“Too Complex to Do in the Hospital”: Is That a Thing?

SOUTH FLORIDA VASCULAR ASSOCIATES
Leading Change in Vascular Care

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Disclosure

Cook and CSI consultant and teach courses

My Background

(hence, my disdain for hospitals, radiology groups, and even the SIR)

- 1991-1992: Fellowship: Cardiac and Vascular Institute
- 1992-2001: Co-founded hospital based radiology group with “separate” I.R. section
- September 2001: Opened South Florida Vascular Associates
- March 2005: Office Interventional Suite

Why I Left Radiology

- Disagreement over partnership issues and the potential sale of the group
- Not allowed to open an office and criticized for rounding on patients
- Reading films and taking general call
- Threat of termination of group contract with the hospital
- Interventional Radiology as intern service for the hospital

Radiologists Hurting I.R.

(IRs can't get on hospital staff!)

4.4 Use of Laboratories. Operator may permit cardiologists and vascular surgeons not affiliate with Contractor to utilize the interventional radiology laboratories at the Health Care Facilities, but Operator shall not permit any radiologists other than the Specialists engaged by Contractor to use such facilities. In addition, the parties shall undertake to market and promote the increased use of interventional radiology services.

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Society of Interventional Radiology
The vision to heal

Society of Interventional Radiology Position Statement: Exclusive Contracts and Carve-outs for Interventional Radiology Services

Background:
In 2012, the American Board of Medical Specialties (ABMS) approved interventional radiology as a primary specialty in medicine. With this approval, ABMS and its member boards confirmed the benefit to patients of the unique interventional radiology skill set comprised of competency in diagnostic imaging, image-guided procedures, and peri-procedural patient care. This was an important step in the formalization of the interventionalist's clinical role. With the establishment of an ACGME-approved IR residency, the American Board of Radiology agreed to certify interventional radiology trainees in interventional radiology and diagnostic radiology.

Interventional radiologists are experts in the field of image-guided interventions. They come by this expertise through years of training in diagnostic radiology residency and interventional radiology fellowship. In the very near future, this training will be acquired during interventional radiology residency. During graduate medical education, these physicians perform hundreds of interventional procedures. No other specialties can exceed interventional radiology's level of training and experience in the three pillars of image-guided intervention: imaging, procedural skills, and peri-procedural patient care.

Diagnostic radiology practices frequently enter into exclusive professional services contracts with their hospitals, with interventional radiology, by default, included under this contractual umbrella. Very typically, non-radiologists are granted exclusions or "carve-outs" (e.g., peripheral interventions, musculoskeletal interventions, non-invasive testing) of procedures/services from these same exclusive contracts in order to provide the same or similar procedures which are generally performed by interventional radiologists.

As interventional radiology has become more clinically based, some interventional radiologists have opted for independent practice outside the traditional radiology group model. In some cases, these independent practice interventional radiologists have found their efforts at gaining new or maintaining existing interventional radiology privileges blocked by exclusive contracting practices.

In such cases, these interventional radiologists may seek SIR support in obtaining or retaining privileges. This policy covers the circumstances in which SIR would consider becoming involved and the type of support that it might provide.

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Policy:
SIR recognizes the practice of exclusive contracting between hospitals and radiology groups for radiology services is long-standing and that such contracts can be mutually beneficial to both parties. However, SIR strongly believes that if the exclusive contract or the hospital/facility excludes interventional radiology services or provides a carve-out (e.g., peripheral interventions, musculoskeletal interventions, non-invasive testing) so that non-radiologists may perform procedures generally performed by interventional radiologists, independent practice interventional radiologists with appropriate training should be afforded the same opportunity to provide these services/procedures at the facility. Interventional radiologists, regardless of their contractual relationship to the hospital, should have the same rights to medical staff membership and privileges as any other clinical specialty.

SIR will not contribute financially to any legal action.

Approved by the SIR Executive Council February 28, 2007. Revised and approved by the SIR Operations Committee September 21, 2015.

