OBL Vascular Access Centers vs Hospitals: The Good and the Bad

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What if dialysis access had a trauma system?

"It is better to debate a question without settling it than to settle a question without debating it" — *Joseph Joubert*.

"I can explain it to you, but I can't understand it for you” Attributed to Mayor Ed Koch

OBL or HOPD?



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OBL or HOPD?

Kidney International, Vol. 66 (2004), pp. 1622–1632

DIALYSIS – TRANSPLANTATION

Effectiveness and safety of dialysis vascular access procedures performed by interventional nephrologists

GERALD A. BEATHARD, TERRY LITCHFIELD, AND PHYSICIAN OPERATORS FORUM OF RMS LIFELINE, INC.

RMS Lifeline, Austin, Texas; and RMS Lifeline, Vernon Hills, Illinois

Effectiveness and safety of dialysis vascular access procedures performed by interventional nephrologists.

Background. The purpose of this report was to analyze the results obtained from a group of interventional nephrologists working in multiple centers performing basic procedures that are used routinely in the management of vascular access problems, with an effort toward establishing standards for evaluating success, complication rates, and acceptable times for procedure

gists who have shown that, with appropriate training, they can perform a major portion of the procedures that are necessary for access management.

Simply stated, an interventional nephrologist is a nephrologist that performs interventional procedures essential to the management of patients with renal disease. Classically, the nephrologist has performed kidney biop-

Changes in the Profile of Endovascular Procedures Performed in Freestanding Dialysis Access Centers over 15 Years

Gerald A. Beathard,[*†] *Aris Urbanes,*[*] *and Terry Litchfield*[*]

Abstract

Background and objectives Marked changes occurred in the vascular access profile of patients receiving hemodialysis in the United States over the 15-year period of 2001–2015. This study was undertaken to evaluate how these changes have affected dialysis access maintenance and salvage procedures performed in freestanding dialysis access centers and to examine the effectiveness, efficiency, and safety of these procedures in this setting.

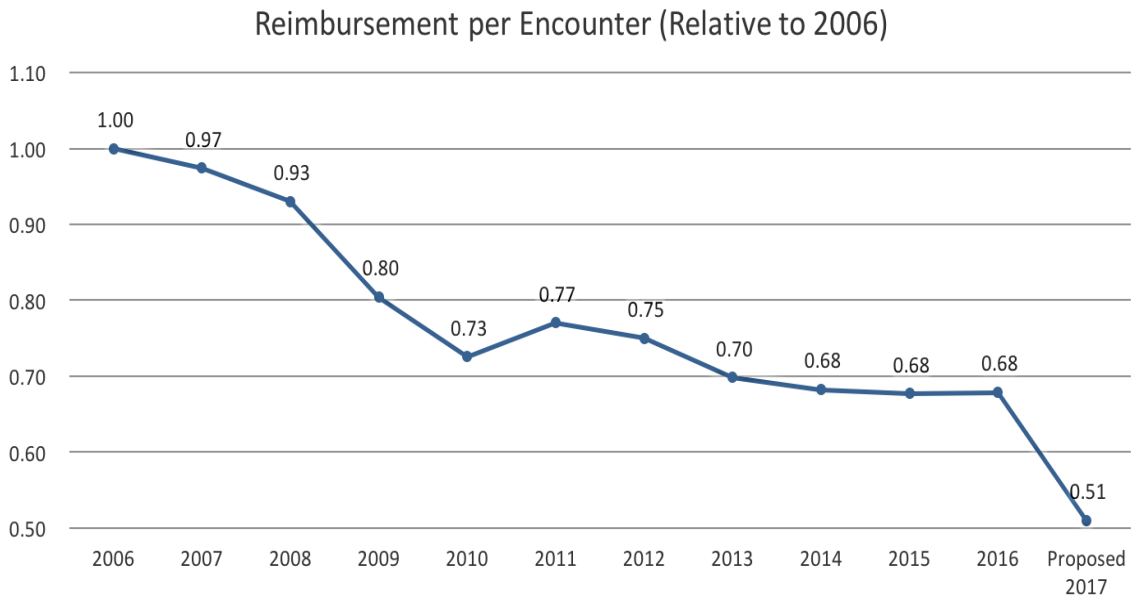
Design, setting, participants, & measurements Data were collected from freestanding, dedicated dialysis access centers operating under a common system of management. Data were available on 689,676 dialysis access procedures. Data relating to case mix, procedure outcome, procedural time, and intraprocedural and immediate postprocedural complications were analyzed.

