Looking Forward: Predictions for Office-Based Labs

The final article in a four-part series discussing office-based labs (OBLs) and ambulatory surgery centers (ASCs) from the perspective of three physicians. This article explores our participants' opinions on recent trends and predictions of regulatory change, technology advancement, industry consolidations, and social changes in the coming years. Previous articles focused on the case for OBLs & ASCs, including lessons learned from physicians who made the OBL leap; a clinical overview of therapies, devices, and equipment in the hybrid and OBL environments; and a discussion of business operations and growth strategies.

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FROM THE PERSPECTIVE OF THE HYBRID (OBL/ASC) MODEL

What major trends are driving the health care industry in the next 5 years?

Dr. Cross: Despite a lot of congressional posturing and hyperbole, I do not anticipate much change. Top issues include whether Obamacare is repealed in whole or part and the extent to which Medicare Access and CHIP Reauthorization Act (MACRA) is implemented. MACRA is the Medicare payment reform framework that rewards physicians for providing higher-quality care. Criteria categories include quality measures (50%), advancing care information (25%; eg, electronic health record technology), clinical practice improvement activities (15%), and cost savings (10%). It has started slow and has experienced several delays, but a pay-for-performance system makes a lot of sense in my view. I think our group is probably a little more prepared than many for MACRA. Our chief operating officer is making sure that we are in line and collecting the right data to assert our quality levels. It is time and resource consuming, and I fear it may be difficult for smaller OBLs to comply. However, even a modest participation in 2017 may allow clinicians to avoid or reduce penalties in 2019.

What changes do you anticipate in the OBL/ASC model in the next 5 years?

Dr. Cross: We will continue to see a migration of medical procedures away from the hospital to outpatient venues such as OBLs and ASCs, with some estimates for outpatient growth as high as 18% by 2019. This realignment will be driven by greater patient convenience, reduced appointment wait times, shorter procedure times, and overall enhanced patient experience. For the physician, OBLs/ASCs offer greater control (and accountability) over the entire medical procedure and a significantly enhanced quality of life. For the health care industry as a whole, the migration results in greater cost savings.

The biggest unknown in today's environment is reimbursement. We cannot predict its precise direction, but our hope is that insurance companies and the government continue to value the product they are getting from OBLs and ASCs in terms of quality and affordability.

What changes do you anticipate in the patient journey?

Dr. Cross: How physicians take care of patients in the United States differs depending on location of the practice. In most places, a primary care physician (PCP) refers a patient to a specialist, a consult ensues, the problem is fixed, and the patient goes back to the PCP. Here in Texas, when we diagnose patient with coronary disease or peripheral vascular disease, we will see that patient in follow-up and become more involved with the PCP and the patient moving forward. I'm not sure which scenario is better in the long term. It's complicated by factors such as PCP workload, patients with several maladies, and patient preference. Interestingly, I do not believe it's driven by insurance. To my knowledge, there have not been any CMS guidelines on how often a patient should be seen based on type and severity of an illness.

What types of procedures do you see transitioning out of the hospital and into an OBL/ASC?

Dr. Cross: Building on past success, I believe we will continue to see procedures transitioning from the hospital and into the outpatient setting. Our record of safety and patient outcomes represents a harbinger of increased migration away from the hospitals, facilitated in large part by improved medical devices and techniques. For example, some insurance companies already reimburse for coronary stenting in the outpatient setting. Other potential outpatient procedures I envision include transcatheter aortic valve replacement (now indicated for high- and moderate-risk surgical patients) and mitral valve replacement or repair.

Improvements in medical technology continue to play a significant role in furthering the outpatient trend. New technologies offer enhanced capabilities in smaller packages and footprints, enabling ever smaller patient access points with quicker recovery times. Combined, these advancements make it easier and cost-effective to treat increasingly complex maladies on an outpatient basis.

What do you see as your two or three biggest challenges over the next 5 years?