SIR 5 yr Strategic Plan

Society of Interventional Radiology

SIR Mission: Improve lives through image-guided therapy

Strategic Vision: 2018-2022: Optimize minimally-invasive patient care

PRIORITIES	GOALS	OBJECTIVES	OUTPUTS & OUTCOMES
IR PRACTICE AND WORKFORCE	IR physicians will thrive in their chosen practice model leading to expanded access to high-quality patient care.	1.1 Eliminate barriers to quality patient care through an improved understanding of IR workforce trends and practice models. 1.2 Stimulate the demand for high quality IR in the market. 1.3 Increase diversity within the specialty to align with the patient population. 1.4 Adopt positions and take actions that increase patient access to high-quality IR care.	• Demonstrate increased quantity and value of SIR resources for helping members and stakeholders build successful, high-quality IR practices. • Demonstrate increased satisfaction with practice among SIR members • Publish workforce analyses and increase distribution of IRs per population • Benchmark increased diversity within IR

Office Interventional Suite

Motivation

- Only one room at my small hospital; lots of procedures (by many doctors)
- Could not get Staff privileges at any other hospital!
- Out of desperation open OIS March 2005
- CMS payments expanded to cover procedures shortly thereafter
- Within a year 80% procedures being performed in office. Now 99%
- Wide range of procedures: CLI, UFE, venous, dialysis, interventional oncology.
- Unrivaled in efficiency, access to care, patient satisfaction
- Has potential to reduce costs of health care delivery

OUTPATIENT ENDOVASCULAR AND INTERVENTIONAL SOCIETY

- Formed in 2013
- Multidisciplinary: VS, IC, IR, other qualified specialists
- Designed for collaboration and inclusivity
- Partner with other established Societies toward common educational, strategic and advocacy goals
- Registry
- Annual Meeting Apr 5-6, 2019. St. Petersburg, FL
- www.oeisociety.com

Hospital

Disadvantages/Challenges

- Not customer service oriented (customer is Doctor and Patient)
- Attitude: "Take it or leave it"
- Inefficient
- Staff not motivated
- Limited supplies/product (especially as procedures move out of hospital)
- Difficult to get new items - laboratory committee
- Politics

Hospital

Lack of Devices/Product

- No Supera stent
- No Laser
- 4Fr catheter but no sheaths
- No short balloons - only 20 cm
- No tech
- Only one size support catheter (150 cm)

Is There Anything Positive About the Hospital?

I Suppose

- Can deal with unstable or sicker patients
- Anesthesia sedation
- Overnight stay
- More help in case of emergency
- Open surgery

Mood Barometer

Site of Service

- OIS - Happy
- Hospital - Not Happy, P.I.T.A., They block me!, say incorrect statements about me like we “cherry pick” (not so much any more)

OIS Advantages

- Room set up; almost every PAD (non iliac) case has pedal prep
- Extensive catheter/devices for pedal access
- Changeable room set up favorable for any access
- Ultrasound - 17 MHZ probe
- Staff excellence and familiarity with our specific procedures (staff is “cherry picked”)
- I control schedule

Who Controls Schedule? Hospital or the Physician?