Results The arteriovenous procedure profile changed from one characterized by approximately equal numbers of angioplasties and thrombectomies performed on arteriovenous grafts (AVGs) to one characterized primarily by angioplasties performed on arteriovenous fistulas. The percentage of angioplasties performed throughout the study was significantly greater than thrombectomies, with a mean of 67.9% versus 32.1% ($P<0.001$). Interventional procedures did not decrease with increasing arteriovenous fistula utilization in prevalent patients receiving dialysis. The incidence roughly paralleled the increasing prevalence of this type of access. A decreasing percentage of AVG utilization resulted in a progressive, roughly parallel, but disproportionately higher, decrease in the

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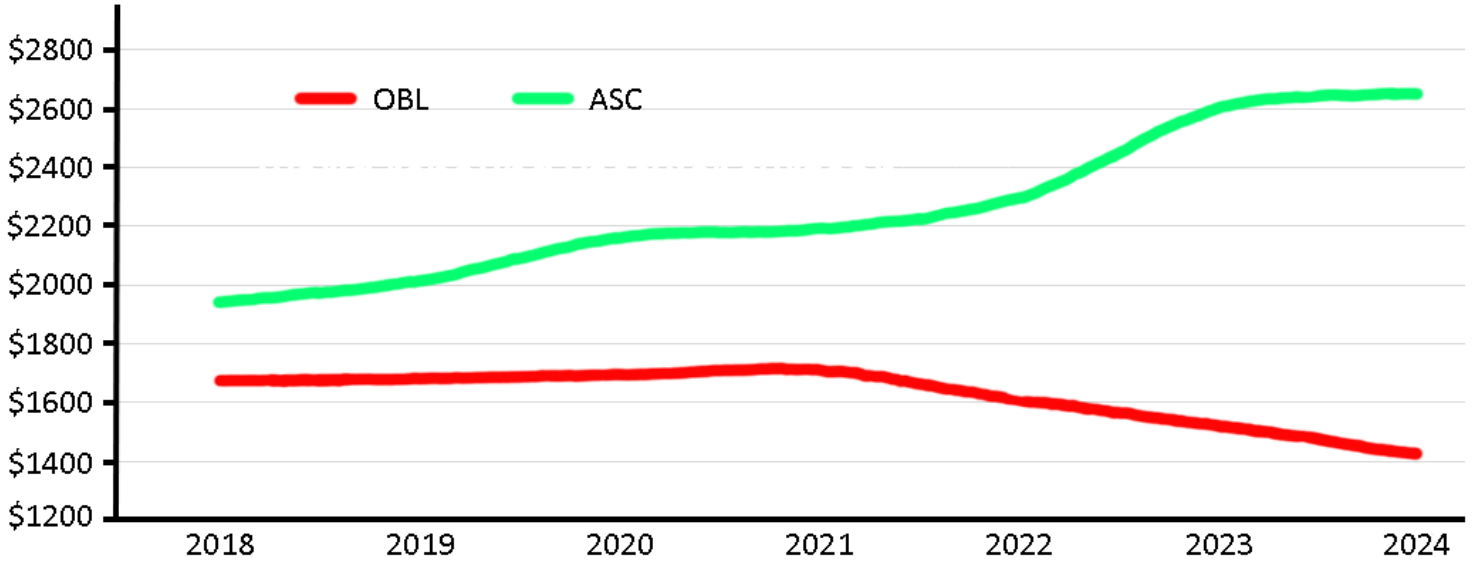
Correspondence: Dr. Gerald A. Beathard, Department of Medicine, University of Texas Medical Branch, 5135 Holly Terrace, Houston, TX 77056. Email: gbeathard@msn.com

