The UCLA Office-Based Lab Experience:
Advantages and Challenges in an Academic Practice

2017 OEIS Annual Symposium
Santa Monica, CA
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UCLA Health

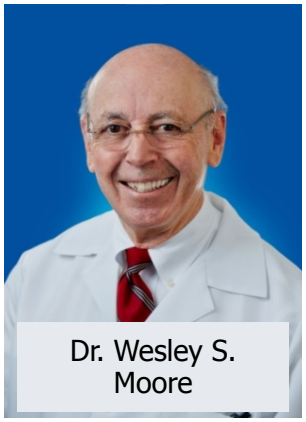
Disclosure Statement of Financial Interest

Within the past 12 months, I or my spouse/partner have had a financial interest/ arrangement or affiliation with the organization(s) listed below.

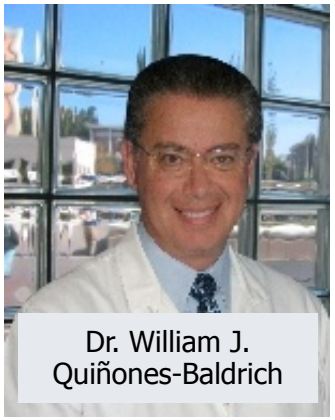
Company	Affiliation/Financial Relationship
• Abbott Vascular	• Scientific Advisory Board • Consulting agreement • Speakers fees / Honorarium
• Medtronic	• Scientific Advisory Board • Consulting agreement • Speakers fees / Honorarium • Research support / REALITY Trial National Co-PI
• Boston Scientific	• CLI Advisory Board
• Cook Medical	• Proctoring and Case Review • Honorarium

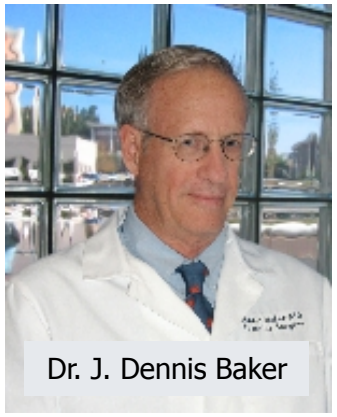
UCLA Division of Vascular & Endovascular Surgery

