Outpatient Endovascular Centers: Fad or Future
How to get Started?
Case Selection?

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Outpatient Vascular Laboratory
Why Office-Based?
Historical Overview

• Outpatient Trending - Outpatient Medical Procedures began its shift approximately 20 years ago with the formation of Ambulatory Surgical Services and Renal Dialysis Centers.

• Cardiac Cath and Endovascular Lab services was just the normal migration of the existing services that moved from previously exclusive in hospital services to the Outpatient Setting.
Office-based endovascular centers are becoming more common:

• More than 450 centers currently in US.

• Most units were opened to provide outpatient management of dialysis access and that is why many facilities are called “access centers.”

• Predating these were office-based venous centers that treated patients with venous insufficiency
Rise of Outpatient Based Procedures

• Several drivers have allowed for, and accelerated growth, in OBS

• The developments of minimally- invasive surgical techniques and new forms of anesthesia have permitted physicians to provide a broader scope of services in their offices.

• Many insurers no longer pay for extended hospitals stays following surgery, promoting the use of OBS and similar outpatient procedural settings, which may not be subject to such restriction

• Patients have been drawn to the office-based surgical setting for the numerous advantages it offers, including lower costs and increased convenience and comfort.

• Additionally, OBS offers physicians a greater degree of control over the administrative aspects of their practice and their patients’ surgical outcomes.
• Office-based outpatient surgeries have significantly increased in recent years, with a growing number of specialists electing to perform surgeries in their own offices rather than at outpatient hospitals or ambulatory surgery centers.

• Over a ten-year period from 1995 to 2005, the number of office-based surgeries (OBS) performed doubled, with 10 million procedures being performed in physician offices in 2010.

• The popularity of OBS has been driven by the potential benefits to provider autonomy but despite these potential benefits, commentators are concerned that the in-office setting has yet to be thoroughly regulated as to the quality of care received.
Case Selection?

• When appropriately screened, almost all peripheral interventions can be performed in the office with minimal complications.

• For dialysis patients, outpatient intervention has a very low complication rate and is the mainstay of treatment to keep the dialysis access patent.

• Venous insufficiency, when managed in the office setting, also has a low complication rate.

• Office-based procedural setting should be seriously considered for percutaneous intervention for arterial, venous, and dialysis-related procedures.
Outlooks for Outpatient Services

• Demand for outpatient or ambulatory surgery centers (ASCs) is growing in Europe, India, and other parts of the world. Since many countries have national health care systems, outpatient surgery is increasingly being offered by the country's hospital system.

• The US outpatient surgical center industry includes about 3,500 companies that operate about 5,000 centers and have combined annual revenue of about $18 billion. The industry is expected to experience high growth over the next two years, driven largely by patients seeking lower-cost alternatives to hospital care.

• Demand is linked to the number of people receiving medical care. The profitability of individual centers depends on efficient operations and good marketing.
Out Patient Procedures - Effect on Future

ACO leaders look to trim costs by eliminating redundancy in personnel and resources. What does this mean? More consolidation, centralization or outsourcing of services such as lab pharmacies, care coordination services.

Hospitals that are transforming themselves into ACOs many no longer look upon office-based procedures as a threat to their business but rather an opportunity to deliver surgical services in a more cost-effective manner under a comprehensive per patient bundled payment scenario.
Problems... Congress Budget Office, Cost Scan, Obamacare.
Why Office-Based?

- Convenient for the patient and Physician
- Less costly for the patient
- Less costly for insurance companies
- More efficient
- SAFE
• Over the last several years there has been a progressive decline in payments for vascular procedures

• DRA of 2005 reduced vascular lab reimbursement between 18% and 51%.

• Overall negative impact has been calculated to be 5% in a vascular practice

• Medicare has started to bundle more interventional procedures
Patient Benefit

• Patient convenience – same day discharge
• Safer for the patients
• Your patients see the same care providers
• Your staff know your patients
• Physician spend more time with patients before and after surgery
• Friendly, familiar environment and staff for patients
• Make it as comfortable as you want
Physician Benefit

- No travel time to the hospital
- Don’t have to wait for the hospital procedure room to be free
- See your other patients in between cases
- More control over the Environment
- Do at your schedule
- Many procedures performed in the office are reimbursed at much higher rates than the professional fees
- The higher “global” fees include professional fees and the “technical/facility” fees that would have gone to the hospital
As of January 1, 2005, Medicare approved physicians performing peripheral interventions in an outpatient facility….

September 2011, CMS approves reimbursement for endovascular interventions performed in outpatient centers!!!

August 2013, CMS proposed a 50% fee cut on non-facility reimbursements!!!

October 2013, the Outpatient Endovascular and Interventional Society (OEIS) was developed!!!

