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# The Benefits of Office-Based Labs

A panel shares insights into using office-based labs to plan for the future.



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**Can you tell us about your back-ground?**

**Dr. Kiesz:** Early in my career in Poland, I recognized many people in the countryside were dying of heart attacks because they could not make it to the cities and the big, beautiful hospitals. My initial thought was—what if we built smaller centers with everything concentrated around the cath lab, because that’s the heart of cardiovascular and vascular care? We built a prototype unit, proved its efficacy, replicated it in 30 rural areas, and decreased mortality from acute myocardial infarction (MI) tenfold. This seminal concept shaped my future.

The model I developed served as a blueprint to establish a network of outpatient interventional labs in Texas and beyond. I have currently been working on the next-generation center of excellence for outpatient coronary and endovascular interventions.

**Dr. McGuckin:** I am an interventional radiologist and opened my first office-based lab (OBL) in 2002, my second in 2003, and my third in 2004. They were part of the American Access Care chain that was acquired by Fresenius in 2006. Next, I started building vascular access centers. We have 18 centers around the country, of which I’m the founder, CEO, and medical director. I also have three centers located in and around Philadelphia that I own exclusively and serve as the primary physician.

**Dr. Gagne:** I’m a vascular surgeon and was with New York University for about 8 years and then moved to southern Connecticut. We opened our first OBL about 4 years ago. From there, we grew rapidly to six offices, and 19

vascular surgeons spread across the southern tier of Connecticut; we expect to add another four offices this year. We use the campus system, whereby we distribute the work by geography and hospital concentrations. Connecticut is not a big state, so you could drive from one end to the other in about an hour and a half easily, but with the awful, unpredictable traffic, our patients pick what is local to them.

### What is your business model—OBL only or hybrid?

**Dr. Gagne:** We are strictly OBL, using only sedation and local anesthesia. In Connecticut, if you want to open the more complex ambulatory surgical centers (ASCs) or hybrid centers with general anesthesia, you must have a certificate of need (CON), which is a high bar to meet. There are 35 states (including Washington, DC) that still have CONs, which designate the types of health care facilities that apply. A state has not successfully eliminated it in total since 1999, but there are changes to the matrix, so it is best to do your homework on state-specific designations before picking a location and business model.

**Dr. Kiesz:** My hybrid business model (OBLs and ASCs) is currently being adopted by my colleagues who want to leave their hospitals. The way medical technology is improving, more and more procedures can be done safely with the hybrid model. However, I believe determining which specific model is best depends on your particular circumstances, the state “need” requirements where you want to work, and the health demographics of the community you’re located in.

### What prompted you to start your first lab?

**Dr. McGuckin:** More than anything, it was the freedom to do what is right by the patient. Hospitals put patients through a lot of rigmarole, none of it efficient or pleasant. From my time in the hospital milieu, I realized they were not particularly patient-focused, nor did I feel like much more than a small cog. Here, the physician gets to be the pitcher or quarterback. We call the plays, set the schedule, drive the tempo, all while being responsible for customer service. There is never a question of accountability or the primacy of the customer. The OBL physician is generally more entrepreneurial and is able to adapt quicker to new technologies and therapies that are also beneficial to the patient.

**Dr. Kiesz:** First and foremost was the recognition that patient safety and long-term outcomes continued to improve with new stent advances and without the

need for immediate surgical backup. I observed this in the early 1990s while director of one of the busiest VA hospitals in the country, where I was able to reduce a 6-month cath lab wait down to zero. Coupled with my early years in Poland, these experiences convinced me that most interventional procedures could be done on an outpatient basis.

My long association with the hybrid model bears this out. They are very cost-effective for the third-party payer—maybe 50% to 60% less than hospital costs because we don’t keep patients 24 hours. On average, a patient undergoing percutaneous coronary intervention (PCI) is discharged within 2 hours because we do not use heparin. We have had just a few transfers to the hospital and no strokes, acute MI, or amputations, and just one or two retroperitoneal bleeds. Further, outpatient models are more convenient with 5-minute check-ins, personable staff, quicker turnaround times, and less chance of infection, all equating to higher customer satisfaction.

**Dr. Gagne:** I think part of it was the need for my patients, staff, and colleagues. I was also motivated by the time it took to perform PCI in the hospital versus how long it was taking my colleagues who went the OBL route. They told me, and now I can confirm, that you can do five or six procedures in the office in the same time it takes to do three in the hospital.

