Considerations for operating as an ASC

Physician Operators Forum
Las Vegas, Jan. 27-29, 2017
Randall L. Rasmussen, MD


Now, in your quietest golf-announcer voice, what seems to be the problem?
8·16·16

EXISTING PARADIGM: Provide dialysis access care in an EOP

* Vessel mapping
* Endovascular dialysis access therapies
* Related vascular procedures
  - PAD - diagnostic and therapeutic
  - Vein ablation
* PD catheter insertion and removal

Mission accomplished, we do a good job:
Clinical and Economic Value of Performing Dialysis Vascular Access Procedures in a Freestanding Office-Based Center as Compared with the Hospital Outpatient Department among Medicare ESRD Beneficiaries

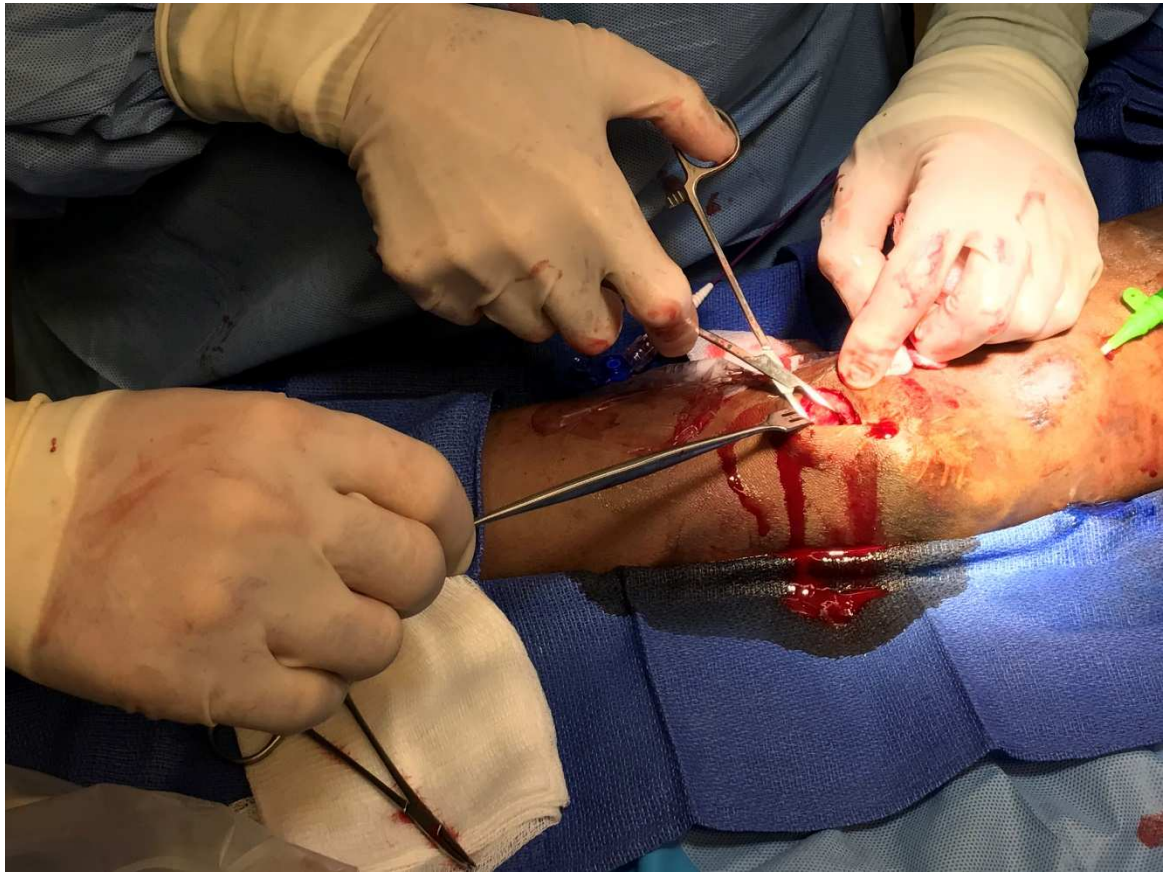
- Matched cohorts (n = 27,613)
- Patients treated in the FOC had significantly better outcomes ($p < 0.001$) including:
- **Fewer related or unrelated hospitalizations** (3.8 vs. 4.4)
- **Fewer vascular access-related infections** (0.18 vs. 0.29)
- **Fewer septicemia-related hospitalizations** (0.15 vs. 0.18)
- **Mortality rate was lower** (47.9% vs. 53.5%)
- **PMPM payments were lower** ($4,982 vs. $5,566).
- This study shows that DVA management provided in a Clinical and Economic Value of Performing Dialysis Vascular Access Procedures in a Freestanding Office-Based Center as Compared with the Hospital Outpatient Department among Medicare ESRD Beneficiaries FOC has multiple advantages over that provided in a HOPD