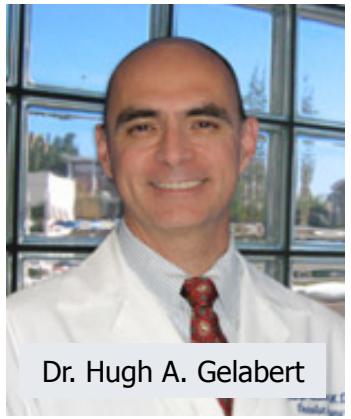
Anatomy of an Academic Practice


Dr. Wesley S. Moore


Dr. Peter F. Lawrence

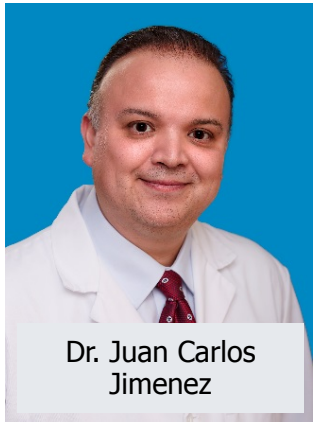

Dr. William J. Quiñones-Baldrich


Dr. J. Dennis Baker

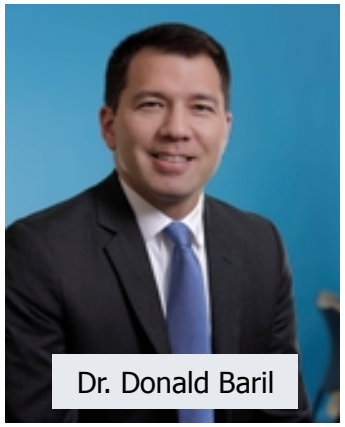

Dr. Hugh A. Gelabert


Dr. David. Rigberg

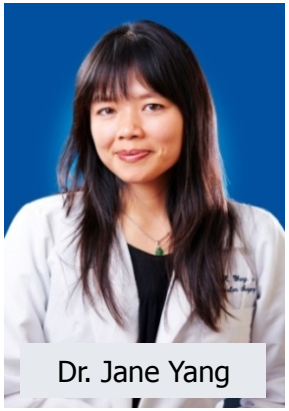

Dr. Brian G. DeRubertis

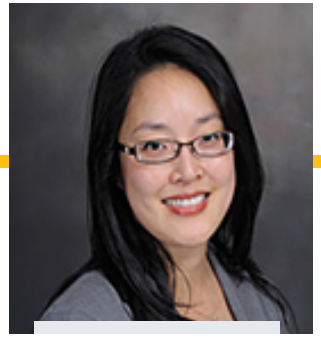

Dr. Juan Carlos Jimenez

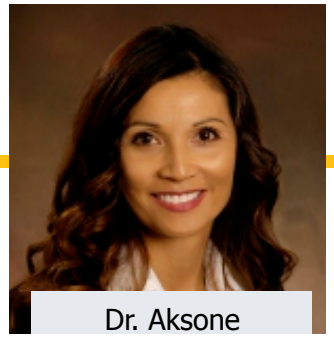

Dr. Jessica B. O'Connell


Dr. Donald Baril


Dr. Steven Farley


Dr. Jane Yang




Dr. Aksone

Salaried employees by Department of Surgery within School of Medicine

Four hospitals, most faculty have some practice at RR-UCLA Medical Center

UCLA Division of Vascular & Endovascular Surgery

Anatomy of an Academic Practice

- Roles of Vascular Faculty in UCLA Health System
  - Patient Care and On-Call Responsibilities:
    - UCLA-Ronald Reagan Medical Center
    - West LA Veterans Administration Hospital
    - SM-UCLA Medical Center
    - Olive View Hospital
    - Harbor-UCLA Medical Center (On-call)