Although you don’t get paid for procedures that you are not doing, the real problem is that you still have 100 patients needing 100 procedures, and if you do them in the hospital at a clip of four or five cases a day, you are working late nights to bring the backlog down. That is neither sustainable nor good for your patients, your team, your family, or you.

### What types of procedures do you perform in your OBL?

**Dr. Kiesz:** When I started my OBLs, we selected stable patients who had relatively simple diseases to fix. Peripheral artery disease (PAD) was approved by Medicare, so we started with that. Initially, we focused on groin area care, but quickly jumped to the radial approach, and now 90% of cases are done that way. This is more technically demanding, but safer for the patient.

As an early pioneer in coronary, carotid, renal, and iliac stenting, we have extensive experience in the full range of intervention. Supported by state-of-the-art testing and diagnostic devices, we can fix anything that interrupts arterial or venous blood flow. For limb salvage, we often use atherectomy devices. I like the Phoenix device (Philips

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Volcano) because it is a front-cutter that captures and contains the calcified plaque. We also have alternative procedures to open heart surgery and recently completed one of the first unprotected left main coronary artery stenting procedures, all on an outpatient basis.

**Dr. Gagne:** We started with dialysis access and maintenance to get our procedures solidified in our new venue. Deep venous interventions have been a mainstay for a decade now, really taking off in just the last 2 to 3 years. It is a huge unmet need and area of growth for us, as few doctors in our locale have our expertise. Related procedures include angiograms and IVUS imaging, atherectomies, and inferior vena cava filters. We've also added fistulograms for dialysis access and vein ablations, superficial vein, and arterial work. Except for aneurysms and carotids, few high-volume areas of vascular surgery remain that we are not already performing in our OBL.

**Dr. McGuckin:** I would say we do over 1,000 arterial and maybe 100 or so venous cases annually. We perform mostly limb salvage procedures, including deep venous occlusions, PAD, and the enigmatic iliac vein compression syndrome. Additionally, we provide access support services for central venous catheter patients, tunneled catheter patients, and dialysis patients.

Digital IVUS has been critical for me and for my patients undergoing more complex interventions. It has really opened our eyes, enabling a more complete assessment of the diseased area, including boundaries and plaque morphology, facilitating accurate stent sizing, and ensuring complete stent expansion/apposition and proper placement postdeployment. I have learned from my patients with long diffused lesions that it can look beautiful on an angiogram and horrific on an ultrasound. That kind of information is priceless in avoiding inappropriate treatment.

### When setting up your first OBL, what were your biggest challenges?

**Dr. McGuckin:** The first challenge was to come up with the financing. The second was the insecurity of going out and practicing on your own. I believe the third was getting the staff to believe in the mission. It takes a lot of buy-in for people to leave their jobs to come and hope and believe in your dream, but we've been very successful in that aspect, and I have had great teams to help me build my programs over the years.

**Dr. Gagne:** At the time, we had maybe two OBLs in the entire state, and some of our prospective staff were

reluctant to give up their day job for something that might not be around in 12 months. Initially, we staffed part-time or on a per-diem basis to get our numbers up before hiring full time. Then, we looked at reimbursement and tracked certain procedures. We found out, for example, that one of the private carriers refused to reimburse for procedures done in an OBL. If we hadn't been paying attention, we would've gone a long way down the road before anyone figured that out.

### As you look ahead, what trends do you see having an impact on the OBL market?

**Dr. Kiesz:** This is an excellent question. Reimbursement always depends on the political winds and sadly, physicians have lost any significant influence there. I think with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) coming, we are in pretty good shape; paying for performance and a greater emphasis on quality is beneficial to the patient. Today, we track everything that happens, and I have a research department that analyzes and provides us feedback on trends, good and bad. I've also been a strong proponent of building out my OBLs in a sort of cookie-cutter fashion, which reduces variability and enhances standardization, compliance, and higher quality.

I think the big hospital, with its overhead, will become smaller and more focused on the really tough, complex cases that require backup. I sometimes wonder if it exists for the patient or if the patient exists for the hospital with long appointment wait times, poor customer service, little communication with the patient, long queues, and congestion. However, the hospitals will remain an important part of health care, and OBLs and ASCs need to maintain good, mutually supportive relationships with them.

