Understanding the Business of Peripheral Interventions. Outpatient Endovascular Centers: Fad or Future

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Chief Medical Officer, Michigan Outpatient Vascular Institute
Why Office-Based?

The Evolution of Obamacare

MY PLAN WILL REDUCE PREMIUMS BY $2,500...

ACTUALLY, IT MAY INCREASE COSTS BY 32 PERCENT.

2008

2013

Affordable Care Act

Society of Actuaries

garyvarvel.com
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
The Rise of Office Based Surgery

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.
The Rise of Office Based Surgery

- 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.
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.

How Physician Office Procedures May Change As Systems Integrate Systems

- 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 labs, 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.
Why Office-Based?
Why Office-Based?

• Convenient for the patient and Physician
• Less costly for the patient
• Less costly for insurance companies
• More efficient
• SAFE
Decline in Payment

• 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
Increase Your Productivity

• 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
Continuity of Care

- Your patients see the same care providers
- Your staff know your patients
- Spend more time with your patients before and after surgery
Patient-Friendly Environment

• Friendly, familiar environment and staff for patients
• Make it as comfortable as you want
• More flexibility to schedule to your patients’ convenience
Have More Control

Control over:

- The patient environment
- Set-up of the procedure room
- Your schedule
Potential for New Revenue

• 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.
MACRA will reward or penalize physicians based on their reporting of measures of quality, cost, practice improvement, and meaningful use of electronic health records.
POS (Place Of Service)

• 11 Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

• 21 Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

• 22 Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

• 24 Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
Potential for New Revenue

• 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
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Angiogram</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Angioplasty</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stent</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X (except carotid)</td>
</tr>
<tr>
<td>Atherectomy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X (except carotid)</td>
</tr>
<tr>
<td>Dialysis Access Maintenance</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Embolization</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
</tbody>
</table>

*However, some procedures may be reimbursable only at the professional rate*

*Refer to handout for list of vascular procedures*
## Reimbursement comparison

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>CPT CODE</th>
<th>PHYSICIAN IN OFFICE</th>
<th>PHYSICIAN IN FACILITY</th>
<th>HOSPITAL OUTPATIENT</th>
<th>HOSPITAL IN PATIENT</th>
<th>ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA</td>
<td>37220</td>
<td>$5,891</td>
<td>$572</td>
<td>APC 0083 $4,023</td>
<td>MS-DRG 252 $16,817</td>
<td>$2,257</td>
</tr>
<tr>
<td>PTA + STENT</td>
<td>37221</td>
<td>$11,675</td>
<td>$738</td>
<td>APC 0229 $8,657</td>
<td>MS-DRG 253 $13,758</td>
<td>$4,858</td>
</tr>
<tr>
<td>EACH ADDL VESS WITH PTA</td>
<td>37222</td>
<td>$8,900</td>
<td>$715</td>
<td>APC 0229 $8,657</td>
<td>MS-DRG 254 $9,303</td>
<td>$4,858</td>
</tr>
<tr>
<td>PTA+STENT+ATHRECTOMY</td>
<td>37232 (USE WITH 37228-37231)</td>
<td>$14,204</td>
<td>$777</td>
<td>APC 0319 $14,596</td>
<td>MS-DRG 299 $7,725</td>
<td>$11,602</td>
</tr>
<tr>
<td>EACH ADDL VESSEL WITH PTA</td>
<td>37233 (USE WITH 37229-37231)</td>
<td>$1,307</td>
<td>$207</td>
<td>APC 0083 $4,023</td>
<td>MS-DRG 300 $5,461</td>
<td>$2,257</td>
</tr>
<tr>
<td>EACH ADDL VESS WITH ATHRECTOMY</td>
<td>37233 USE WITH 37230-37231</td>
<td>$1,562</td>
<td>$338</td>
<td>APC 0229 $8,657</td>
<td>MS-DRG 301 $3,742</td>
<td>$4,858</td>
</tr>
<tr>
<td>EACH ADDL VESSEL WITH STENT</td>
<td>37234 (USE WITH 37230-37231)</td>
<td>$4,277</td>
<td>$285</td>
<td>APC 0229 $4,023</td>
<td></td>
<td>$2,257</td>
</tr>
<tr>
<td>EACH ADDL VESSEL WITH STENT &amp; ATHRECTOMY</td>
<td>37235 (USE WITH 37231)</td>
<td>$4,310</td>
<td>$395</td>
<td>APC0083 $4,023</td>
<td></td>
<td>$2,257</td>
</tr>
</tbody>
</table>