April 2015, The house of representatives approved Medicare Access and Medicaid Reauthorization Act (MACRA). That will eliminate the dreaded SGR (sustainable growth rate) payment cut.
## What Can We Do in the Office?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Lower Extremities</th>
<th>Upper Extremities</th>
<th>Abdomen</th>
<th>Cardiac</th>
<th>Head and Neck</th>
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<tbody>
<tr>
<td>Diagnostic Angiogram</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Angioplasty</td>
<td>X</td>
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<td>X</td>
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<td>Stent</td>
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<td>Atherectomy</td>
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<td></td>
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<tr>
<td>Dialysis Access Maintenance</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
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<tr>
<td>Embolization</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
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</table>
Doc - can you see the problem?

I'm afraid so.
But for how long?

- The Affordable Care Act has unknowingly proven to be a driver in the Office Based Lab landscape.
- Performing procedures in the Office Based Lab at a cost of 50% less than a hospital setting will continue to encourage the office based model.
- Financial Analysis studies by third party payers will solidify the office based model.
  - Blue cross Blue Shield of Michigan
Future of vascular surgery is in the office

Krishna M. Jain, MD, John Munn, MD, Mark Rummel, MD, Sarat Vaddineni, MD, and Chris Longton, RN, *Kalamazoo, Mich*

**Objective:** The practice of vascular surgery is under pressure from various specialties and payers. Our group started office-based procedures in May 2007. This article reports our study of the effect of this change on our case volume, office revenue, and the financial impact on the health care system.

**Methods:** Between May 1, 2006, and April 30, 2007 (period 1), and between June 1, 2007, and May 31 2008 (period 2), 3041 and 3351 cases, respectively, were performed. In period 1, only venous cases could be done in the office. Before arteriogram, serum levels of urea nitrogen and creatinine were obtained. The number of percutaneous cases done in the hospital and office setting was analyzed, and revenue was calculated based on the 2008 Medicare fee schedule for our region. Amputation and mortality rates at 30 days were documented. Hospital DRG payment schedule was obtained.

**Results:** In period 1, 670 (22% of total) percutaneous procedures were performed compared with 1502 (44.8%) in period 2, a twofold increase. In period 1, 1.5% of total cases were done in the office compared with 31% in period 2. There was a fivefold increase in revenue from these procedures. No deaths or amputations occurred as a result of procedures performed in the office. No anesthesiologist’s expense and minimal preprocedural expenses were incurred. Total payment by Medicare, DRG payment to the hospital, and the physician component were higher in all the cases.

**Conclusions:** A vascular surgery practice can benefit from office-based procedures. Procedures can be done safely. It results in an increase in the number of percutaneous procedures and revenue with a significant savings to the health care system. Surgeons can control their schedule. Every vascular surgeon should consider doing these procedures in office. *(J Vasc Surg 2010;51:509-14.)*
Office-based endovascular suite is safe for most procedures

Krishna Jain, MD, John Munn, MD, Mark C. Rummel, MD, Dan Johnston, MD, and Chris Longton, RN, Kalamazoo, Mich

Objective: This study was conducted to identify the safety of endovascular procedures in the office endovascular suite and to assess patient satisfaction in this setting.

Methods: Between May 22, 2007, and December 31, 2012, 2822 patients underwent 6458 percutaneous procedures in an office-based endovascular suite. Demographics of the patients, complications, hospital transfers, and 30-day mortality were documented in a prospective manner. Follow-up calls were made, and a satisfaction survey was conducted. Almost all dialysis procedures were done under local anesthesia and peripheral arterial procedures under conscious sedation. All patients, except those undergoing catheter removals, received hydrocodone and acetaminophen (5/325 mg), diazepam (5-10 mg), and one dose of an oral antibiotic preprocedure and three doses postprocedure. Patients who required conscious sedation received fentanyl and midazolam. Conscious sedation was used almost exclusively in patients having an arterial procedure. Measurements of blood urea nitrogen, creatinine, international normalized ratio, and partial thromboplastin time were performed before peripheral arteriograms. All other patients had no preoperative laboratory tests. Patients considered high risk (American Society of Anesthesiologists Physical Status Classification 4), those who could not tolerate the procedure with mild to moderate conscious sedation, patients with a previous bad experience, or patients who weighed >400 pounds were not candidates for office based procedures.

Results: There were 54 total complications (0.8%): venous, 2.2%; aortogram without interventions, 1%; aortogram with interventions, 2.7%; fistulogram, 0.5%; catheters, 0.3%; and venous filter-related, 2%. Twenty-six patients required hospital transfer from the office. Ten patients needed an operative intervention because of a complication. No procedure-related deaths occurred. There were 18 deaths in a 30-day period. Of patients surveyed, 99% indicated that they would come back to the office for needed procedures.

