfaction. "Patients avoid overnight hospital stays and hospital-acquired infections and enjoy lowered health-care costs and optimized care."

One might think such diverting of patients would have caused friction with Memorial Hospital, "… but it didn't," counters Dr. Raja. "The point is, it's important to maintain a strong working relationship with your hospital by becoming a thought leader and expert right within your hospital network. This will ensure patients requiring inpatient care have the best continuity and optimal outcomes. This is an important factor in keeping the hospital engaged in your success and in a relationship that is mutually beneficial. There are situations where patients are too complex and critically ill for outpatient treatment; the hospital is an essential partner in managing these patents." This partnership helps provide quality care regardless of the site of service and focuses on the patient's best interest for the best outcome.

## THE ADMINISTRATIVE VIEW

David Konur, FACHE, CEO of Cardiovascular Institute of the South (CIS), founded in 1983 by the aforementioned Dr. Craig Walker in Houma, Louisiana, has handled hospital cath lab programs since 1986. He, too, attests to the symbiotic relationship between OBLs/ASCs and hospitals.

"We were always solidly aligned with our hospital partners, so opening an OBL was a prohibited competitive move in another time," Konur recalls. "Most of our co-management agreements included a contractual prohibition from building our own OBL/ASC."

But then something pivotal happened. Competing cardiology groups started building them. "One summer we lost 2 excellent clinical candidates we'd been recruiting throughout their interventional and cardiology training, because groups with OBLs/ASCs were more attractive to them," says Konur. Those groups were making strategic decisions for their cardiologists and actualizing a business model that was financially successful. It wasn't the revenue stream that was the eye-opener for CIS, however; it was that stinging loss of clinical talent.

"I sat down with one of our hospital partners and said, 'We have to build an OBL. I suspect we will lose some cases from the hospital, but I also believe that new physicians we recruit will be more aggressive in looking for peripheral arterial disease (PAD).'"

CIS opened its first OBL in May 2017. Two years later, Konur presented data from the rollout. "It showed hospital volume actually went up, not down," says Konur. As he had suspected earlier, physicians became proactive in looking for PAD, and the success of the OBL bolstered the success of the hospital.

"Also, we did a better job of screening for PAD because we were investing in our first cath lab," he explains. "When we discovered PAD in a patient, we didn't stop there. If there was plaque buildup in the arteries of the legs causing claudication, often there was also plaque in the coronary arteries, or in the carotid artery. So, we identified various problems, and opened additional areas of treatment, some of which needed to be done in the hospital. Not only did our partner hospital see an increase in their peripheral vascular procedures, but also they saw an increase in their total procedures."

Furthermore, with the recruitment of additional physicians, Konur says, "We picked up market share. In the end, it was very clear in our case: there was an upward trend in hospital peripheral procedures, from an average of 375 per quarter to more than 500. The hospital's reaction was, 'Wow! This is really working.' They grew their program, and we added an access point for patients to get procedures done safely, at lower cost to them and their insurer."

Traditionally, the cardiac/coronary world never was heavily invested in ASCs, reminds Konur, because interventions were not reimbursable by Medicare. "Just go back 5 years to see that no one discharged a coronary intervention patient on the same day of the procedure. Some ASCs were bringing patients in just for angiograms, and because they weren't reimbursed for outpatient interventions, they would send patients to hospitals for stenting. We didn't feel that was best for patients."

But "… there was a tidal wave change in the coronary space last year," says Konur, explaining Medicare approved PCI reimbursement in an ambulatory setting effective in January 2020. "Once we could be reimbursed to actually fix what's wrong in the arteries of the heart following an angiogram, opening a center made sense. We opened an ASC amidst 4 markets in Louisiana. It's been successful thanks to strong demand from the community for procedures in a lower acuity setting. Also, there is a positive change in society at large about the outpatient world. Health care in general has never done a great job actually listening to patients about what they want. We listened."

## THE LONG VIEW OF EXPERIENCE

CIS now manages 14 programs, as its network of hospital partnerships continues to expand. "It's easier for us now because we have a proven track record," says Konur. With 2 Chicago-based hospital programs poised to join with CIS, Konur says he was able to connect hospital executives with peers at Louisiana hospitals.

Dr. Raja, too, is expanding the reach of Memorial's CLI program to 3 other hospitals, also in Tenet Healthcare system, in different parts of El Paso.

"The objective is to create the same program in the other hospitals," says Dr. Raja. "The CEOs are very enthusiastic about that, because it doesn't make sense that when patients show up in one hospital limbs are saved, but at another

hospital they are amputated. It should not be a lottery."