**Dr. McGuckin:** There is no doubt we will be doing cancer surgeries and aortic endografts in the outpatient space in the not-too-distant future. I think interventional oncology is going to continue to grow as well; these are high-impact, typical hospital cases that will surely migrate to outpatient OBLs/ASCs because it is safe to do, and patients favor the convenience.

**Dr. Gagne:** MACRA will try to provide more oversight to ensure that the quality standards, safety, and outcomes are being met. I think it's been very hard for hospitals to be regulated from the quality and safety perspectives. I have worked in hospital systems where we had three or four hospitals. What goes in one hospital doesn't necessarily go in another. There are a lot of

nonstandard protocols and processes that don't equate to high quality or customer satisfaction.

I think the other part is going to be the interplay between the OBLs and the carrier(s). We probably do 60% or 70% of vascular surgeries in the community, with quality equal to the hospital, but in a more patient-focused environment. We are doing it at a cost that's below hospital costs. I think payers will continue to carve out certain disease processes and certain treatments that are best accomplished in OBLs like mine.

### What role(s) did industry serve in helping you get up and running?

**Dr. McGuckin:** It all fell on my own shoulders initially. However, when we recently rolled out IVUS across the country, our vendor, Philips Volcano, structured a utilization program for our entire network versus buying the machines and hardware outright, a huge benefit and advantage. More importantly, the imaging IVUS provides enables us to do amazing therapies. An industry partner, especially for imaging products that can focus on small access, helps us to improve patient outcomes.

There are certainly times when a full-solution partner can really help—during rapid expansion, keeping us current and compliant, and advising on the trends and next big thing.

**Dr. Gagne:** A full-service partner would be very helpful if it is coordinated and seamless. We met with Volcano recently and have had a long-standing relationship with them. They have newly merged with Philips, and I think because of their complementary imaging equipment, they have a natural place in the OBL niche.

When we were 2 years into the OBL, we started keeping a closer eye on operating expenses. When you bring in younger doctors out of training, sometimes they're inclined to go through more supplies. You do have to be cognizant of your strategy and think through supply utilization with your physicians and staff. We also decided to go with fewer supply vendors, focusing on those that provided best value support.

Advisory support would be beneficial for anyone just getting started, rapidly expanding, or when multiple, single owners decide to merge. Let's face it, sometimes, you just don't know what you don't know. If a consultancy goes full bore into the OBL business and they're meeting 100 or 1,000 practices that are doing OBLs, they become the de facto expert. After initial setup support, we will want to meet with them once or twice a year and ask, "What have you learned this year?

What's new out there? What can we do differently and better?"

**Dr. Kiesz:** If you are asking whether or not I would use industry to help set up or expand my practices, I would say absolutely. If you have good corporate partners, you're not alone. I've been using Philips and GE equipment for a very long time and noted that Philips is now supporting the OBL space from a disposables and consulting perspective as well. It is very important to have trustworthy, long-term service, good equipment that doesn't break, and is not crazy expensive.

### What advice do you have for a colleague who is looking to start their own OBL?

**Dr. Gagne:** Just do it. Do your research, get your team, run the numbers, talk to people, but do it. Try to put together your effort with other interventionists, such as cardiologists, radiologists, or vascular surgeons. Get a group of people skilled with synergistic capabilities together, and just do it. Your life will improve, and the patients will be happier and better served.

We found that starting in dialysis access allowed us to get procedurally comfortable very quickly. Others may want to start with angiograms and venograms and simple angioplasty/stent cases. Initially, pick your cases wisely because you are training your staff and yourself on how to work in a different environment. When you have your procedures down, slowly move to more difficult procedures and cases such as atherectomy, chronic occlusions, and deep vein thrombosis. You're looking at maybe a 12- to 24-month transition from the hospital environment to being 90% OBL.

**Dr. Kiesz:** Like most new business ventures, you have to proceed cautiously. What you do depends on the collective skills of the physicians you align with. Look at how your reimbursements work with the OBL or ASC in your state(s). I have protocols written for just about everything to help with compliance and quality, including how the patient is greeted, how the patient is taken care of, etc. Working with industry can relieve you of some of the early burdens, especially partners who can offer full solutions like Philips or others. You begin gradually, and as your experience grows, you add more complexity, but patient safety and attention should remain the focus.

Small centers are where most of the interventional procedures can be performed safely because of the advancing technology and I intend to push the envelope in this direction. I believe this is the 21st century of health care. ■