Conclusions: When appropriately screened, almost all peripheral interventions can be performed in the office with minimal complications. For dialysis patients, outpatient intervention has a very low complication rate and is the mainstay of treatment to keep the dialysis access patent. Venous insufficiency, when managed in the office setting, also has a low complication rate. Office-based procedural settings should be seriously considered for percutaneous interventions for arterial, venous, and dialysis-related procedures. (J Vasc Surg 2014;59:186-91.)
<table>
<thead>
<tr>
<th>Procedure type</th>
<th>Procedures, No.</th>
<th>Patients, No.</th>
<th>Complications, No.</th>
<th>Complications per</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Procedure, %</td>
</tr>
<tr>
<td>Venous</td>
<td>1019</td>
<td>785</td>
<td>22</td>
<td>2.20</td>
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<tr>
<td>Aortogram</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No interventions</td>
<td>571</td>
<td>464</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>With interventions</td>
<td>368</td>
<td>191</td>
<td>10</td>
<td>2.70</td>
</tr>
<tr>
<td>Fistulogram</td>
<td>2719</td>
<td>829</td>
<td>13</td>
<td>0.50</td>
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<tr>
<td>Catheters</td>
<td>1477</td>
<td>342</td>
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<td>Inferior vena cava filters</td>
<td>57</td>
<td>24</td>
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</table>
Table III. Patients transferred to the hospital

<table>
<thead>
<tr>
<th>Complication</th>
<th>No.</th>
<th>Transfer, %</th>
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</thead>
<tbody>
<tr>
<td>Hematoma</td>
<td>9</td>
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<tr>
<td>Thrombosis</td>
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<td>11.50</td>
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<tr>
<td>Cardiac</td>
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<td>11.50</td>
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<tr>
<td>Pseudoaneurysm</td>
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<td>7.70</td>
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<tr>
<td>Hypotension</td>
<td>2</td>
<td>7.70</td>
</tr>
<tr>
<td>Syncope</td>
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<td>7.70</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>1</td>
<td>3.80</td>
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<tr>
<td>Seizure</td>
<td>1</td>
<td>3.80</td>
</tr>
<tr>
<td>Bleeding</td>
<td>1</td>
<td>3.80</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>1</td>
<td>3.80</td>
</tr>
<tr>
<td>Irretrievable wire</td>
<td>1</td>
<td>3.80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>
Ingredients for Success….

Accreditation

Accreditation is a voluntary process through which a health care organization is able to measure the quality of its services and performance against nationally-recognized Standards.

Accreditation with a nationally recognized organization is resource intensive but is invaluable in helping to maintain a high quality of operational standards.

AAAASF  The American Association for Accreditation of Ambulatory Surgery Facilities

AAAHC  Accreditation Association for Ambulatory Health Care
Ingredients for Success….

Multi-Specialty Approach:

- Interventional Cardiologists
- Vascular Surgeons
- Interventional Radiologists
- General Surgeons
Ingredients for Success....
Ingredients for Success….

State of the Art Interventional Suites
State of the Art Recovery area
SCALE

Satisfaction
Collaboration
Adaptation
Location
Education
DETERMINE THE RESULTS YOU WANT TO ACHIEVE IN THE NEXT YEAR

In the next 12 months, what are the major results I want to deliver at work?

- **Customers:** Identify customers who directly or indirectly receive value from the goods or services you produce. How can you add value for them?
- **Investors:** What do they want? What can you and your group do to meet their expectations?
- **Employees:** What employee outcomes do you seek: greater creativity, better collaboration, higher retention? What do your employees need from you?
- **The organization:** How can your team help the organization execute on its strategy?

While identifying innate strengths is an important part of defining your leadership brand, the starting point is clarifying what is expected of you.
DECIDE WHAT YOU WISH TO BE KNOWN FOR

Develop a list of attributes that you want to be known for

- Putting Patients First
- Unsurpassed Service
- Superior Patient Outcomes
- Patient Friendly Environment; Accepts Widest Range of Insurance
- Compassionate
- Advance Technology & Research
- Knowledgeable and Friendly Staff
- Easy to Schedule Appointments
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“I’m prescribing exercise. Think of it as a stress pill that takes 30 minutes to swallow.”

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DEFINE YOUR IDENTITY

Combine list of attributes (previous slide) to form a desired identity....

• ‘Putting patients first by combining leading technology with superior outcomes’

• ‘Patient friendly environment accepting all types of insurance with easy to schedule appointment’

• ‘Compassionate, knowledgeable and friendly staff focused on superior patient outcomes based on science’

JUST DO IT.

® Nike, Inc