UCLA Division of Vascular & Endovascular Surgery

Academic Practice Locations

University of California at Los Angeles

200 Med Plaza Building

Ronald Reagan UCLA Medical Center

UCLA Division of Vascular & Endovascular Surgery

Academic Practice Locations

West Los Angeles VAMC

Santa Monica-UCLA Medical Center

Olive View Medical Center

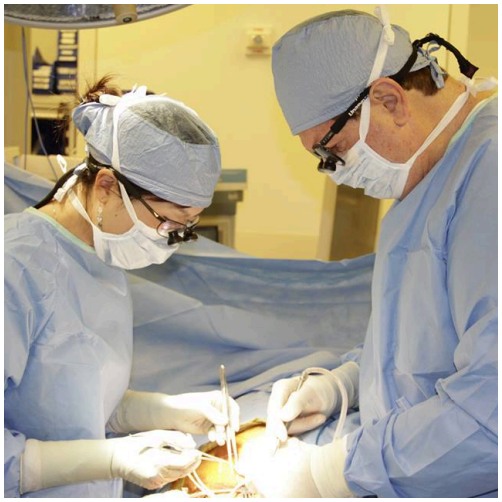
David Geffen School of Medicine

UCLA Health

UCLA Division of Vascular & Endovascular Surgery

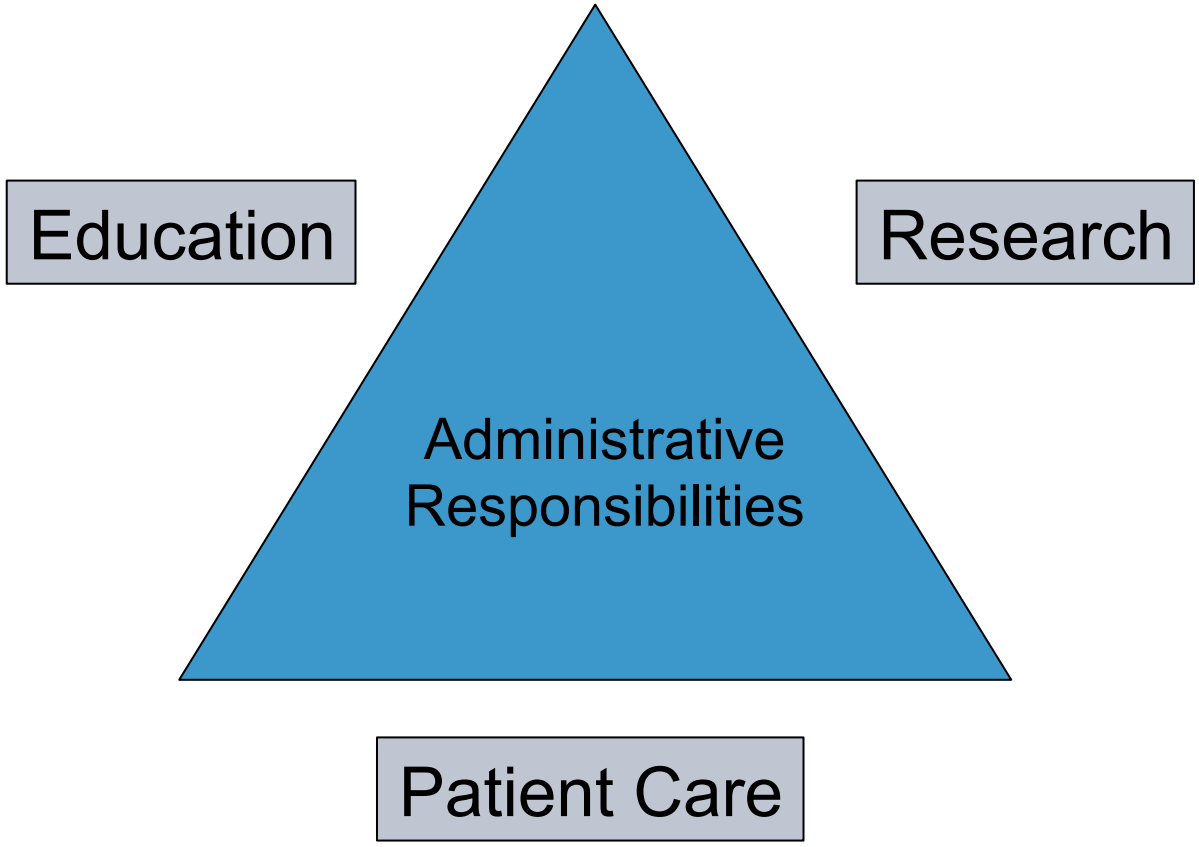
Academic Practice Locations

- RRMC: OR/cath lab/surgery center/APU
- West LA V.A.: OR/IR suite at VA
- Olive View: OR/Cath lab
- SM-UCLA Medical Center: OR/IR suites



UCLA Division of Vascular & Endovascular Surgery

Anatomy of an Academic Practice



UCLA Division of Vascular & Endovascular Surgery

Anatomy of an Academic Practice

- Roles of Vascular Faculty in UCLA Health System
  - Training of Vascular Surgery Fellows
  - UCLA School of Medicine Admissions Committee
  - UCLA General Surgery Residency
  - UCLA School of Medicine Vascular Clerkship

UCLA Division of Vascular and Endovascular Surgery

Anatomy of an Academic Practice

- General Surgery Residency Program
- Vascular Fellows (5+2 Program)
- Vascular Residents (0+5 Program)

FELLOWS:

- 2nd yr Fellow: Warren Chow, MD
- 1st yr Fellow: Taimur Saleem, MD
- Incoming: Kevin Chang, MD

RESIDENTS:

- PGY 5: Johnathon Rollo, MD
- PGY 4: Mark Archie, MD
- PGY 3: Meena Archie, MD
- PGY 2: Rameen Moridzadeh, MD
- PGY 1: Rhusheet Patel, MD
- Incoming PGY1: Ethan Yang, MD

UCLA Division of Vascular & Endovascular Surgery

Anatomy of an Academic Practice

- Roles of Vascular Faculty in UCLA Health System
  - Training of Vascular Surgery Fellows
  - UCLA School of Medicine Admissions Committee
  - UCLA General Surgery Residency
  - UCLA School of Medicine Vascular Clerkship
  - Gonda Vascular Lab
  - UCLA Wound Care Center