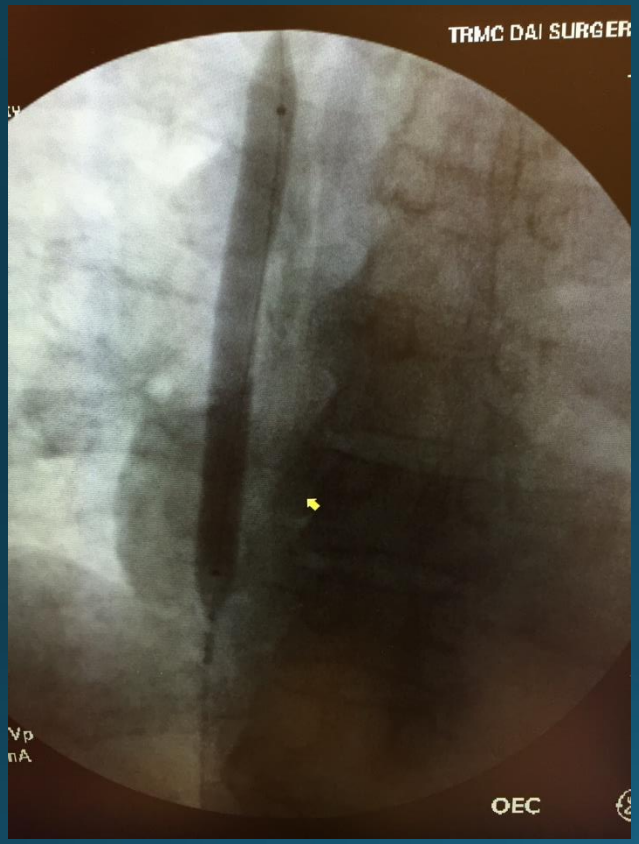
Change in Reimbursement per Encounter



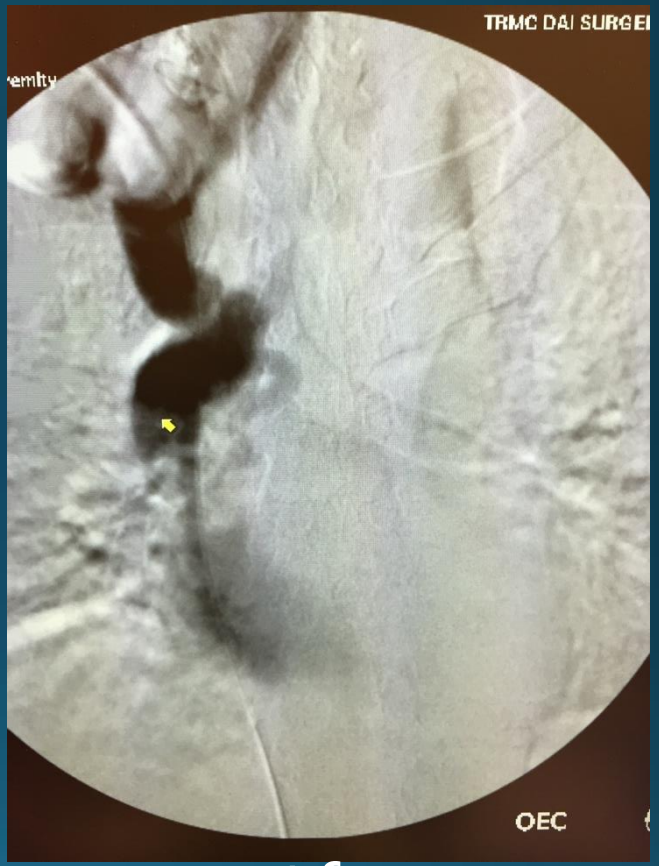
Source: Lifeline Vascular Access, internal data

Reimbursement Comparison OBL vs ASC
2018 - 2024





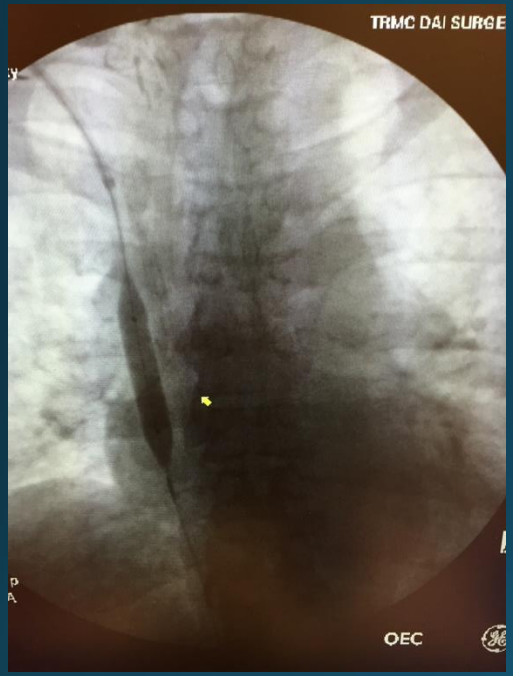
8x8 balloon



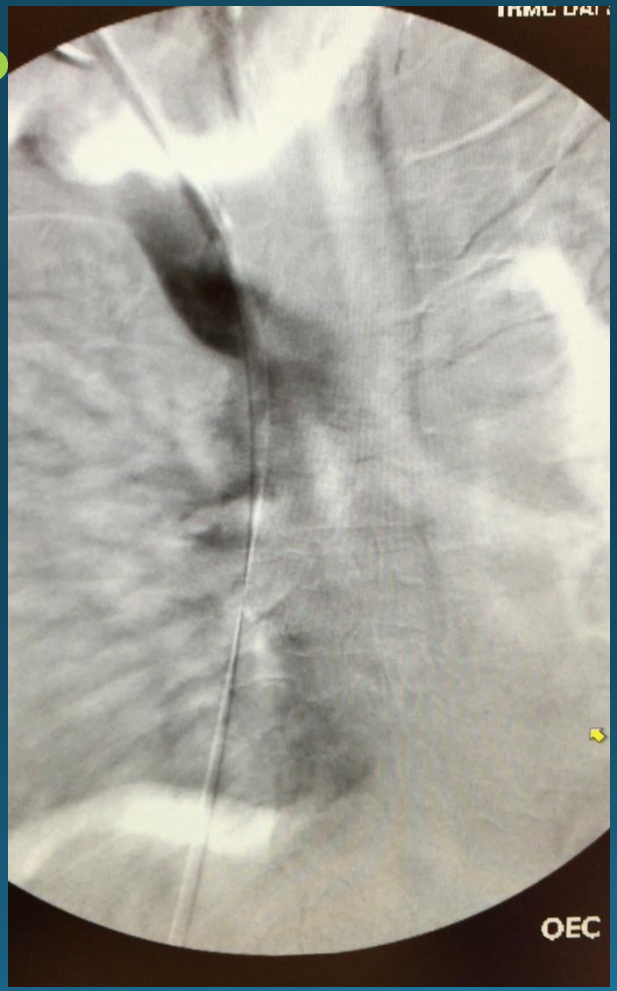
After

OBL VS HOPD?