Audrey M. El-Gamil,* Matthew T. Shimer,* Joan E. DaVanzo,*Aris Q. Urbanes,† Gerald A. Beathard,‡ and Terry Foust Litchfield†*Dobson DaVanzo & Associates, LLC,
cular Access, a DaVita Healthcare Partners affiliate, and ‡Lifeline Vascular Access a DaVita Healthcare Partners affiliate and Clinical Professor of Medicine at the
Texas Medical Branch

ialysis—2013
/sdi.12120
y Periodicals, Inc.

Difficult cases can be done in the EOP model:

37 YOM on dialysis
Right brachial artery->cephalic vein AVF
Central Vein Stenosis
Flow 3,400 cc/min



PTA of central stenosis and
a banding procedure

2 months later

Existing paradigm – partial ownership of the access

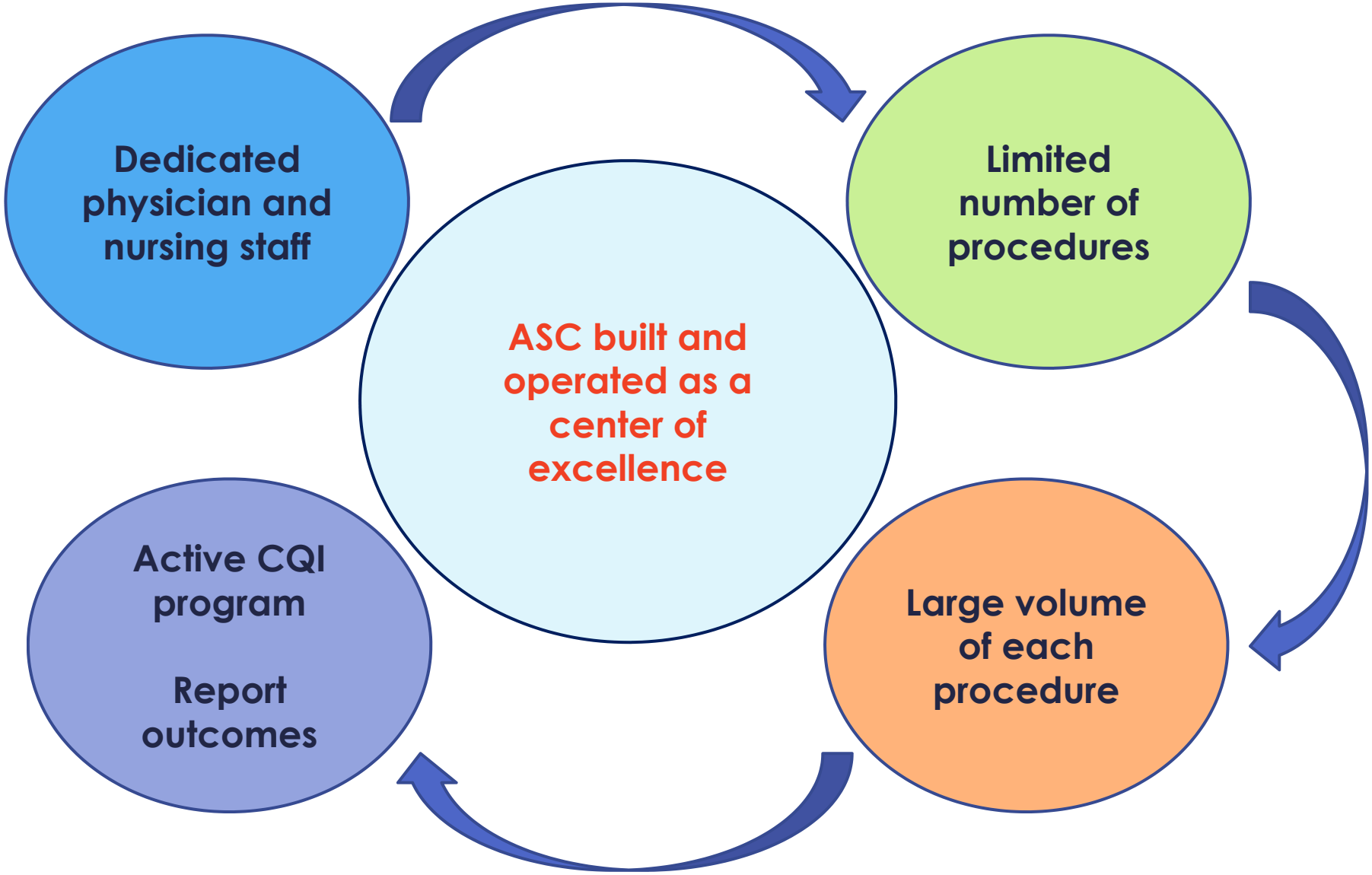
There is a limited amount of dialysis access care in an EOP