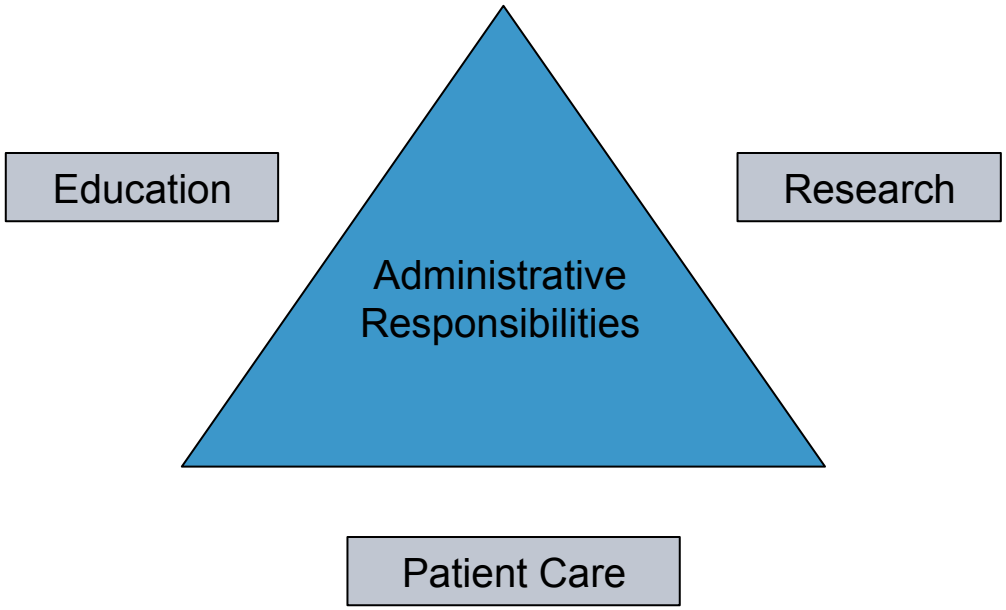
UCLA Division of Vascular & Endovascular Surgery

Anatomy of an Academic Practice

- Roles of Vascular Faculty in UCLA Health System
  - UCLA Hyperbaric Oxygen Chamber
  - UCLA-RRMC Aortic Center
  - UCLA-RRMC Value Analysis Committee
  - UCLA-RRMC Interventional Directors committee
  - Industry-related Case Proctoring & Consulting
  - Medical-Legal Consulting

Office-Based Interventional Suite:
What is the motivation for an academic surgeon?

- Priorities of an Academic Vascular Surgeon



- ***How would an OBL fit into this balance?***

UCLA Division of Vascular & Endovascular Surgery

Gonda Ambulatory Procedure Unit

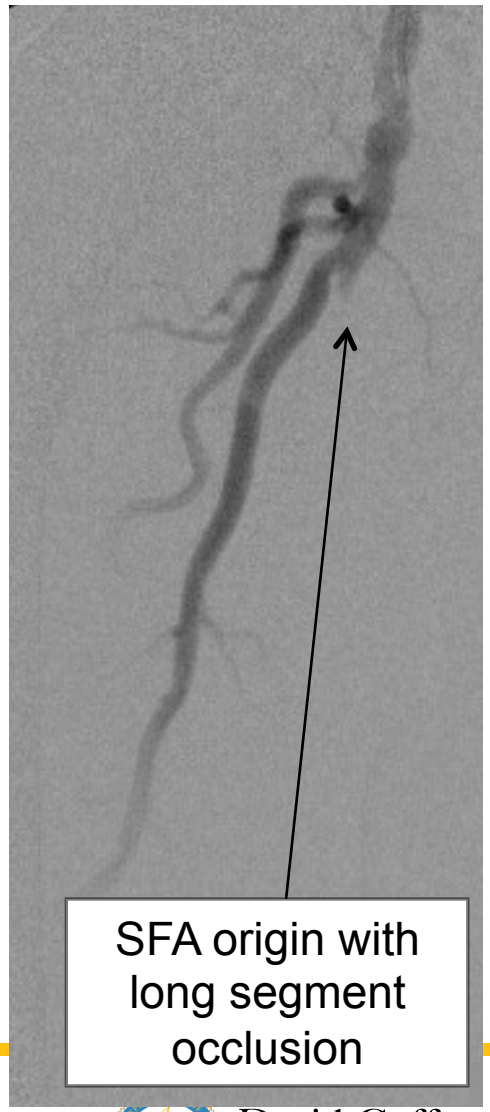
Gonda (Goldschmied)
Venous Center
&
Ambulatory Procedure Unit