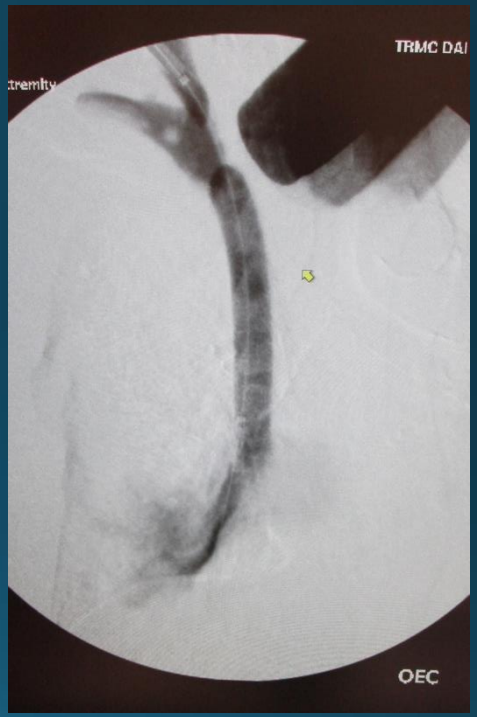
OBL VS HOPD?



10x4 balloon



After



13x10 Stent

THE STARTING LINE

74%

of patients start hemodialysis with a catheter — not an AVF, not a graft.
Despite “Fistula First.” Despite KDOQI. Despite forty years of trying.

USRDS 2024 ADR, Ch. 4 (data year 2022)

ONE PATIENT, THREE FAILURES

She lost her access three times in five months.

Composite case. Every detail is real; only the name is not.

Created.
AVF placed. Surveillance gap.

Clotted.
Stenosis missed. Thrombosis.

Catheterized.
Rescue line. Hospitalized.

M0 — M4 — M5

***Three failures. One patient. No system caught any of them**. #SILOS!!!!*



1976

Trauma stopped being a service.

It became a system.

Survival doubled.

2026

Dialysis access today
is where trauma was

in 1975.
They started ACLS,
do we need ADLS?

Same problem. Same solution.

WHY “TRAUMA” ISN’T A METAPHOR

Catheters kill.

All-cause mortality

1.53×

vs AVF (95% CI 1.41–1.67)

Fatal infection

2.12×

vs AVF (95% CI 1.79–2.52)

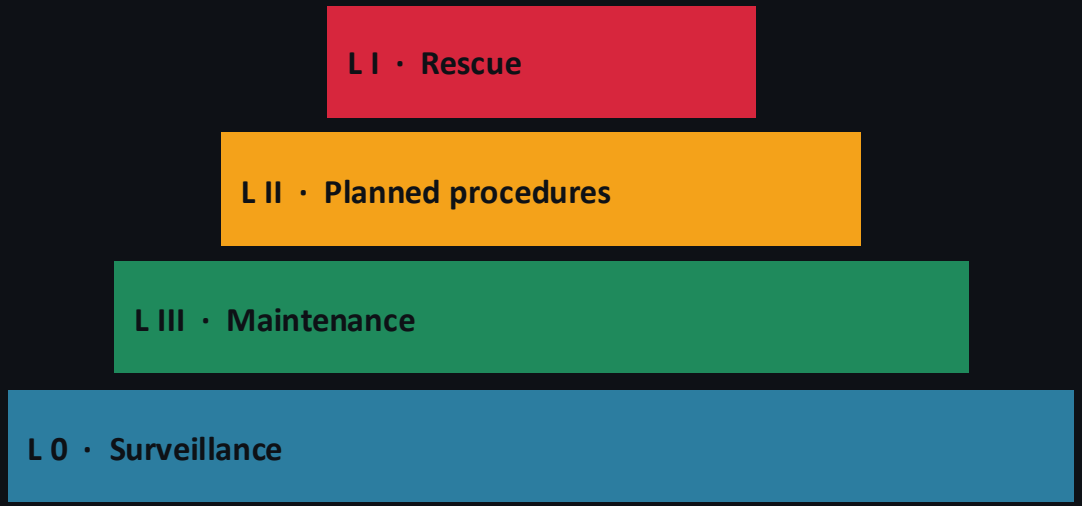
Every preventable catheter day is a mortality exposure.

BMC Nephrology 2025 meta-analysis

THE SYSTEM

Four levels. One patient.