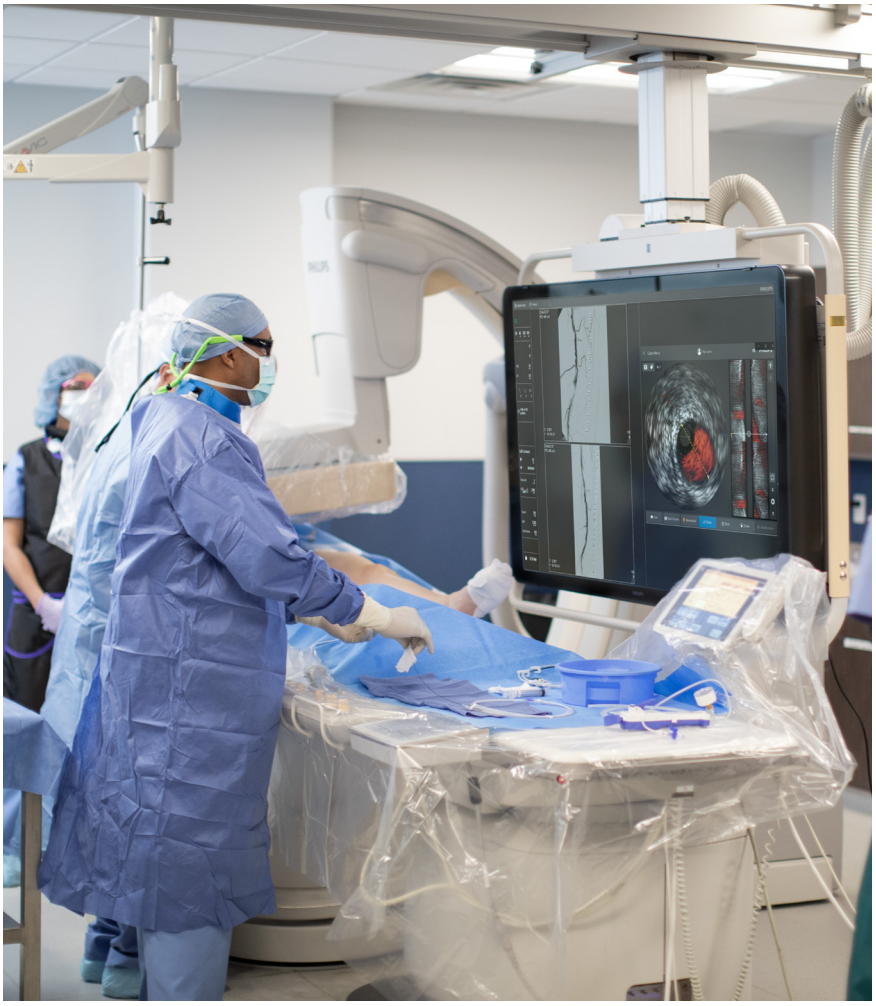
It is all part of a larger strategy to continue to bring greater excellence to health care partners and better outcomes to patients. "Our expertise allows us to set up programs, and thereby raise the reputation and credibility of the hospital. We make the hospital better, and in turn they see value in us. Then our OBLs become part of that value."

With years of experience under their respective belts, Dr. Raja and Konur are positioned to offer insights to others considering opening an outpatient facility. "I like to advise others that opening an OBL must be more than a financial issue," says Dr. Raja. "The objective must be providing better care to patients. That's number one."

"The second consideration is the size of their practice before opening an OBL. Some OBLs close within their first year because they don't have enough patient volume to support it," he warns. "There is equipment to purchase, staff to hire, bills to pay. In my case, I started practice 15 years ago, had a huge buildup of vascular patients, and did tons of cases in the hospital. So, my OBL quickly became very busy. Others must build up their practices, build up their referrals. They must reach out to GPs, podiatrists, wound-care specialists and say, 'I can do this work. I can give patients the best results. I'm always available.' They must cultivate a network of physicians who share a passion."

Once an OBL opens, Dr. Raja recommends assembling a top-notch clinical support team to assist physicians and hiring an office manager to handle nonmedical tasks like contracts, reimbursements, payroll, and staffing. He turned to a lab management group for such help before eventually handling those operations internally.

"Of critical importance, physicians must maintain a good relationship with a hospital, rather than seeing it as a competitor, and have treating privileges in case a patient needs to be transferred to a hospital should an emergency arise. It's necessary for continuity of care for patients."



Konur stresses the importance of doing an analysis to determine financial feasibility of opening an OBL/ASC. Current payer-specific volume must be compared against the number of daily cases required to break even.

With such caveats understood, Konur firmly believes OBLs/ASCs present tremendous opportunities for owners, those who partner with them, and those who avail themselves of their services.

"I promise you there are many patients out there who are not receiving the care they need, and access is one reason," he says. "In health care we shoot for the 'triple aim' – access to high-quality care at an affordable price. OBLs have a quadruple aim, adding consideration for providers. In an outpatient center, providers can set their schedule, and are not interrupted for emergencies. They do the same level of procedures without distractions every single day and are experts at them. Patients, treated and discharged the same day, are amazed."

And – finally – patients receive life-saving care that does not include amputation, reminds Dr. Raja. "Taking care of patients effectively and preventing amputations has always been the main goal at my OBL. We've attained that."

Konur adds, "Providers and others in health care must always ask, 'Is this in the best interest of patients?' That's the lens we must look through every day. The voice of patients matters. If you are in a big market and there is not an OBL or ASC then someone just isn't listening. Patients much prefer their procedures done in outpatient settings. So ultimately the decision to open an OBL/ASC must be made standing in the shoes of a patient."