Care remains fragmented – a lot of access care is not done in an EOP

New Paradigm - full ownership of the access

In an ASC provide end-end care -> from vessel mapping -> AVF surgery -> maturation procedures and TDC removal

ASC/EOP Models



1. ASC is a highly regulated and safe environment for patient care

Specific Federal and State requirements to insure patient safety:

* Maximum number of patients who could require “assistance for self preservation” (sedated patients)

* Transfer agreements with the hospital and receiving physician agreements


WELCOME


EXIT


AADCO
AADCO

ASC medical staff is fully credentialed:

Privileges are granted at the ASC in an identical manner as hospital

*** If you do not have hospital privileges you must be proctored**

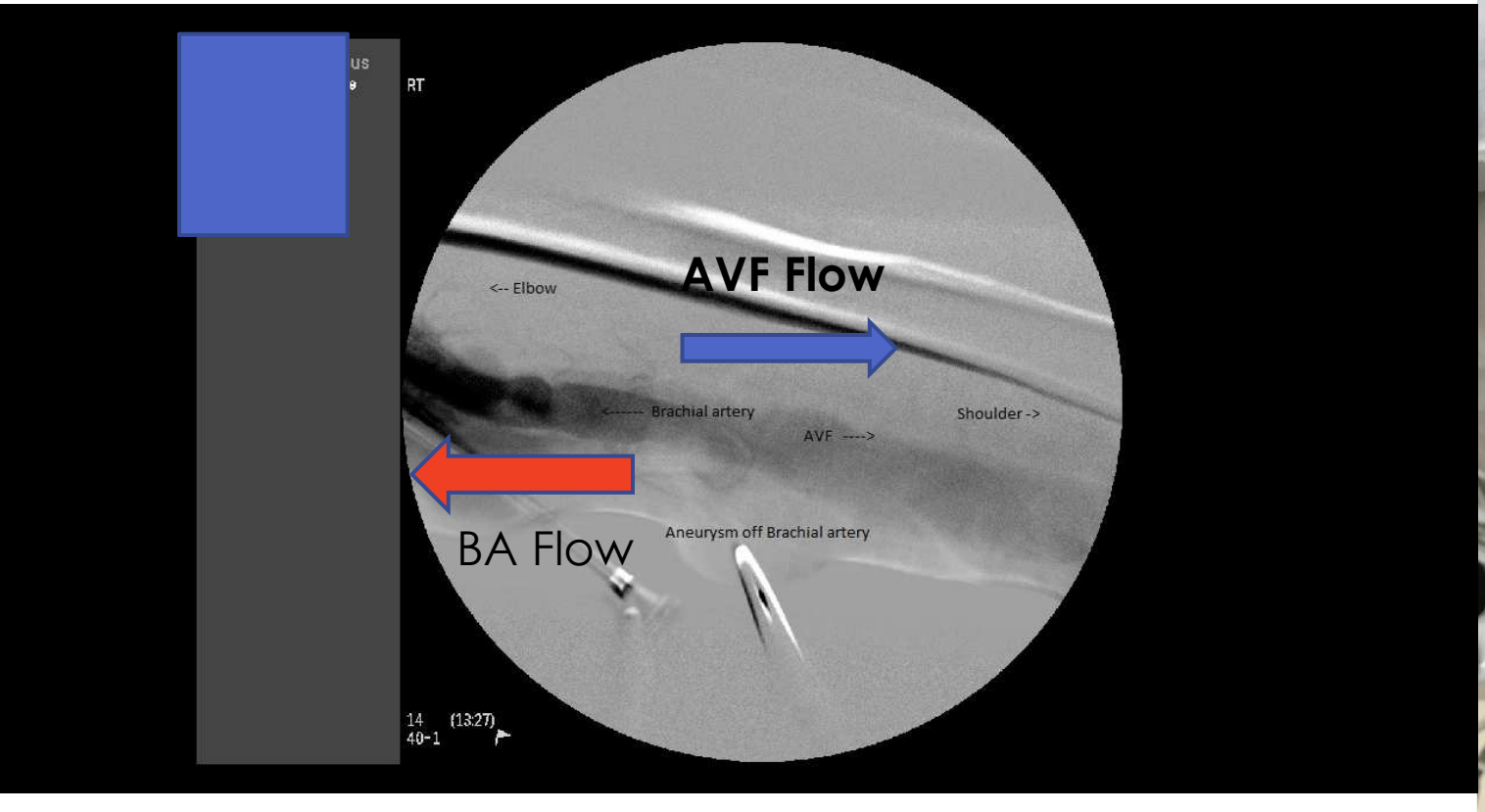
2. ASC Model

Same procedures that are done in EOP model but add additional procedures, potentially more complex procedures, and surgery

ASC – high risk patients should be referred to the hospital

What are examples of a more complex procedures?

* AV fistula creation
* Second stage brachial artery -> brachial or basilic vein AVF transposition
* AVG surgery
* Surgical treatment of access aneurysms
* DRILs
* Other



Same patient that had the banding procedure:

Make the diagnosis and plan the surgical treatment

An example of a new and more complex case that can be done in an ASC.

3. Demonstrate improved patient outcomes and as a result, better value based outcomes

Without quality outcomes you cannot produce value based outcomes such as was demonstrated in the Dobson study

Quality outcome-> value based outcomes?

Same criteria that were reported in the Dobson study along with additional data gathered in concert with the dialysis provider:

* Time (days) from vessel mapping -> Sx consult -> working AVF
* Incidence of patients starting HD with an AVF
* Prevalence of patients using a TDC at 90 days
* Increase % of home patients primarily on PD

* These are the type of metrics that are tracked for determining value based outcomes

What Local Issues Drive the ASC Model?

What we faced in San Jose:

- Fragmented care
- Significant delay in surgery
- Poor surgical outcomes
- Oftentimes bad patient experience
- High costs: Hospital > HOPD > ASC
- In some dialysis facilities:
  - Low prevalence of AVF
  - High prevalence of TDC at 90 days (some units >30%)