FEWER PATIENTS · HIGHER ACUITY



Hospital-based, emergent

Scheduled interventions, ASC

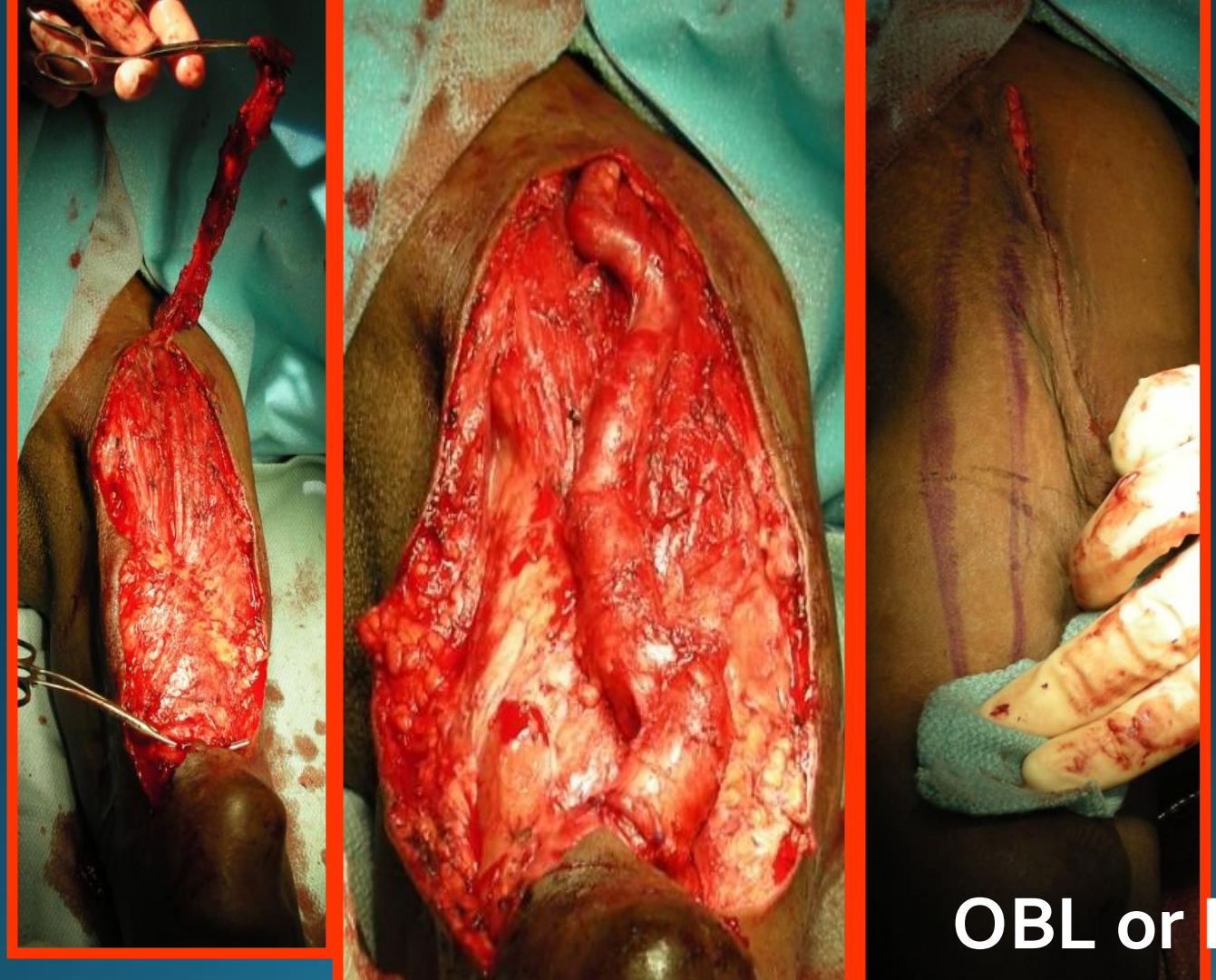
Routine access care, OBL

Catch failure before it happens, Clinic

MORE PATIENTS · LOWER COST

Triage by acuity: Red → L I · Yellow → L II · Green → L III · Blue → L 0

Evidence: Dobson 2013 (L III) · El-Gamil 2017 (L III) · Beathard 2026 (L I → L 0)



OBL or HOPD?

THE TRIAGE PROTOCOL

Every patient gets a color. Every color has a clock.

COLOR	TRIGGER	TIME-TO-ACTION	DESTINATION	OWNER
RED	Access stopped working or active bleeding	≤ 4 hours	L I HOPD	On-call MD
YELLOW	Function declining, flow ↓ or pressure ↑	≤ 72 hours	L II ASC	Access nurse
GREEN	Stable, on protocol surveillance	Routine	L III OBL	Care team
BLUE	CKD 4–5, approaching dialysis	≥ 6 mo. ahead	L 0 Surveillance	Nephrology

If a patient misses the clock, the system has failed — not the clinician.