Dr. Cross: I think the biggest challenge is remaining flexible and responding properly to the known and unknown changes on the health care horizon. Secondly, we must stay abreast of the technology and procedural changes, such as structural heart disease, and evolve our practice accordingly. This will enable us to remain competitive and continue to provide outstanding care and an improved patient experience.

From a leadership standpoint, we are seeing a shift in demographics that has prompted discussions within our practice. There is a new group of physicians coming on board now who are practicing medicine and will be the leaders in 10, 20, 30 years. They also happen to be millennials—they have been trained differently, they communicate differently, and their goals and even values are different, but they are exceptionally capable. We also have doctors who are vibrant and practicing well into their 70s. That is 4 decades of difference, and it is interesting and challenging, but we can and do learn from each other.

FROM THE PERSPECTIVE OF THE OBL MODEL

What major trends are driving the health care industry in the next 5 years?

Dr. Wright: Patients are slowly becoming more health care savvy, and the internet is helping with the patient-doctor discussion. Yes, there are still patients who are preconditioned to do whatever the doctor recommends. Most of our patients are at least in their 50s, often older. They are not the people who grew up going to the internet for information. However, I think as the 30- and 40-year-olds start aging and developing vascular disease, they are going to be better informed

by the internet. The good thing is that doctors who are the same age will be comfortable with it because that is how they grew up.

With today's culture of immediate gratification and "fix this right away," there is a risk that unrealistic patient expectations may strain the doctor-patient relationship, or worse, start to influence physician decision making. My team recently attended a valuable training session as part of our malpractice insurance that discussed how to identify red flag patients and outlined techniques on how to handle them in the very few minutes you have together. Adopting a sensitivity insight early on to these issues may prevent problems down the road.

At a macro level, there are multiple influences—administrators and lobbying groups that can take control and decision making away from physicians. They impact the types of procedures that we perform, where we perform them, what we charge, and even the technology we can use. We believe the value proposition for OBLs and physicians is just too compelling for the health care industry to ignore.

Toward this end, OBLs are starting to band together to have a voice. We now have the Outpatient Endovascular and Interventional Society (OEIS), composed of cardiologists, interventional radiologists, vascular surgeons, and similar specialists. OEIS is a forum and conduit to health care decision makers regarding the great things being done in the outpatient setting and why OBLs must be part of the health care future. This group helps pull us together to get the outpatient message expressed, especially in Washington, DC.

Another group is the Specialty Society Relative Value Scale Update Committee (RUC), a private group of mostly specialty physicians who make influential recommendations on how to value a physician's work when computing health care prices in Medicare. They help set the billing rates for certain procedures and often give us a heads up on what is coming down the pike for outpatient centers. These organizations give us a collective mass and opportunity to affect change. I strongly encourage OBL and ASC clinicians to actively participate in one or more of these organizations so we can better influence the direction of our businesses.

What changes do you anticipate in the OBL model in the next 5 years?

Dr. Gonzalez: I see OBL practices converting to hybrid models that combine both the OBL and ASC. This transition allows for greater flexibility in procedures that we can provide to our patients. We planned ahead for this possibility by building out our second OBL facility to the required specifications for an ASC. We had to ensure that we had sufficient capability and capacity to install the required equipment and infrastructure for when we decide to make the transition. This is a very specialized process and I strongly recommend working with a firm that specializes in the design, build-out, and licensing of ASCs.

Dr. Wright: Outpatient venues will be more widespread and will leverage different business models. For example, there are joint ventures being set up with hospitals where physicians are brought in to work at the centers. Another model includes hospitals partnering with OBL and ASC physicians.

Technology-wise, the miniaturization of pressure and guidewires, catheters, and other disposables is enabling a wider array of procedures to be performed in the OBLs and ASCs. Access sites are getting smaller, aiding in shorter recovery times. Even some of the capital equipment seen in the big hospitals has downsized to enable installation in outpatient offices.