The hospital gets the rates in the Hospital column + cost of supplies + anesthesia fee + Physician fee + any additional amounts if patient gets admitted.
The OIS is planning its first educational meeting to be held May 16-18, 2014! More information coming soon!

# 2014 CMS Fee Schedule For Facility and Non-Facility

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>2014 Total Non-Facility Payment</th>
<th>2014 Total Facility Payment</th>
<th>2013 Total Non-Facility Payment</th>
<th>2013 Total Facility Payment</th>
<th>2014 Non-Facility % Change</th>
<th>2014 Facility % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>37220</td>
<td>Iliac revasc</td>
<td>$3,236</td>
<td>435</td>
<td>$3,425</td>
<td>$424</td>
<td>-5.52%</td>
<td>2.59%</td>
</tr>
<tr>
<td>37221</td>
<td>Iliac revasc w/stent</td>
<td>$4,750</td>
<td>531</td>
<td>$5,010</td>
<td>$516</td>
<td>-5.19%</td>
<td>2.91%</td>
</tr>
<tr>
<td>37222</td>
<td>Iliac revasc add-on</td>
<td>$911</td>
<td>196</td>
<td>$964</td>
<td>$191</td>
<td>-5.50%</td>
<td>2.62%</td>
</tr>
<tr>
<td>37223</td>
<td>Iliac revasc w/stent add-on</td>
<td>$2,638</td>
<td>224</td>
<td>$2,796</td>
<td>$219</td>
<td>-5.65%</td>
<td>2.28%</td>
</tr>
<tr>
<td>37224</td>
<td>Fem/popl revas w/tla</td>
<td>$3,919</td>
<td>481</td>
<td>$4,125</td>
<td>$468</td>
<td>-5.00%</td>
<td>2.78%</td>
</tr>
<tr>
<td>37225</td>
<td>Fem/popl revas w/ather</td>
<td>$11,190</td>
<td>649</td>
<td>$11,844</td>
<td>$632</td>
<td>-5.52%</td>
<td>2.69%</td>
</tr>
<tr>
<td>37226</td>
<td>Fem/popl revasc w/stent</td>
<td>$9,188</td>
<td>533</td>
<td>$9,733</td>
<td>$518</td>
<td>-5.60%</td>
<td>2.90%</td>
</tr>
<tr>
<td>37227</td>
<td>Fem/popl revasc stnt &amp; ather</td>
<td>$15,065</td>
<td>782</td>
<td>$16,002</td>
<td>$763</td>
<td>-5.86%</td>
<td>2.49%</td>
</tr>
<tr>
<td>37228</td>
<td>Tib/per revasc w/tla</td>
<td>$5,569</td>
<td>587</td>
<td>$5,883</td>
<td>$572</td>
<td>-5.34%</td>
<td>2.62%</td>
</tr>
<tr>
<td>37229</td>
<td>Tib/per revasc w/ather</td>
<td>$11,021</td>
<td>759</td>
<td>$11,665</td>
<td>$738</td>
<td>-5.52%</td>
<td>2.85%</td>
</tr>
<tr>
<td>37230</td>
<td>Tib/per revasc w/stent</td>
<td>$8,434</td>
<td>736</td>
<td>$8,892</td>
<td>$715</td>
<td>-5.15%</td>
<td>2.94%</td>
</tr>
<tr>
<td>37231</td>
<td>Tib/per revasc stent &amp; ather</td>
<td>$13,463</td>
<td>806</td>
<td>$14,195</td>
<td>$778</td>
<td>-5.16%</td>
<td>3.60%</td>
</tr>
<tr>
<td>37232</td>
<td>Tib/per revasc add-on</td>
<td>$1,238</td>
<td>213</td>
<td>$1,305</td>
<td>$207</td>
<td>-5.13%</td>
<td>2.89%</td>
</tr>
<tr>
<td>37233</td>
<td>Tib/per revasc w/ather add-on</td>
<td>$1,486</td>
<td>348</td>
<td>$1,561</td>
<td>$338</td>
<td>-4.80%</td>
<td>2.90%</td>
</tr>
<tr>
<td>37234</td>
<td>Revs opn/prq tib/pero stent</td>
<td>$3,935</td>
<td>295</td>
<td>$4,223</td>
<td>$286</td>
<td>-6.82%</td>
<td>3.15%</td>
</tr>
<tr>
<td>37235</td>
<td>Tib/per revasc stnt &amp; ather</td>
<td>$4,017</td>
<td>428</td>
<td>$4,307</td>
<td>$395</td>
<td>-6.73%</td>
<td>8.35%</td>
</tr>
</tbody>
</table>
Gone tomorrow?
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 II. Patient complications and procedures