Continuous quality improvement is a dynamic process

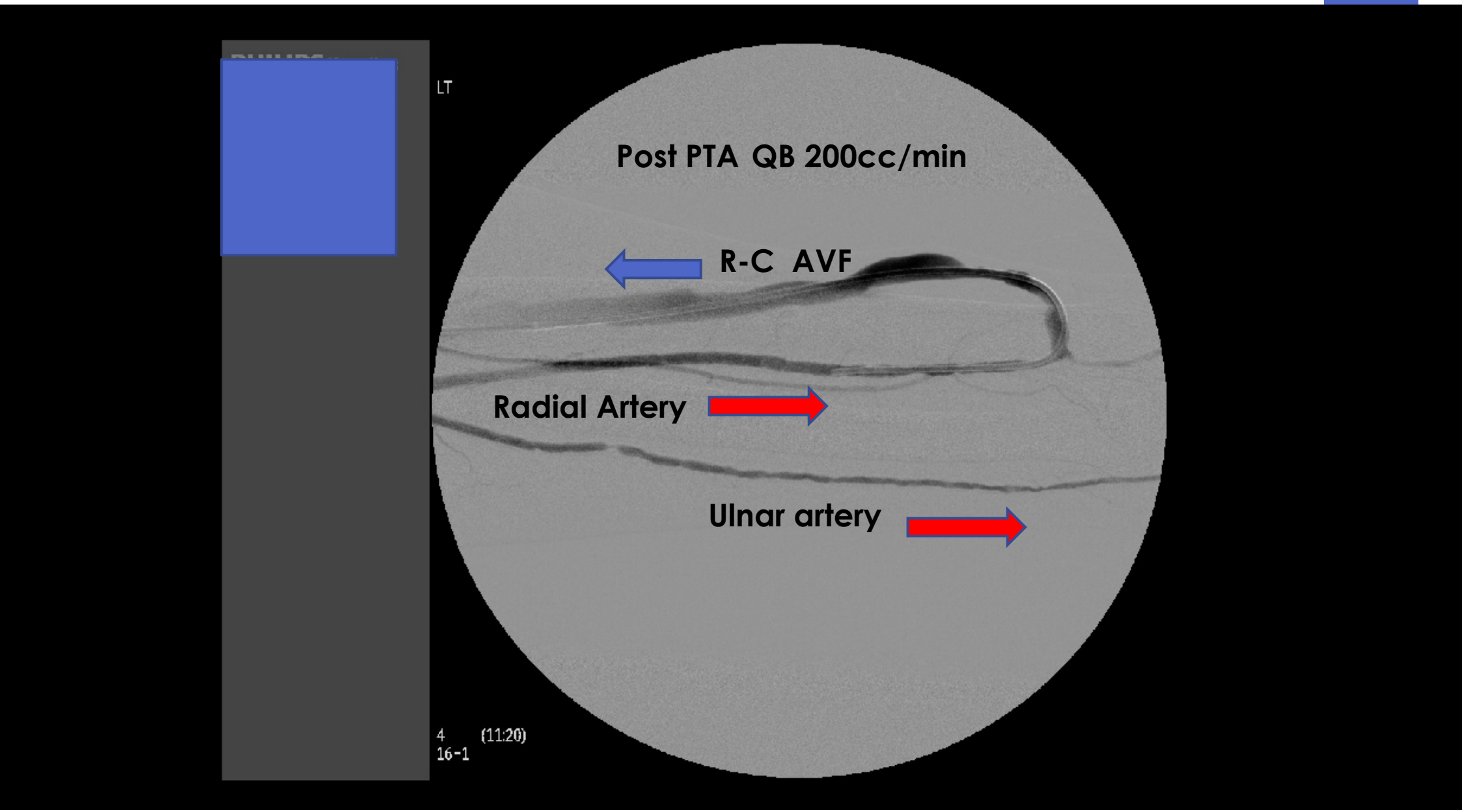
Use a multidisciplinary approach and re-examine how you resolve the problem based on:

* Best patient care
* Value based outcome analysis

Case: 69 YOM with a newly created radial->cephalic AVF with distal RA, arterial anastomosis and arterial inflow stenosis

Question is how many times and in what time period should the same treatment be done on the same pathology?

DOQI guidelines exist but what would you do in your own ASC?


LT
Post PTA QB 200cc/min
R-C AVF
Radial Artery
Ulnar artery
4
16-1
(11:20)

