Which trends in outpatient vascular care are most concerning to you right now? The most encouraging?

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The growth of outpatient centers seems to be a logical transition in vascular care, and yet, the trend has certainly been anything but constant. There are many factors that have accelerated, and slowed, the growth of outpatient endovascular procedures. I am going to focus my discussion on the sole-proprietor or small-group facility. If you are considering starting an outpatient center, you will probably evaluate: (1) what services to offer, (2) market potential, (3) profit forecasts, (4) safety requirements, and (5) personal satisfaction.

The first consideration is what services your office will provide to the community. I find this to be one of the most encouraging aspects of outpatient vascular procedures because there are so many new procedures that are well suited to this type of office (eg, saphenous vein ablation). Other procedures that were previously limited to hospitals or outpatient surgical centers are now possible in outpatient offices. A recent example is the opportunity opened up by the broadening uses of radial access. In the future, renal denervation may be very well suited to outpatient care using a radial approach.

A market analysis for outpatient endovascular services often looks rosy but involves a lot of speculation. Acquiring new patients, unless you are transferring your existing patients from another facility, is difficult to predict. A long-term market analysis should model the effects of market consolidation. Unfortunately, as outpatient centers are incorporated into established health systems, an individual practioner's ability to create efficient local care systems is diminished.

Perhaps the most daunting aspect of creating an outpatient center, in my opinion, is the growing difficulty in predicting profits. The governmental initiatives driving insurance changes make long-term predictions of income extremely difficult. Choosing to offer self-pay procedures can mitigate this dependence on insurance regulations but opens up susceptibility to economic swings. The recent recession has certainly reminded us that many outpatient procedures are elective.

Safety is always on a physician's mind, and in an outpatient center, the demands are great and increasing. Patient and staff safety are complex issues that need expertise and extraordinary effort to correctly implement. In the future, I foresee that physicians interested in setting up shop will be more consumed with the quality programs they need to establish than with the finances. These requirements may threaten the ability of small-group outpatient centers to compete with larger health systems.

Personal goals and satisfaction require careful analysis before diving into creating an outpatient procedure center. The potential personal satisfaction that comes with helping to expand the role of outpatient vascular procedures and of molding every aspect of the patient experience are exciting. However, the fee-for-service tradition is threatened by the rising tide of accountable care, the administrative responsibilities are growing, and market consolidation seems inevitable.

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The most concerning aspect of outpatient vascular care is that American health care became monetized when innovation created expensive platforms for delivering health care. This has resulted in miraculous breakthroughs and opportunities for patients. The monetization of the health care industry has brought in multiple stakeholders all wanting a slice of the pie, and the federal government responded with the Affordable Care Act. The United States Government is creating an environment in which only large integrated systems will have the capacity to comply with the excessive and overreaching rules and regulations of this act, which is designed to overhaul 16% of the economy. Physicians are becoming increasingly marginalized and subjugated as this rolls out.

Hospitals have become large integrated systems—a requirement for the complex infrastructure and teams of people necessary to take care of the life-threatening acute illnesses. However, for the outpatient treatment of non-life-threatening, chronic illnesses, hospital delivery of care is bloated and expensive. Office-based endovascular labs, also known as physician-owned labs (POLs), provide a lower-cost alternative for the delivery of outpatient vascular care. POLs can be efficient and streamlined and have been well received by patients. Catheter-based platforms for arterial and venous interventions, smaller footprint laptop ultrasound units, and portable C-arm fluoroscopy equipment have created an opportunity for physicians to have more control in patient care. Unfortunately, POLs function as small businesses and are inherently dependent on adequate reimbursement.

Now in our 12th year of operating a dedicated POL focused on venous disease in downtown Miami, Florida, we are beginning to have concerns. The Centers for Medicare & Medicaid Services have steadily cut reimbursement for office-based endovascular therapy, including another 5% to 7% for 2014, and to further exacerbate the problem, fixed expenses continue to rise. In Miami, we have already assumed higher overhead costs in our POL during the past several years in order to employ the extra staff needed to collect and input government-mandated data into a labor-intensive electronic medical records system. I'm afraid we will need to consolidate in the near future to build efficiencies in the back office—the days of the solo practitioner may be coming to an end.

However, there are some encouraging aspects as well. Physician specialty societies, such as the Society for Vascular Surgery, Society of Interventional Radiology, and American College of Surgeons have organized political action committees and seem to be making an impact, including recently:

1. A cap on payment for services performed in angiography suites was averted.
2. Barriers to abdominal aortic aneurysm screening for at-risk Medicare beneficiaries were removed.
3. Additional cuts to vascular ultrasound reimbursement were averted.
4. Independent Payment Advisory Committee repeal was introduced in the House and Senate.
5. Work has been done with Congressional committees to repeal and reform the Sustainable Growth Rate.

Will physicians ever be a large enough special interest group to effectively combat the lobbying behemoths in our space (the insurance industry, attorneys, pharmaceutical industry, and hospital administrators)? We shall have to wait and see how it all plays out… ■