# Outpatient Centers: The Academic Perspective (or Lack Thereof)

Can academic centers evolve to a community approach for outpatient interventional care?

BY ROSS MILNER, MD, AND RAVI VEERASWAMY, MD

Most academic centers have resisted the burgeoning trend of outpatient-based therapy that has become prevalent in the community setting. Despite the steep increase in community practice physicians (interventional radiologists, interventional cardiologists, and vascular surgeons) utilizing and developing outpatient centers, the same development has not occurred in the academic setting. As far as we know, there are very few academic centers participating in outpatient interventional suites. The two players, the academic administration and the treating physicians, have differing reasons for not participating in the growth seen in community practice. In this article, we will focus on each one individually.

## ACADEMIC ADMINISTRATION

The academic administration is clearly interested in patient satisfaction and efficient use of resources. This aspect of outpatient care has been well demonstrated by coeditor for this issue of *Endovascular Today*, Dr. Krishna Jain, and many other physicians. The data demonstrate a huge increase in patient satisfaction when having their procedures performed at an outpatient center. And, despite many concerns about financial incentives, the data show a decreased number of interventions needed per patient. This decrease is especially true in the dialysis-dependent population. So, what is the restriction? The financial resources necessary to purchase or lease one of these centers is not a priority in the current era of financial constraint. The hospital is already collecting all of the technical fees in the current paradigm of in-hospital procedures. The incentive is not there to develop relationships in the outpatient arena. Furthermore, an outpatient center may result in physicians requesting some model of revenue sharing for the technical fees—a concept of which many hospitals are wary.

The data demonstrate a huge increase in patient satisfaction when having their procedures performed at an outpatient center.

## PHYSICIANS

The physicians have different restrictions. Most academic practitioners are salary-based employees of a university. Although many have productivity-based incentives, the increase in available salary does not reach the difference that community physicians can achieve with an outpatient center. As previously noted, most academic practices are precluded from any collection of technical

fees, even with an efficient practice model. Moreover, there are many logistical hurdles such as meeting the exact definitions of "outpatient," screening patients appropriately, establishing protocols, and incorporating these cases into an otherwise busy clinical schedule. So, most academic physicians do not actively seek opportunities to practice in an outpatient center. But, should we?

## THE IDEAL MODEL

We have struggled with this concept since we first became aware of outpatient centers many years ago. Our skeptical point of view was that the transition to this model was purely financial. Academic centers clearly need to make money, but the individual physician's incentive to make more does not exist in the current academic paradigm in most centers. The outpatient concept has clearly persevered and been very successful for many physicians. So, it is not solely financially based. Patients enjoy the experience, and doctors are able to take care of their patient effectively and in a timely fashion, as the turnover time in the procedure room is minimized. The other "X factors" that make the hospital experience inefficient are eliminated, and doctors and staff learn to use the equipment and supplies in the most cost-effective fashion. Finally, the entire staff partners in the success of the center and the patient experience.

Is it possible for this model to even exist in an academic environment? We say yes. We think that the physicians and administration need to start thinking outside of the traditional models. Most academic centers have a full operating room and full interventional suite. The elective schedule needs to be arranged days in advance. It can be challenging to add urgent cases of any type without affecting your partners in a negative way. This scenario is equally frustrating to patients and physicians. Also, the hybrid operating room is an inefficient (in regard to finances and time) location to perform straightforward procedures that can safely be completed on an outpatient basis. The inefficiency includes the need for preoperative nursing care, anesthesia care, and separate postoperative nursing care.

## PARADIGM SHIFT

How do we safely and effectively change our paradigms? We think outpatient centers can exist within an academic model. Physicians will need to partner with administration to design a scheme that allows for profit sharing that is mutually beneficial. On the other hand, physicians need to have some stake to ensure efficiency and productivity. An outpatient center that leads to financial losses needs to affect the physicians as well.

As academicians, we are comfortable with this approach. We think our patients will benefit from the change in treatment paradigm. We will increase patient satisfaction and likely, physician productivity. We believe the outpatient experience has already demonstrated these two points to be very true. The finances are a little more concerning, but with appropriate planning and incentives, this model can work to benefit all parties. The exact financial relationship between the physicians and the hospital will need to be individualized based on the needs on each center. We are hopeful that we can evolve to allow the more straightforward procedures to be completed in a more cost-efficient, profitable environment that ultimately provides the best possible care for our patients. ■

We think that the physicians and administration need to start thinking outside of the traditional models.

*Ross Milner, MD, is Associate Professor of Surgery; Director, Center for Aortic Diseases; Associate Program Director, University of Chicago Pritzker School of Medicine in Chicago, Illinois. He has disclosed that he has no financial interests related to this article. Dr. Milner may be reached at rmilner@surgery.bsd.uchicago.edu.*

*Ravi Veeraswamy, MD, is Associate Professor of Surgery, Division of Vascular Surgery, Department of Surgery, and Program Director, Vascular Surgery Fellowship Program at Emory University School of Medicine in Atlanta, Georgia. He has disclosed that he has no financial interests related to this article. Dr. Veeraswamy may be reached at rveeras@emory.edu.*