Captains of IR

“A little bit of effort and some good planning and marketing can result in profitable ROI.”

— Eric Wang, MD, Vascular and Interventional Specialists of Charlotte Radiology

WHAT’S INSIDE?

Refurbished Market: Better Than New p24
Functional, Flexible Facility Design p28
Captains of IR

Growing an interventional practice from a small start-up to a solid success takes business acumen, marketing savvy, and strong leadership.

By Elaine Sanchez Wilson

Location, demand, and the financial climate: for any physician interested in starting up a private practice, these are the typical things they need to consider.

For interventional radiologists, however, effective marketing—you, your practice, and your services—is absolutely crucial for survival. That’s because even fellow physicians are unsure about what these specialists offer.

“When you look at interventional radiology, there tends to be a lot of confusion as far as what we do,” said Eric Wang, MD, of Charlotte Radiology, in Charlotte, NC, adding that his practice fields many phone calls relating to IV access, biopsies, and drainages. While these “bread and butter” procedures are certainly important for patients and referring physicians, they don’t require the added subspecialty training that Wang and his colleagues have completed. “Our focus area is on sophisticated, minimally invasive procedures that have developed over the last 5, 10, 15 years,” he said.

Charlotte Radiology is comprised of more than 90 radiologists, making it the third largest radiology group in the country. “To a certain degree, this can be a detriment to interventional radiology,” Wang said. “[Referring physicians and patients] think of general imaging. They think of us as the experts in diagnostic services—and though we want the community to know that, at the same time it is very difficult for most people, including a lot of our medical colleagues, to make that jump from general radiology to IR, to get beyond the fact that yes, we read CTs, MRIs, and ultrasounds. But we are also hands on; we are clinicians and are able to treat the diagnosis.”
As a result, Wang and his partners decided that the IR section of the practice needed to undergo a rebranding process. This not only would make their specialty recognizable to the referring physician, but it also would make it easy for the patients to understand. Known as the Vascular and Interventional Specialists of Charlotte Radiology, the section now has its own distinct logo, with the goal to increase awareness and recognition of IR as a separate entity of services.

Initial Steps

John Rundback, MD, managing partner of Advanced Interventional Radiology Services, of Teaneck, NJ, is part of what he refers to as “a thriving and growing, academic private practice” with two other interventional radiologists and two office personnel. As the interventional radiology arm of a six-member diagnostic radiology group, Rundback and his colleagues see a caseload of approximately 2,400 patients, or 3,800 procedures, a year, performing angioplasty and stents for treatment of blockages in leg, kidney, and carotid arteries; dissolving clots causing deep venous thrombosis and pulmonary embolism; and doing nonsurgical repair of aortic aneurysms, among others. Rundback is also involved with 10 clinical trials, including one that is using bone marrow aspiration to amplify stem cells for reinjection into patients with peripheral arterial disease to promote new blood formation.

Rundback said that when he left Columbia Presbyterian Medical Center, he wanted to maintain—or even exceed—the level of care and academic intensity that existed at the academic center. “Academic centers are increasingly moving toward the productivity model and less toward a performance model,” he explained. A private practice, on the other hand, enjoys a number of advantages, such as controlling the number of cases it takes, contracting outside groups, and making its own personnel decisions.

Michael J. Hallisey, MD, of Jefferson Radiology, in East Hartford, Conn, started out in surgery but switched over to radiology when interventional radiology was developing in the late 1980s. “Up until that time, general radiologists would do procedures, but some other doctor would take care of [patients], admit them, and make decisions on their care,” he said. Hallisey received his IR training in Alexandria Hospital in Alexandria, Va, where he said there was a strong focus on the clinical practice of IR. Interventional radiologists took medical histories and performed physicals, enabling patients’ direct admission for treatment. “There became a
greater need for IR to guide patient care,” Hallisey said, adding that IR exploded 15 years ago with the development of high-end, image-guided technology. “A lot of people look at us like the doctor’s doctor in that we were sought out to help with difficult cases.”

Fifteen years ago, Hallisey started building an outpatient interventional practice, for which he would see 32 patients a week in his clinical office. Some patients were new, while others were follow-ups; some patients he treated, others he would offer consultation for issues such as uterine fibroid embolization and varicose vein treatment. Initially housed in a small space adjacent to a hospital, Hallisey’s practice eventually had to move to a larger site that could accommodate the growth in volume.

When Melvin Rosenblatt, MD, former director of interventional radiology at Yale New Haven Hospital and Memorial Sloan Kettering, decided to start up his own business in 2005, he was eager to dedicate himself to the practice. For Rosenblatt, an independent interventional radiology environment meant more efficiency, less costs for third-party payors, and a more pleasant atmosphere for patients, due to less waiting, less bureaucracy, and less chance for error. With favorable charges that occurred within the reimbursement schedule, it had become financially viable to perform certain procedures outside of the hospital environment. Still, opening up his own practice meant that Rosenblatt had to be certain he was good at what he did.