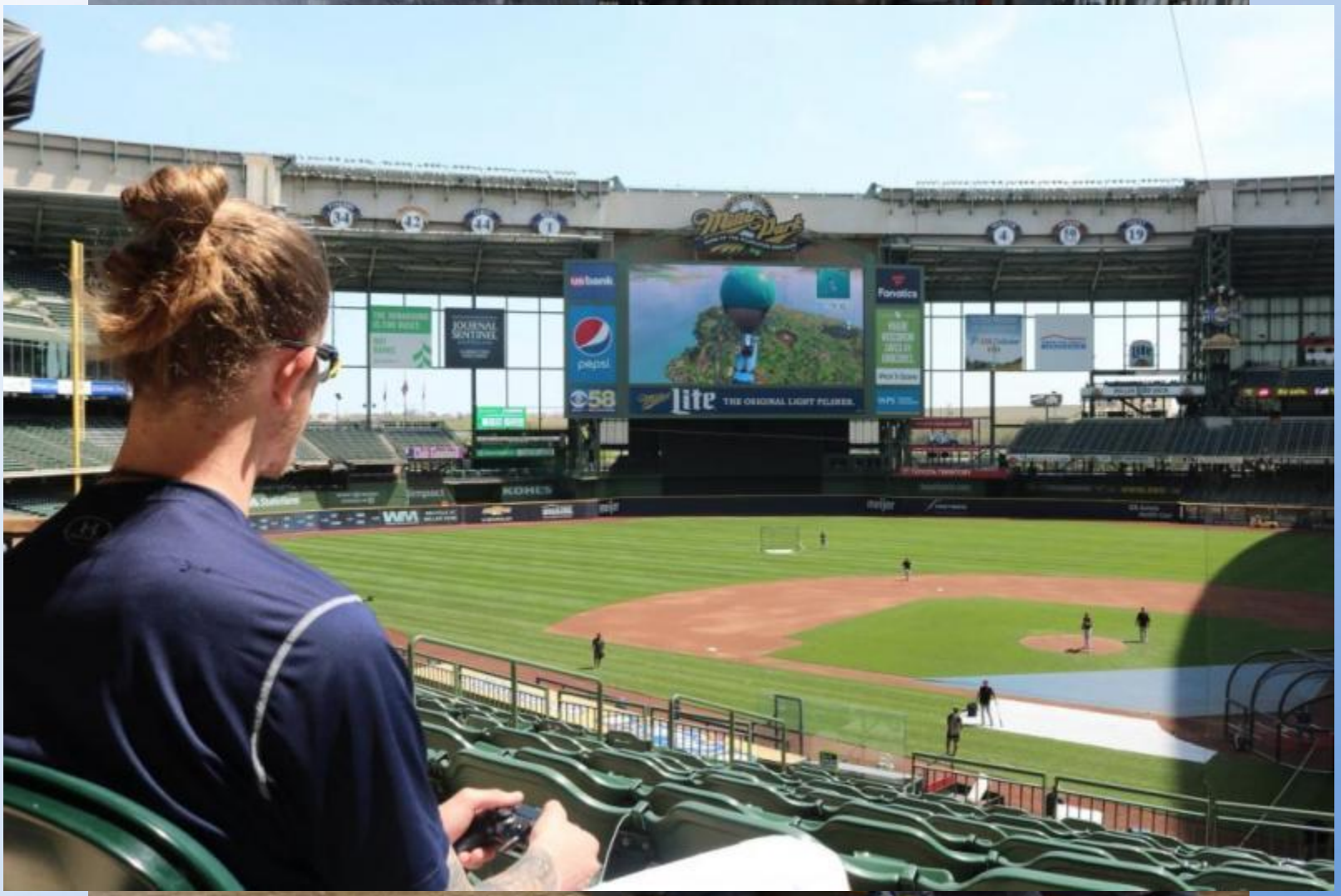
Radiologists Hurting I.R.

- Hospital Based Radiology groups let Vascular Surgeons & Cardiologists practice endovascular but block independent I.R.

- The I.R's in radiology groups have no clinical practice so lose whatever few cases they initially had.

Pedal Access Experience

1. SFVA - > 1650 cases
2. Hospital # 1 - 14 cases
3. Hospital # 2 - 4 cases
4. Hospital # 3 - 0 cases


Lite
THE ORIGINAL LIGHT PILSNER.
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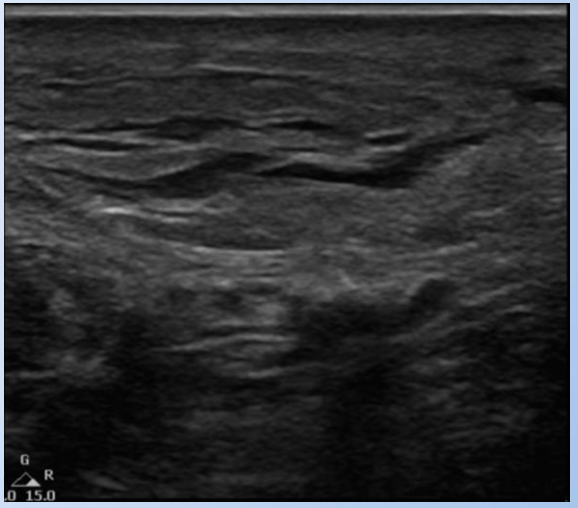
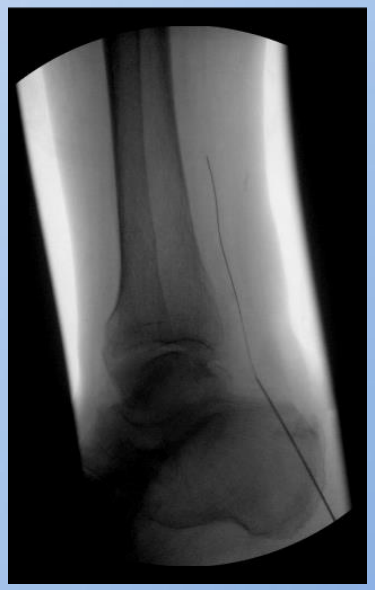
JOURNAL SENTINEL
KOHL'S

