

Developing an Interventional Pulmonary Service in a Community-Based Private Practice

A Case Study



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Interventional pulmonology (IP) is a field that uses minimally invasive techniques to diagnose, treat, and palliate advanced lung disease. Technology, formal training, and reimbursement for IP procedures have been slow to catch up with other interventional subspecialty areas. A byproduct of this pattern has been limited IP integration in private practice settings. We describe the key aspects and programmatic challenges of building an IP program in a community-based setting. A philosophical and financial buy-in by stakeholders and a regionalization of services, within and external to a larger practice, are crucial to success. Our experience demonstrates that a successful launch of an IP program increases overall visits as well as procedural volume without cannibalizing existing practice volume. We hope this might encourage others to provide this valuable service to their own communities.

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In an era of mounting costs and quality initiatives from clinical integration networks and accountable care organizations, we have seen care models shift from specialty silos to integrated delivery systems.¹ The field of interventional pulmonology (IP) is well positioned to enhance the care and coordination among general pulmonary medicine, critical care, thoracic surgery, and oncologic specialties. This article describes the experience of a large, community-based, single-specialty

practice in successfully developing an IP program.

IP encompasses a range of minimally invasive diagnostic and therapeutic thoracic procedures in a specialty that overlays many fields (Table 1). Although the main focus is on the diagnosis, staging and palliation of thoracic malignancies, other thoracic and critical care diagnoses are appropriate for IP evaluation. To date, these procedures have been offered by a small number of

ABBREVIATIONS: APN = advanced practice nurse; CCC = Chicago Chest Center; EBUS = endobronchial ultrasound; E/M = evaluation and management services; IP = interventional pulmonology; SLA = Suburban Lung Associates; TBNA = transbronchial needle aspiration

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IP providers, but are more commonly provided by various specialties in a piecemeal fashion. Many communities have either limited access or no IP service at all. Growth of IP has been somewhat limited to academic medical centers and to narrow geographic regions.² With this wide variation of IP service delivery, it is incumbent upon institutions or even geographical

regions to assess community need and how best to serve it.

We present a model for developing an IP program in a community setting that balances a desire to provide necessary services against the realities of practice in our medical economic milieu.

Methods

Community-Based Needs Assessment

A comprehensive needs assessment should precede the implementation of a new technology or service.³ This includes an evaluation of the regional prevalence of lung cancer and related diagnoses. In most communities, there is a structural and functional lack of coordinated thoracic care. IP specialists perform a broad spectrum of procedures and have expertise in thoracic disease. This positions them to coordinate care and to lead thoracic initiatives in clinical quality, volume generation, and efficient throughput.

Market Analysis

Historically many pulmonologists have not prioritized performing procedures. Known barriers include relatively low reimbursement coupled with increased technical effort and physician time compared with other aspects of practice such as critical care, evaluation and management (E/M) services, and sleep medicine.⁴ Current reimbursement patterns do not incentivize pulmonary procedures, so they are neither time nor cost efficient. This may limit provision and access to procedures that improve clinical outcomes. A dedicated IP service can proficiently overcome these obstacles. Navigating local politics is a frequent challenge. Practice patterns tend to be

entrenched, so one should not minimize the effort required to effect change. The challenge of credentialing pulmonologists in nontraditional advanced procedures that cross specialties may be daunting. Demonstration of appropriate training and acceptance of published guidelines are fundamental.⁵ With the implementation of IP, general pulmonologists are freed to grow other aspects of their practice, including E/M volume, while improving access and increasing revenue. The provision of a dedicated procedural service supports long-term practice viability, as well as vertical and horizontal integration.

Economic Buy-In

Introducing IP to the region requires organizational and economic buy-in by key stakeholders. The practice, affiliated hospitals, staff pulmonologists, and associated services need to invest in the concept philosophically and financially with an understanding of the inherent risks and potential benefits. The economic impact of endobronchial ultrasound (EBUS)-guided transbronchial needle aspiration (TBNA) has been well studied. Patis et al⁴ demonstrated that the implementation of EBUS not only attracts new referrals and revenue but also benefits related institutional services such as radiology, surgery, and oncology.

Opportunities for decreasing costs exist. Analyses of EBUS-TBNA show that the cost of staging was reduced by 25% by eliminating the need for many mediastinoscopies in the evaluation of mediastinal and hilar lymph nodes.^{6,7} IP impacts not only pulmonary and oncologic specialties, but critical care as well. Procedures such as percutaneous tracheostomy and percutaneous endoscopic gastrostomy are performed safely at the bedside while decreasing cost and length of stay.⁸ These are frequently performed IP procedures. Expanding to a broad range of IP procedures serves as a driver of referrals and coordinated thoracic care delivery. These are just some examples of offerings that can impact cost, practice, and hospital revenue. Although these services are often offered piecemeal by multiple practitioners, a wider range of services, from basic to advanced diagnostic and therapeutic bronchoscopy to pleural procedures, in a consolidated program accomplishes greater benefit.

Procedural Gap Analysis

The assessment of key drivers such as demographics, breadth of thoracic service lines, baseline referrals and procedure volume, scope of diagnoses, personnel, equipment, and access to state-of-the-art care is integral to program planning.³ Each entity must determine the best approach to offering IP services. As many of the procedures are performed in an outpatient setting, the medical community should address the question as to whether patients are best served by local care or by referral to a regional center.⁹

Dedicated IP Team

The decision to recruit fellowship-trained, board-eligible/board-certified IP physician(s) is an important consideration. Evidence suggests that more advanced training leads to better procedural

TABLE 1] Representative Spectrum of Interventional Pulmonary Procedures

Diagnostic bronchoscopy—all aspects
Basic
EBUS
Navigational bronchoscopy
Therapeutic bronchoscopy (flexible and rigid)
Thermal ablative therapies
Airway stents
Endobronchial valves
Bronchial thermoplasty
Pleural procedures
Basic (thoracentesis, chest tubes, pleurodesis)
Medical thoracoscopy
Tunneled pleural catheter placement
Coordinated management
Others
Percutaneous tracheostomy
Percutaneous gastrostomy tube placement
Procedure-based research

EBUS = endobronchial ultrasound.

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