“When you are in a radiology group, you get fed whatever the hospital throws you,” said Rosenblatt, founder of Connecticut Image Guided Surgery, in Fairfield, Conn. “When you are an independent guy, you have to live off your skill as a proceduralist because people are only going to refer to you if you’re good at what you do, not because they have to.”

As one of the first physicians in his community to offer some of the newer vein procedures, Rosenblatt had built a relatively large vein practice. “Varicose vein problems were very common, and not many people were doing minimally invasive techniques at the time,” he said. “There was certainly a void.” According to Rosenblatt, looking for a niche, or procedures that not many clinicians offer, is one way to keep a practice going. “Because I’d been doing this a long time in relatively large academic centers, I was familiar with techniques that some of the private interventionalists were not that familiar with,” he said. “They didn’t have the opportunity to do those kinds of volumes of cases. My expertise was a little better than theirs, and as a consequence, I was able to develop a practice based on expertise that did not exist in the community. I would get called for procedures that others couldn’t do.”

Building a Presence

According to Wang, “It’s important to educate the referring physician on the scope of services we offer.” In order to learn more about what physicians didn’t know, one of the practice’s administrators interviewed several physicians representing different fields, including emergency department, ob/gyn, surgery, and primary care. “They were largely very surprised at the number of procedures that we did,” Wang recalled. “We thought we had done a good job educating, but from these interviews, we learned they were unaware of the extent of IR services.” While referring doctors were familiar with an in-house patient needing a vascular stent or line placement, embolization or biopsy, they weren’t aware that interventional radiologists could see patients in consultation for uterine fibroid embolization, oncology procedures, or various vascular interventions, Wang continued.

“The referring community understood how the patient arrives at IR if they are admitted to the hospital,” said Mary Margaret Williford, vascular and interventional marketing manager at Charlotte Radiology. “But they didn’t get that IR physicians have dedicated clinic time.”

According to Hallisey, relationship-building is at the heart of how to build a good IR practice. Referring gynecologists and other physicians need to see interventional radiologists as people they can trust with their patients. “They need to realize that they can trust you to take care of the patient rather than do something and dump the problem back to them,” he said. Hallisey and his team have worked to establish their credibility with referring physicians. They made themselves available to the dialysis centers for patients with renal concerns, both emergently and electively. They went to the gynecologists and offered to see patients before and after proce-

Attending conferences also should be a top priority for interventional radiologists, so that they are perceived as clinicians and regarded as a key component in the continuum of patient care, said Wang.

“I think it’s important to show up at these different conferences and be present for the discussion of cases in order to determine who is best able to take care of the patient,” Wang said, pointing out that different specialties have different skill sets. For example, microwave ablation can be performed by laparoscopic surgery, a minimally invasive procedure requiring only three incisions. However, interventional radiologists are trained in an even more minimally invasive technique utilizing CT or ultrasound guidance to insert the same, exact microwave antenna into the cancer. “Every case is different. There have been times when I’ve received a patient referral, and I thought their treatment would be best suited laparoscopically, and vice versa, when a surgeon felt it was better handled through interventional radiology. It’s up to us to establish good working relationships with the referring physicians,” Wang said.

Hallisey agrees with this sentiment. “What we don’t want to do is just focus like we are a proceduralist,” he said. “We want to focus like we are a consulting doctor for problems. If you’re perceived that way, they will continue to see you and respect your opinion on how to treat patients.”

Marketing to Patients

Rosenblatt said he is unsure about how much volume is produced by magazine advertisements, radio spots, television commercials, and websites. “Most of it is word of mouth,” he said.

Hallisey concurs, “Your best calling card is doing good work on a patient. Word of mouth is really what sets you apart.”

Vascular and Interventional Specialists of Charlotte Radiology markets interventional radiology procedures directly to consumers, specifically branding its uterine fibroid embolization offering. The problem is that many consumers think that interventional radiologists can diagnose, but not treat, their fibroids, Williford said. After focus group discussions with its target demographic—African American females—the marketing team developed the procedure’s own logo, dedicated phone line (704-FIGROID), and website (http://www.704fibroid.com/). “We want to provide this as an op-
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—Michael J. Hullsey, MD, Jefferson Radiology

competition to women who are searching for solutions,” Williford said. “Maybe they don’t want to undergo surgery, and perhaps they want to keep their uterus. If their physician is not providing them with this option, how are women supposed to hear about it if we don’t market to them?”