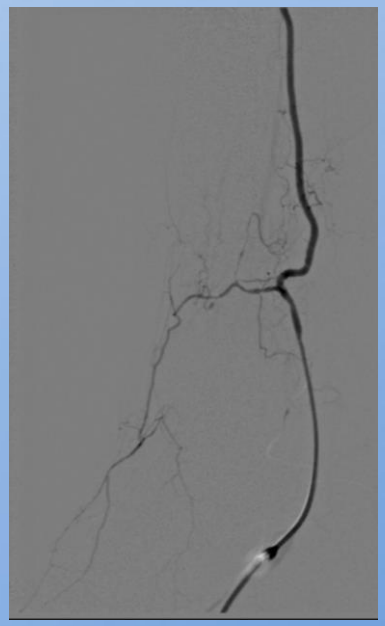
Case Study

- 95 y/o male with slow healing painful bilateral great toe wounds that occurred 6 weeks prior after a "traveling" podiatrist trimmed his toenails. Hospitalized 1 week ago for antibiotics. Hospital vascular consultant said "nothi[illegible]atherosclerotic change without obstruction"

- PMH: HTN, CAD with M[illegible]ependency, lower back pain. Sleeps sitting up in recl[illegible]







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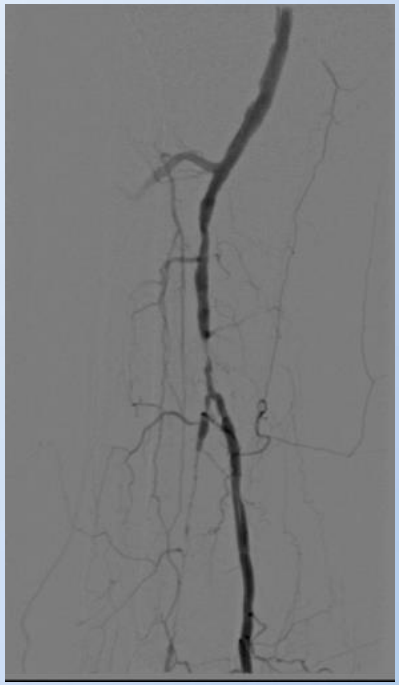

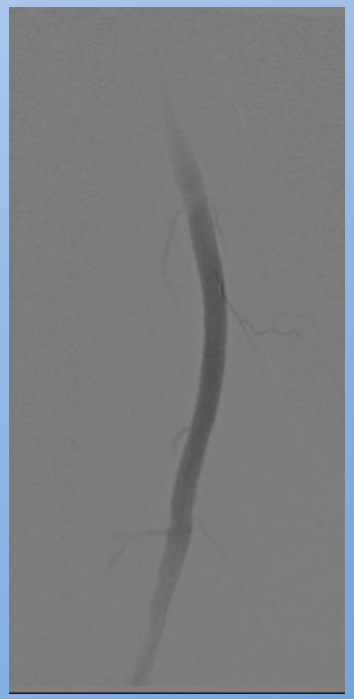

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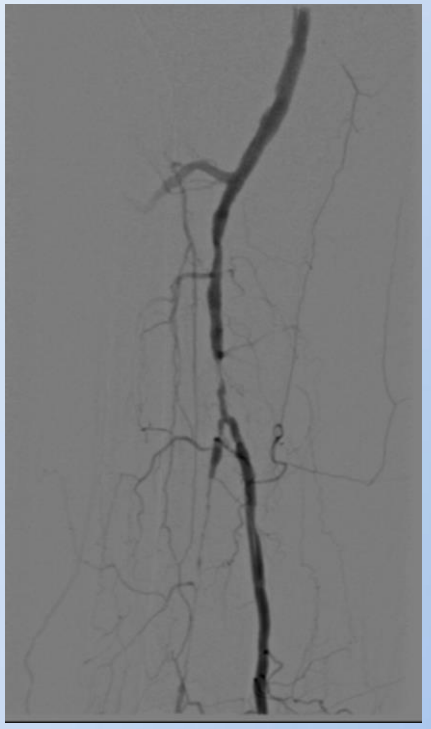