<table>
<thead>
<tr>
<th>Procedure type</th>
<th>Procedures, No.</th>
<th>Patients, No.</th>
<th>Complications, No.</th>
<th>Complications per Procedure, %</th>
<th>Complications per Patient, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous</td>
<td>1019</td>
<td>785</td>
<td>22</td>
<td>2.20</td>
<td>2.80</td>
</tr>
<tr>
<td>Aortogram</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No interventions</td>
<td>571</td>
<td>464</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>With interventions</td>
<td>368</td>
<td>191</td>
<td>10</td>
<td>2.70</td>
<td>5.20</td>
</tr>
<tr>
<td>Fistulogram</td>
<td>2719</td>
<td>829</td>
<td>13</td>
<td>0.50</td>
<td>1.60</td>
</tr>
<tr>
<td>Catheters</td>
<td>1477</td>
<td>342</td>
<td>4</td>
<td>0.30</td>
<td>1.20</td>
</tr>
<tr>
<td>Inferior vena cava filters</td>
<td>57</td>
<td>24</td>
<td>1</td>
<td>2</td>
<td>4.20</td>
</tr>
</tbody>
</table>
### Table III. Patients transferred to the hospital

<table>
<thead>
<tr>
<th>Complication</th>
<th>No.</th>
<th>Transfer, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematoma</td>
<td>9</td>
<td>34.50</td>
</tr>
<tr>
<td>Thrombosis</td>
<td>3</td>
<td>11.50</td>
</tr>
<tr>
<td>Cardiac</td>
<td>3</td>
<td>11.50</td>
</tr>
<tr>
<td>Pseudoaneurysm</td>
<td>2</td>
<td>7.70</td>
</tr>
<tr>
<td>Hypotension</td>
<td>2</td>
<td>7.70</td>
</tr>
<tr>
<td>Syncope</td>
<td>2</td>
<td>7.70</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>1</td>
<td>3.80</td>
</tr>
<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
Ingredients for Success....

Large 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

“T’m prescribing exercise. Think of it as a stress pill that takes 30 minutes to swallow.”

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’

Espoused but *unlived brands* create *cynicism* because they promise what they *do not* deliver.

**Effective Ways To Ensure You Are Living Up to Your Brand**

- **Ask Those Around You**
- **Do They See You As You Wish To Be Seen?**
- **Can You Measure Your Effectiveness?**
- **Can Others Articulate Your Brand**

How do current and prospective customers *socialize* or *discuss* your brand?
Conduct a Brand Audit

1. Business / brand resource strengths
2. Value of the brand
3. Awareness of the brand in the market
4. Deficiencies of the brand
5. New trends and market opportunities
6. Outside threats
7. New product development and future channels of profitability
8. Competitive standing in the market
9. Perception, image, reputation and attitude to the brand in the market
10. Effectiveness of brand management efforts
Facts about customer experience(s)