Williford said the practice plans to brand more IR procedures, such as interventional oncology and various vascular interventions, in the future.

Turf Wars?

Vascular surgeons serve as clear competition to the independent interventional radiologist, Rosenblatt said. But competition exists in all aspects of medicine and is not necessarily bad, he noted. The trick, said Rosenblatt, is to try to be better than your competition, at least in certain areas. This approach has allowed him to enjoy a good relationship with one of the larger vascular groups in the area, teaming up with them in the outpatient practice. “Even though our procedures are overlapping, we often cross refer. I refer patients that I don’t do, and they refer patients that they don’t do,” he said. “We have been able to work out a symbiotic relationship.”

According to Rundback, his practice does not engage in turf battles, which he attributes to a few factors. First, he and his colleagues maintained clinical independence and came in with their own admitting service. Also, the business does a lot of marketing, for example to nursing homes, and therefore secures vascular patients that others don’t interact with. Furthermore, they refer to surgeons and cardiologists on a regular basis. For example, in the medical service agreement that the practice has with the hospital, Rundback agreed to supply support for current vascular providers and guide them in a variety of service areas, while still allowing them to bill for services. “They can expand what they do, and we would support them,” he said. “Over time, I’m referring to them, and they refer to me. I’m bringing in clinical trials, and they can participate. There is no threat there.”

Competition from other interventional radiologists is much more of a problem than competition from other specialties, according to Rosenblatt. Radiologists often use exclusive contracting to prevent other interventional radiologists from practicing in a hospital environment. “This type of competition is not based on quality or skill and often prevents individuals with highly specialized skills from practicing in a particular environment even when a vacuum exists,” he said. “This type of competition can not only prevent a physician from practicing in an inpatient setting but can also prevent them from working in an outpatient setting.” Certain states and insurance companies require a physician to have hospital privileges as a prerequisite for third-party billing. If a physician is prevented from obtaining such privileges, then they will be unable to establish an outpatient practice in that community.

Financial Tactics

Rundback said interventional radiologists are in a good position. They can point out to hospital leaders the procedures they offer that other clinicians are not providing. These days, that portfolio will be cancer radioembolization, radiofrequency ablation, and chemoembolization, along with unique treatments for DVT and uterine fibroids, he said. “You need to go in as a clinical equal,” he said. “You can’t go to the CEO with the idea that you will be clinically subservient to others. You have to establish your own identity and not acquiesce.”

His biggest selling point to hospitals is what he describes as “the halo effect,” or the value beyond the point of service. Interventional radiology procedures have shorter recovery times compared to surgery. So bringing in IR can help the hospital by expediting discharge. IR procedures are also frequently solutions that can prevent nonreimbursed repeat operations, keeping hospitals out of potentially costly scenarios. “While we do our 2,400 patients a year, we also admitted 700 patients last year, and we ordered almost 1,000 cross-sectional imaging studies,” he said. “We referred out 250 patients for consultation to various services, not even including laboratory and pathology. We’ve become a backbone of the institution. You need to track the numbers of patients referred, not just the revenues.”

Wang said it is imperative to collect accurate return on investment (ROI) data, and his practice tracks everything through various access points. “Tracking is key,” he said. “Track, track, track. You want that data to find out what is working and what is not. Those metrics are key as we proceed forward. We need to make sure that dollars are going toward the most productive tactics. What works in our community may not work with other IR practices around the country. We need to be targeted and focused and make moves that are cost-effective.”

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stand how many IR procedures it will take to recoup the amount of money spent on marketing,” said Wang. “Usually, once that is broken down in such a fashion, our physicians have a much easier time understanding that it doesn’t take much to recoup the upfront costs of marketing. A little bit of effort and some good planning and marketing can result in profitable ROI.”

For example, in order to recoup costs, Charlotte Radiology’s uterine fibroid embolization marketing must bring in five new UFE self-referred patients to its system. Not only did the practice meet that number in 2012, but it also ushered in another 45.

“I feel that with the market challenges right now, we can’t afford to pull away from marketing dollars,” Wang said. “You need to put money into educating referring physicians and the community about IR treatment options available. I think it’s a mistake to not put any marketing dollars toward procedures that we believe in and that are effective for our patient population.”

Hallisey’s philosophy is to focus on what you can control, instead of what you can’t. “We can’t control the cuts that come for payments,” Hallisey said. “It’s too big a machine to control. But what we can do is work on the areas that we can control, meaning do really good care, doing it full time, and following up with that care.

“I think there will always be a demand for what we’re able to do,” he concluded. “If you do it well, and you do it efficiently, there will be a need for it. If you do a good job, there is always room for you in the marketplace.”

Elaine Sanchez Wilson is a contributing writer for Imaging Economics.

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