Considerations for operating as an ASC

Hypothetical hemodialysis population 1,000 patients

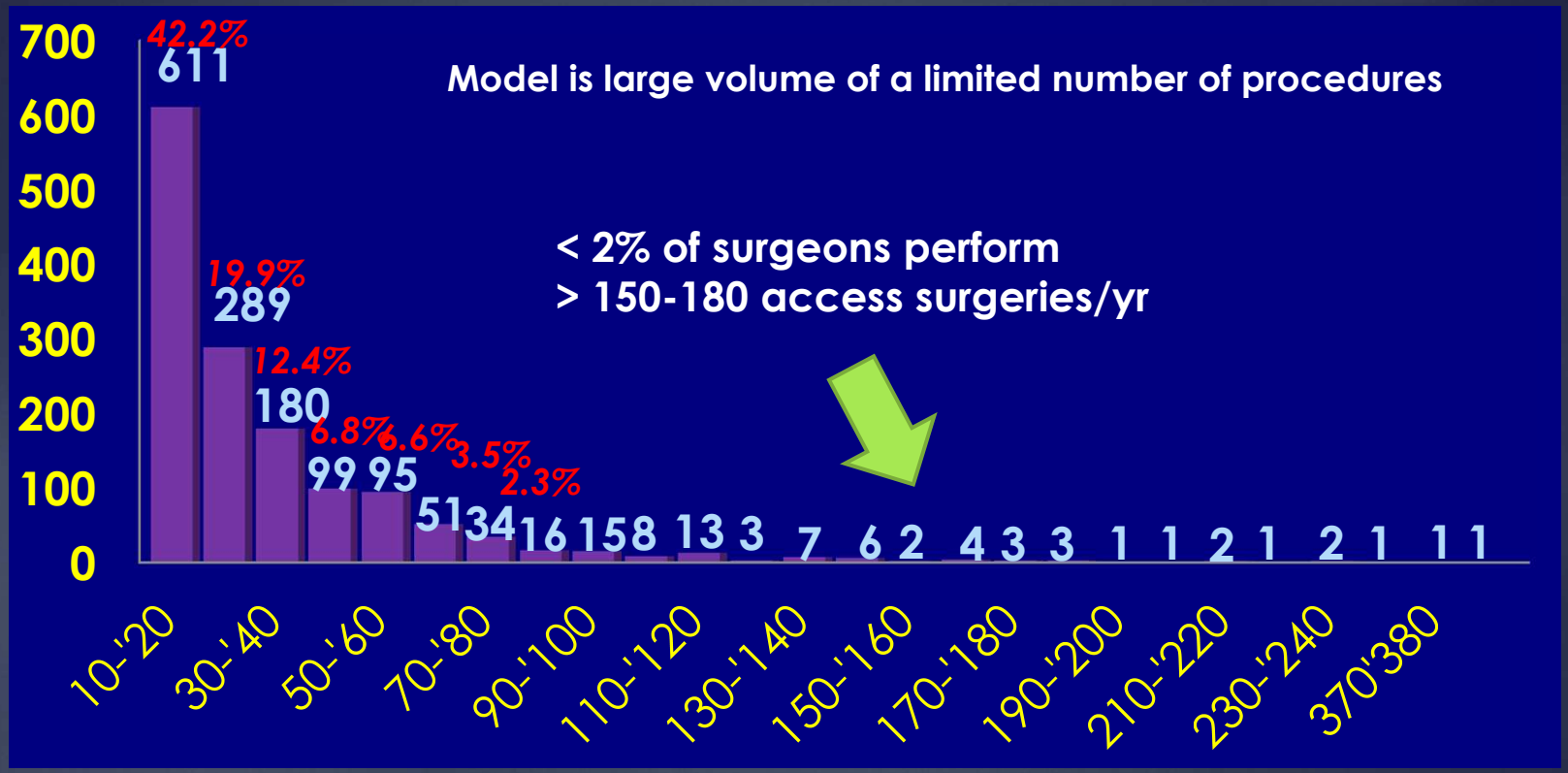
17% mortality/year driven primarily by aging population
At 70 3.8 yr life expectancy
At 80 2.6 yr life expectancy

3 % growth of the hemodialysis population
A majority starting with TDC

The surgery piece is critical -> Goal > 70% AVF prevalence →
Factor in 30% AVF Sx failure rate -> >150 AVF/yr

USRDS 2015 data

Only small percentage of access creations are done by physicians who focus primarily on AV access surgery



2012 MC data
Gary A. Gelbfish, MD FACS
Medical Director, Advanced Vascular Care
Assistant Clinical Professor of Surgery, Mt. Sinai School of Medicine NYC
Data "underestimated total amount of surgeries": 49,089 cases access surgery by1,449 Physicians

4. Designated vascular surgeon(s) for dialysis access surgery

7 Radial artery -> cephalic vein AVF
2 Brachial artery -> cephalic vein 1st stage AVF
6 Brachial artery -> basilic vein 1st stage AVF
2 Brachial artery -> brachial vein 1st stage AVF
3 Brachial artery -> brachial or basilic vein as a one stage procedure
2 Radial artery -> transposition forearm basilic vein
1 Preservation surgery PTFE jump graft from brachial artery -> distal forearm cephalic vein AVF
1 DRIL procedure

2 failures
1 upper arm AVF thrombosis - surgically declotted 1 wk p op
2 steal syndromes – 1 banded, 1 DRIL

All done using moderate sedation and local anesthetics

New paradigm

Nephrologist take full ownership of dialysis access care

IN/IR performs endovascular therapies

Multidisciplinary staff:
* Vascular surgeon
* Can include IR

Change a paradigm of interventional nephrology started 20 years ago

ASC Environment
* Highly regulated
* Safe patient care

Market forces:
High costs of access care mandate
* Integrated care
* Report outcomes

Result:
* More cases
* More complex cases
* Access surgery
* Improve outcomes
* Lower cost