Standard Risk Color Coding

- 🔴 **Red (Danger):** Indicates immediate danger where death or severe injury is probable (e.g., fire, high-voltage, emergency stops).
- 🟠 **Orange (Warning):** Warns of hazardous parts of machinery or equipment that can cause serious, but not immediately fatal, injuries.
- 🟡 **Yellow (Caution):** Alerts to potential hazards, such as tripping, falling, or slippery surfaces. It represents a lower risk than red or orange.
- 🔵 **Blue (Notice/Information):** Used for non-immediate, informational messages, such as safety instructions or equipment location.

THE NETWORK

Three sites. One patient pathway.

Escalate up ↑ · Return down ↓

OBL

Office-based lab

L III · Maintenance

HANDLES

Routine cannulation issues. Outflow stenosis. Tune-ups.

HANDS OFF

When clinical instability or rescue is needed.

→ ASC

Ambulatory surgery ctr

L II · Planned procedures

HANDLES

Fistulagrams. Angioplasty. Scheduled revisions.

HANDS OFF

When inpatient admission or full OR is needed.

→ HOPD

Hospital outpatient

L I · Rescue

HANDLES

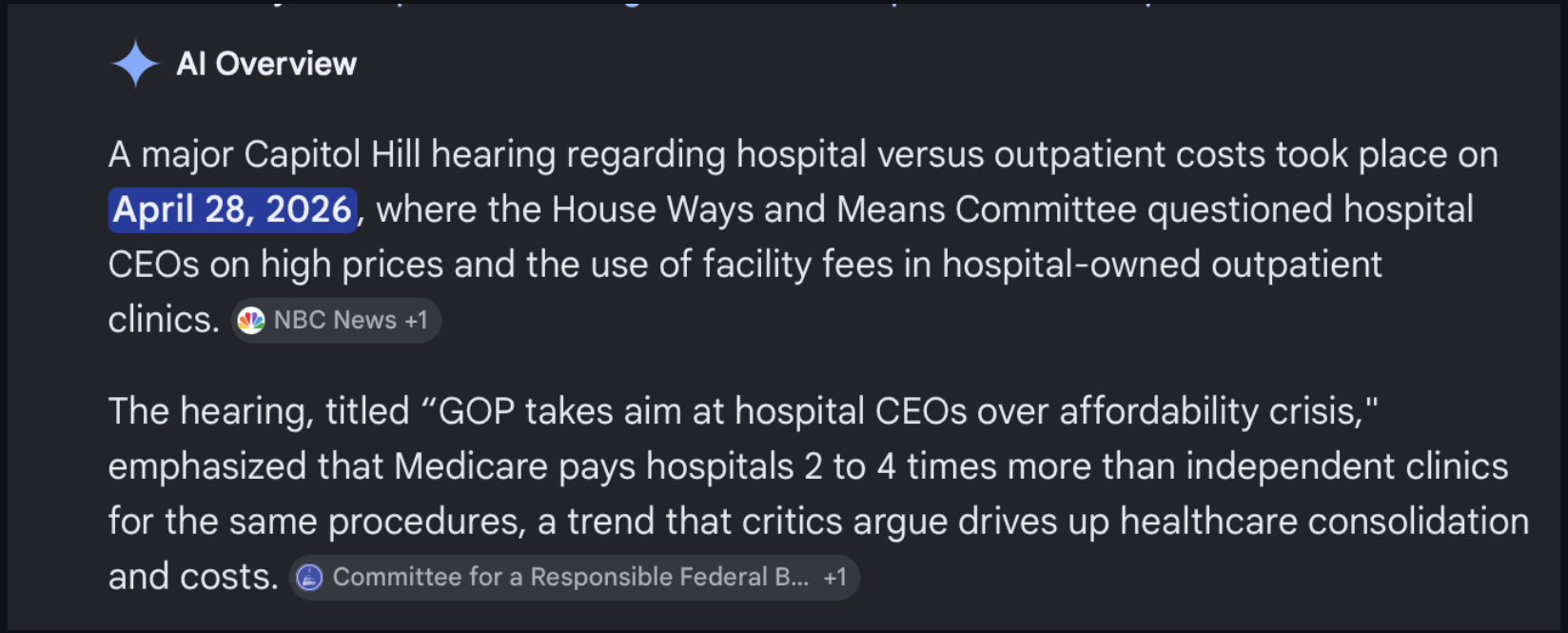
Catheter-dependent crises. Thrombectomy. Sepsis-adjacent.

HANDS OFF

When patient stabilizes for downstream care.

Patients move with the disease — not the patient chasing the building.

And what say the government? AI take it away . . .