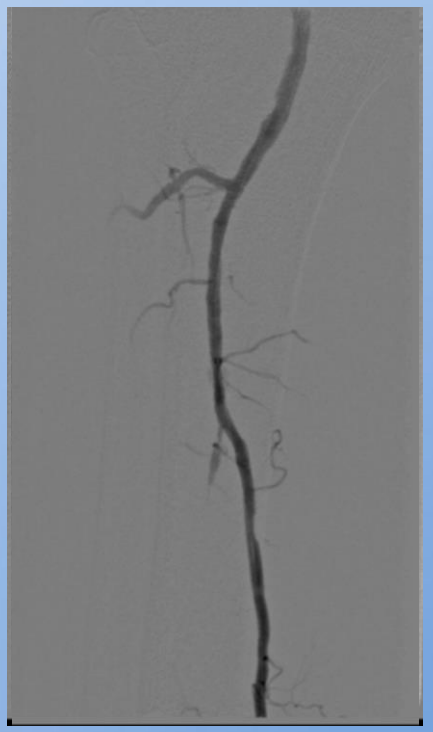

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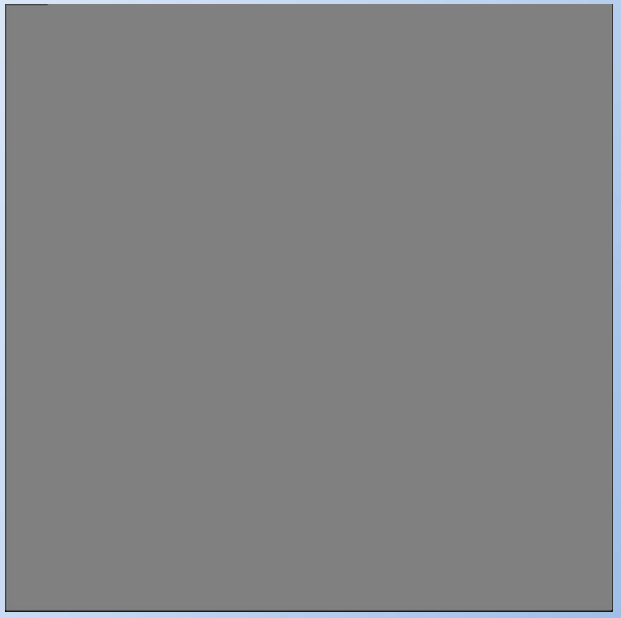

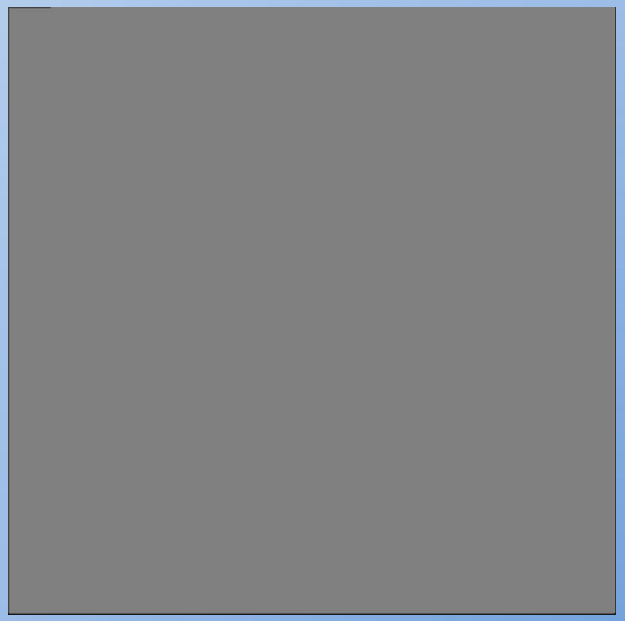

PR

90 minutes later

PR

Summary

- There is a long history of professional frustration towards the hospital, radiology groups, and even the SIR
- Half our (SFVA) patients have failed revascularization at hospital facilities including the from many so-called “Heart and Vascular Centers”.
- The OIS can be the Center of Excellence in the community for your area of expertise (CLI, fibroids, cancer, veins, dialysis, men’s health).
- Yes, many of my CLI patients are “Too complex to do in the hospital”.