In some cases, reimbursement policies are hampering new technology migration into the OBLs. For example, the drug-coated balloon is a proven technology that is making a difference in combating peripheral artery disease (PAD). For the last few years, each balloon has been reimbursed in the hospital via a pass-through payment, regardless of how many balloons are required. This potential limb-saving device should be reimbursed similarly in any patient setting. This case is another example of why OBL physicians need to ensure their voices are heard, through OEIS or other societies, to ensure equitable patient care and reimbursement.

What types of procedures do you see transitioning out of the hospital and into an OBL/ASC?

Dr. Gonzalez: From an endovascular standpoint, I can see aneurysm repairs and carotid stenting moving to an OBL in the next 5 to 10 years. The patient comes in, gets the procedure, and goes home a few hours later. Probably not for everyone, but a majority of patients will qualify. Of course, we'll need the right CPT codes and payers willing to reimburse the procedures. A new device may be less invasive with improved recovery times and less costly in the long term, but it needs to be reimbursable. So, for medical device manufacturers, it's critical that reimbursement

issues are worked in parallel with US Food and Drug Administration approvals, or we collectively risk not being able to use a potentially life-saving product.

What impact will greater industry consolidation have on your business?

Dr. Gonzalez: I think it's a balance and you hope to find that sweet spot. You don't want to create a monopoly and drive up prices and anticompetitiveness. At the same time, some decrease in competition may allow the medical device manufacturers to produce higher-quality products at a better price. I think the recent merger of Philips with Spectranetics Corporation will result in new products and solutions that allow us to deliver more efficient and effective patient care. It certainly presents a broader product portfolio opportunity for our physicians and patients.

Dr. Wright: I am certainly hoping it will help us. I think industry is an ally in the health care tug of war. They understand who the decision makers should be, whether in the outpatient setting or the hospital. Therefore, I believe any kind of consolidation or strengthening of industry is a good thing because it will benefit physicians in the long run. If you take Philips, for example, I see value in getting the full OBL solution from one company: equipment, service, financing, and devices from one place. Not only does this establish a partnership in which we both have a vested interest in my practice, but it also aligns me with a company that can address my needs as my practice grows and expands.

What do you see as your biggest challenges over the next 5 years?

Dr. Gonzalez: Patient education is a big one. We have to get patients more involved in their care. They need to be educated about the pros and cons of their options and have skin in the game. I think it is in the patient's best interest to come in and be able to ask the right questions about clinical options, devices, and follow-up. Of course, I never miss an opportunity to encourage them to stop smoking, reduce their drinking, make sure their cholesterol's controlled, and eat right. Then when the time comes to intervene, it's not a crisis. Nevertheless, we can and must try to work the prevention side and not have to treat everything.

We have started doing some outreach, going to the community centers and giving talks. We were just invited to a podiatry meeting to give a 30-minute presentation about PAD, including information on what we can do for them and their patients. There are a couple of screening companies we work with. They do the cholesterol readings, quickly look at the patient's legs and take pulses, and do a quick scan on the carotid artery to see what it looks like and if there is anything that should be addressed. We're with them side-by-side to try to facilitate getting to people early and preventing bigger future problems.

Dr. Wright: I think one of my biggest challenges will be remaining viable in the marketplace. For me, this means transitioning to the physician-businessman. Certainly, many physicians will continue to prefer practicing medicine inside the hospital or academic setting. Others will derive more satisfaction by embracing their entrepreneurial spirit and starting a business, ergo an OBL. It has a different set of issues, but in my experience, the personal and patient benefits significantly outweigh the challenges.

I believe in what we're doing. OBLs offer physicians control over their entire medical business from office greeting to postop and billing. Health care savings accrue from reduced overhead; freedom to decide on the best devices, equipment, and disposables; and streamlined business procedures. For the patient, OBLs offer convenience, a customer focus, and friendly, familiar staff. Patient outcomes and safety are on par with the hospitals, but without the long wait and treatment times. Indeed, the OBL/ASC future is bright! ■