United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

Chairman Smith to Hospital System CEOs: The Prices You Charge Patients Are Borderline Extortion

Key Takeaways from the 2026 Hearing

- **Site-Neutral Payment Focus:** Lawmakers strongly advocated for "site-neutral" payment policies, which would equalize Medicare reimbursements for services regardless of whether they are provided in a hospital outpatient department (HOPD) or an independent physician's office.
- **Facility Fee Scrutiny:** Hospital CEOs were questioned about "facility fees"—additional charges added to bills for using hospital-owned, off-campus facilities—which often double the cost of services like colonoscopies compared to independent surgical centers.
- **Hospital Defense:** Hospital leaders argued that higher payments are necessary due to the higher acuity of patients they treat and the increased operational costs (staffing, equipment, and compliance) associated with emergency-ready hospital systems.
- **Market Consolidation:** Concerns were raised that the higher reimbursement rates for hospitals encourage them to acquire independent practices, reducing competition. American Hospital Association +4

American Hospital Association™

Advancing Health in America

- Sicker patients with higher medical complexity with chronic illnesses
- Need to provide other services
- Rural area dependence
- Regulatory burdens

A key distinction between HOPDs and other care settings, such as physician offices or ambulatory surgical centers, is the patient population they serve. HOPDs consistently see patients who are sicker and more medically complex than those treated in other settings. These patients are more likely to experience severe chronic illnesses, dual eligibility for Medicare and Medicaid, and recent hospitalizations or emergency department visits, as well as living in lower-income communities.[12] Caring for these individuals requires advanced clinical capabilities, multidisciplinary support and integrated resources uniquely available in hospital-based settings.

The reliance on HOPDs is even more pronounced in rural communities. Medicare beneficiaries living in more rural counties are significantly more likely to receive care in HOPDs, and, in many cases, these facilities serve as the only accessible option for essential outpatient services.[13]

In addition to treating more complex patients, HOPDs must comply with far more rigorous regulatory and safety requirements than independent physician offices. These include strict infection control standards and fire and life safety codes, as well as compliance with oversight from Joint Commission, the Food and Drug Administration, U.S. Pharmacopeia, and other accrediting or regulatory bodies. While these standards are essential to ensuring patient and provider safety, they also substantially increase operating costs.

THE PATENCY (AKA Affordability) GAP

48.8%

AVF primary patency
at 12 months
in usual care.

97.3%

AVF primary patency
at 12 months
under structured surveillance.

Surveillance + structured maintenance trials, pooled.

THE OPERATING GOAL

Five zeros.

0 preventable catheters

0 missed maturations

0 avoidable admissions

0 access deserts

0 patients lost between sites

THE MATH NOBODY CAN IGNORE

<1%

of the U.S. population
has end-stage renal disease.

→ *consumes* **6.7%**

of total Medicare spend
goes to that <1%.

USRDS Annual Report; CMS expenditure data.

THE EVIDENCE

It already works.

$2,300

saved per access episode
in office-based labs

Dobson, 2013

32%

lower total cost of care
for managed access cohorts

El-Gamil, 2017

82%

reduction in catheter-dependence under a system

Beathard, 2026

Three studies. Three angles. One conclusion: the system pays for itself.

THE REVOLVING DOOR

33%

of dialysis patients are readmitted within 30 days — roughly twice the rate of the general Medicare population.

USRDS hospitalization data; CMS readmission benchmarks.