- 96% of unhappy customers don’t complain, however 91% of those will simply leave and never come back – 1st Financial Training services
- A dissatisfied customer will tell between 9-15 people about their experience. Around 13% of dissatisfied customers tell more than 20 people. – White House Office of Consumer Affairs
- Happy customers who get their issue resolved tell about 4-6 people about their experience. – White House Office of Consumer Affairs
- 70% of buying experiences are based on how the customer feels they are being treated – McKinsey
- 55% of customers would pay extra to guarantee a better service – Defaqto research
- Price is not the main reason for customer churn, it is actually due to the overall poor quality of customer service – Accenture global customer satisfaction report 2008
- 94% of customers do not want to be transferred to another representative more than once – Mobius Poll 2002
- 80% of customers prefer to speak with a representative at the weekends – Mobius Poll 2002
- 84% of customers are frustrated when a representative does not have immediate access to account information – Mobius Poll 2002
- It takes 12 positive experiences to make up for one unresolved negative experience – “Understanding Customers” by Ruby Newell-
Adaptation

Vascular Disease by the Numbers

With millions of patients affected by vascular disease, only a small fraction of patients are currently receiving endovascular treatment.
Making our Decision to Open a Lab

Due to the increase demands of time and productivity for physicians, the decision to open a stand alone lab become evident.

- Improve work efficiency by removing the unknown variables affecting the hospital schedule and case turnover.

- Enhance patient satisfaction by becoming involved in the decisions that affect the care, supplies and quality outcomes.

- Increase practice income by recovering more of the technical and facility fees.
What are your options...

• Going Solo

• Joint venture with hospital

• Joint venture with national company
Going Solo:

PROS

• Complete control over the management of the facility
• Collect 100% of the technical fee

CONS

• Take all the financial risk
• Potential conflict with Hospital
• Delay in breaking ground; procrastination
• lack of time, lack of expertise
Joint-Venture with Hospital:

PROS

- Avoid conflict with the hospital
- Sharing financial risk
- Secure contracts with third party payers

CONS:

- Incomplete control over the management of the facility
- Sharing collection of technical fee
- Affiliation with one hospital in a multiple hospital city
- Bureaucracy, bureaucracy, bureaucracy, bureaucracy
Joint-Venture with National Company:

PROS:
• Partner’s primary focus is the Office –based facility
• Shared financial risk
• Equity participation relative to financial risk involvement
• Partner with building and regulatory experience
• Ability to adopt new technologies when clinically relevant
• Independent 3rd party to facilitate the formation of partnership involving multiple groups

Cons:
• Potential hospital conflict
• Incomplete control over the management of the facility
• Sharing collection of technical fee
Attractive Proposition for Patients, Partners and Payers

Outpatient cath labs are an attractive proposition for physician and hospital partners and offer a cost-effective alternative for patients and payers.

**Patients**
- Lower co-pays for the same procedures that can be received in a hospital lab.
- US Cardiovascular facilities have a proven track record of better clinical outcomes than hospitals.
- Freestanding outpatient facilities consistently deliver better service and amenities, resulting in superior patient satisfaction.
  - Less paperwork.
  - Improved personal attention.
  - Friendlier staff.
  - Timelier service.
  - Less institutional environment.

**Partners**
- Majority facility ownership is a highly valuable proposition for physician partners.
- Increased autonomy over patient scheduling, equipment, supplies and staff selection.
- Customized work environment creates more personal control over the delivery of care.

**Physicians**
- Allows hospitals to retain and attract talented physicians.
- Enhances reputation and capabilities of a hospital’s heart facility.

**Management Company**

**Business Model**

**Payers**
- Payers benefit from the cost-effectiveness of procedures performed on an outpatient basis.
Regulatory Expertise

Comprehensive and Integrated Service Offering

Development Services

Management Services

Regulatory Expertise
Allows Physicians to Focus on Clinical Work
Managed Care Expertise

Business Model
How the Management Company Supports the Network of Facilities

Center
Clinical Director
Business Office Manager

General Management
Finance / Accounting
Information Technology
Managed Care
Reimbursement Support
Risk Management
Quality Assurance / Compliance
Human Resources
Purchasing
Development
JUST DO IT.

® Nike, Inc
Understanding the Business of Peripheral Interventions. Outpatient Endovascular Centers: Fad or Future

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