Embracing Chaos as a Growth Strategy

Structure your outpatient endovascular center practice for flexibility and autonomy to mitigate setbacks and stimulate growth.

By Chas E. Sanders

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The last 2 years have wreaked havoc on both new and established outpatient endovascular centers. Facilities have faced extensive disruptions brought on by COVID-19, such as staffing shortages, supply chain restrictions, lack of construction materials, accreditation delays, and even, in some circumstances, local prohibition of treating patients.

These obstacles were not forecasted, and many facilities did not have plans in place to alleviate operational inefficiencies and delays. Just as they are beginning to overcome these challenges, centers now face looming catastrophic rate cuts from the Centers for Medicare & Medicaid Services (CMS).

In the 1980s, Tom Peters introduced a business concept known as Chaos Theory. The theory's premise is that organizations gravitate toward complexity, creating inefficiency and making them more susceptible to chaos. As organizations grow, they can either resist change or band together to address chaos. Organizations that do the latter often appreciate exciting new systems, service lines, and growth.

So how can your outpatient endovascular center prepare for chaos?

Get Horizontal and Flexible

Anyone who has worked in an outpatient center knows how a small issue can completely disrupt organizational flow, consuming hours of staff time. For example, a minor device recall could produce hours of work for the clinical team, accounting, operations, and the owners. Why? Most facilities are structured in a hierarchical, vertical, top-down manner, where each team seeks the approval of another team or leader.

However, if every team had autonomy, the organization could be much more efficient. Organizations that are more horizontal in their leadership structure are more adaptable. Chaos Theory teaches us that the more flexibility an organization can maintain, the better its ability to address unforeseen events.

Flexibility lends more optionality; optionality prevents an organization from being backed into a corner. How is this apropos to the obstacles faced by outpatient endovascular centers today? Let's first explore the scenarios brought by COVID, as this remains a daily threat. COVID has hit centers with a whirlwind of challenges, everything from supply chain disruptions to the infection of staff and patients. This has left centers grappling with reduced caseloads and scrambling to find the right product for scheduled procedures.

The authority chain hampers the ability of a center to be nimble. As it relates to supply chain restraints, if teams are empowered to react freely, without extensive cross dialogue among stakeholders, staff can quickly pivot from one product to another. For example, changes to product supply would typically require buy-in from financial, operational, and clinical leadership. But if centers were to plan and select "approved" alternatives for products, staff could easily move from one product to another and increase par levels to deal with unforeseen backorders.

Managing the struggle of infections among staff is a bit more challenging. Centers must have a minimum number of staff members to operate safely. Unfortunately, for many facilities, staff work in specific lanes and do not deviate from their assigned, day-to-day responsibilities. But cross-training staff to assume multiple roles could mitigate the consequences of a sudden absence of a staff member.

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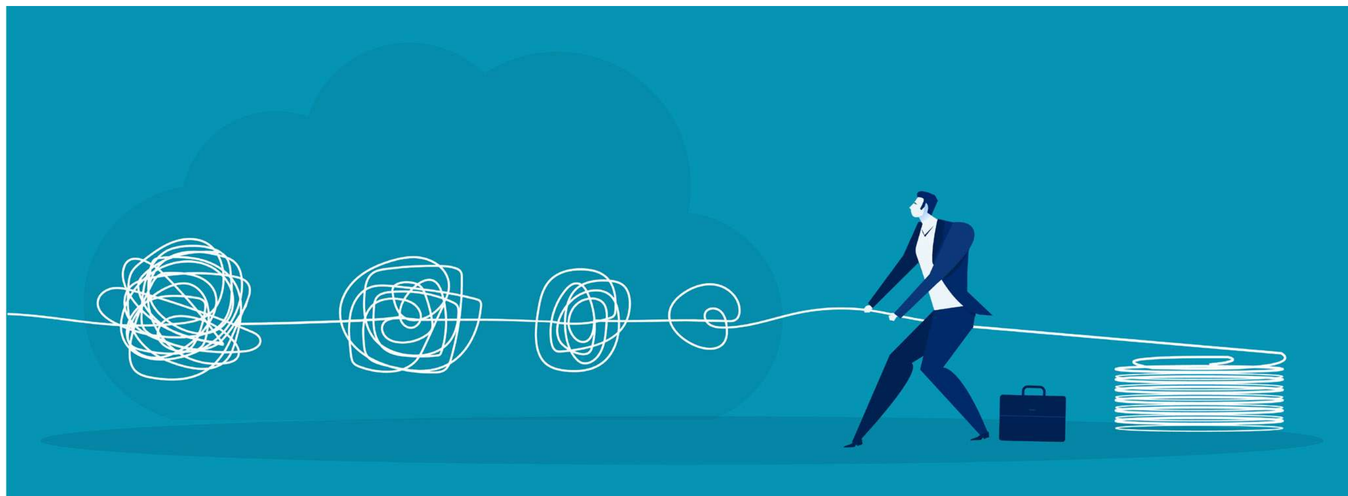

Practices can mitigate chaotic outcomes with autonomous teams and collaborative planning. Image courtesy Shuttterstock/TaTa Idea.

Evaluate as a Team

The CMS rate cuts, though postponed until March, are a looming threat for many outpatient endovascular centers. For most facilities, they represent a 12% to 18% reduction in reimbursement. Rate cuts of this magnitude can be catastrophic, which was the case for many dialysis centers following drastic rate cuts in 2017. So, how should a facility navigate this type of uncertainty? By bringing all stakeholders together to face this threat as a team.

First, your team should look at your current procedure mix and determine if there are opportunities for alternative procedures that could be both clinically valuable to the community and offer better financial security for the center. For example, many centers focus on peripheral artery and deep vein procedures, while neglecting procedures like prostate artery embolization or uterine fibroid embolization. These procedures are greatly needed in many communities and utilize inexpensive technology coupled with strong reimbursement. The willingness to learn and perform new procedures allows a facility to respond to reimbursement changes while still bringing value to the community.

Another way to manage the threat of rate cuts is through improved supply management. Collectively, stakeholders should consider if they are primarily using products because of familiarity and relationships with medical salespeople. If these are the driving forces for product selection, it makes sense to evaluate new products and see if you can negotiate better pricing without compromising clinical care. Adding competition to current vendors often yields more attractive pricing and enhanced support.

Capacity is another area to evaluate. Many facilities have the capacity to perform more procedures than currently offered. However, either due to lingering commitments by their physicians to service local hospitals or hampered referral streams, many centers allow their excess capacity to go unrealized. This scenario presents the perfect opportunity to rent space to another physician or to bring on a physician to address new procedures. While trusting someone new may at first seem like an insurmountable challenge, pushing through this discomfort could reap strong partnerships and better financial security, and bring needed clinical services to the community.

Consider a New Structure

Finally, considering the shifting trends in reimbursement, you may want to evaluate your operating structure. Is the center operating as an office-based lab when an ambulatory surgery center (ASC) would make more sense, given the procedure mix? There are many other factors, such as certificate of need laws that could prohibit the opening of an ASC, but given the uncertainty of the times, doing this research could open a path forward for enhanced optionality.

Organizations must structure their leadership, teams, and operations to allow for change, evolution, and a speedy pivot. At no time in the history of health care has this been more relevant. Uncertainty and threats, though draining, offer facilities an opportunity to evolve and emerge from the chaos stronger than before. Are you affording your center this opportunity for growth?

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