THE STAKES

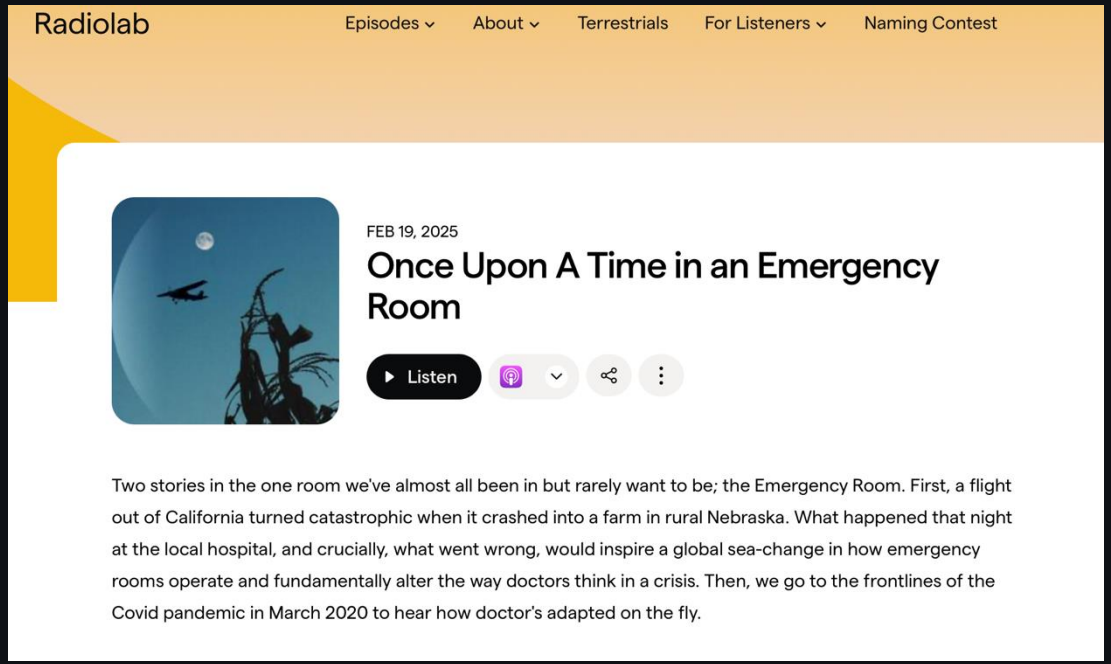
82%

reduction in catheter-dependence when access is delivered as a system, not a service.

Beathard et al., 2026

BONUS MATERIAL- PodCast

Origin of ATLS - Dr. Styner and his Plane Crash 1976

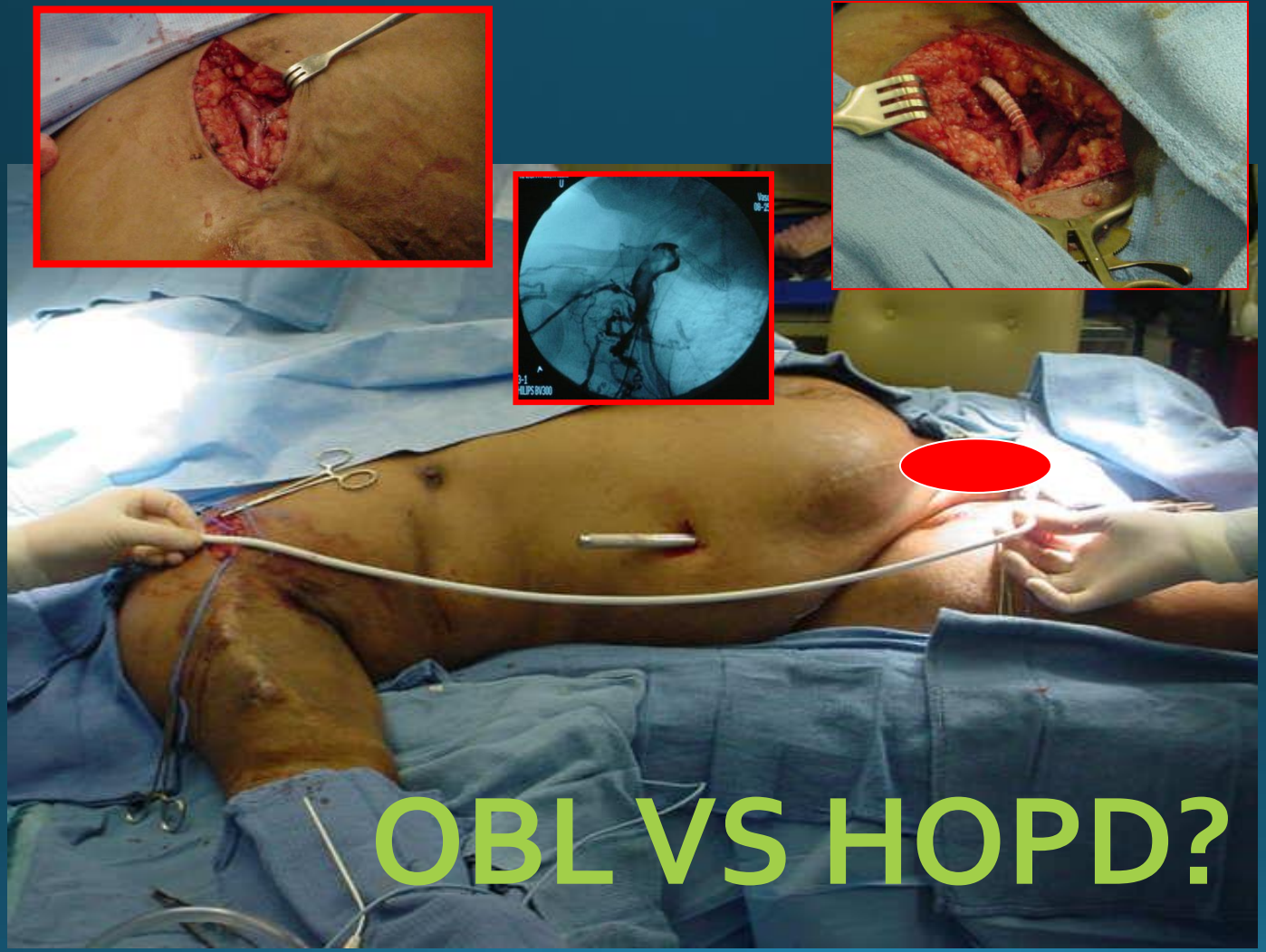


Trauma didn't wait for perfect data.

Neither should we.

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OBL VS HOPD?