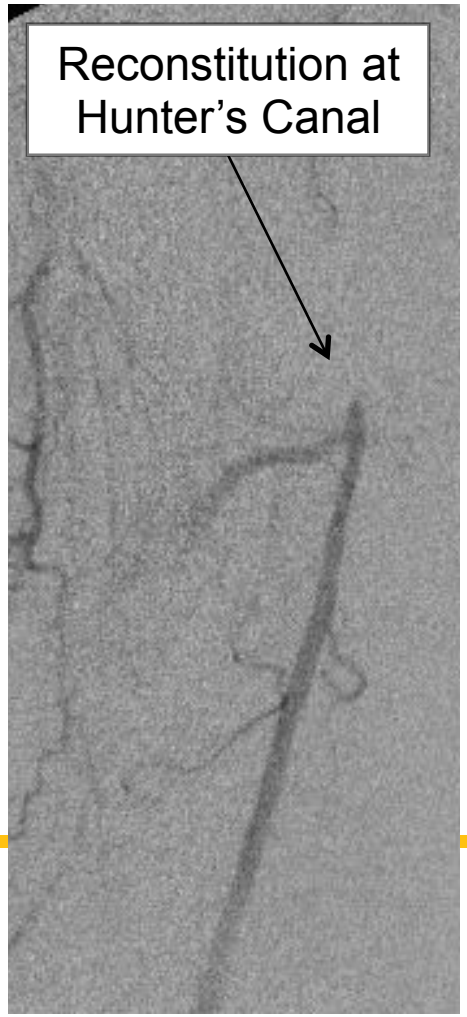
Procedure Room

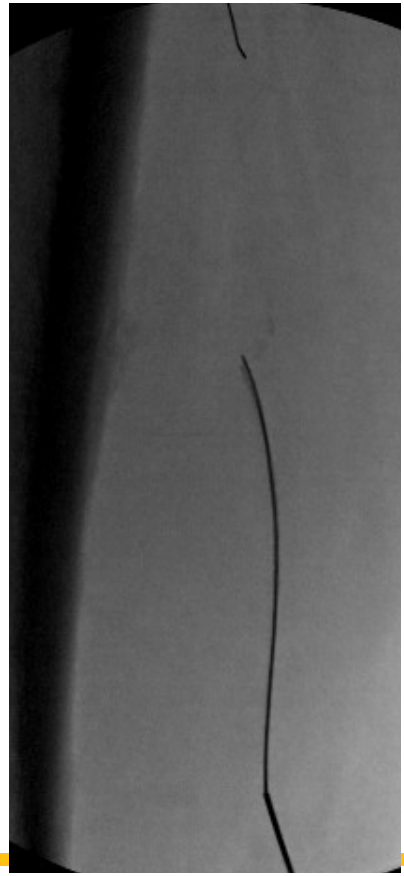
Recovery

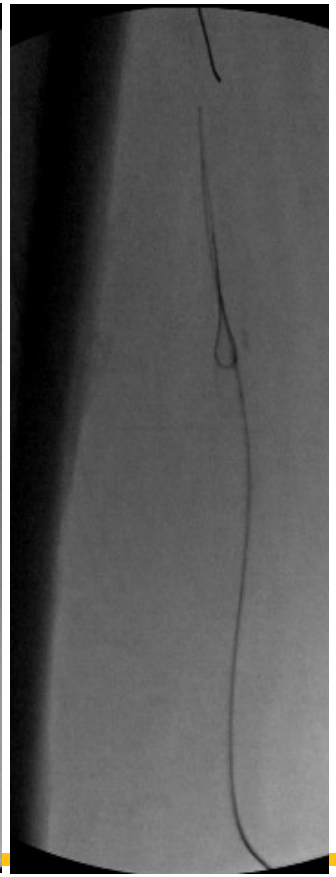
UCLA Division of Vascular & Endovascular Surgery

UCLA Gonda Ambulatory Procedure Unit



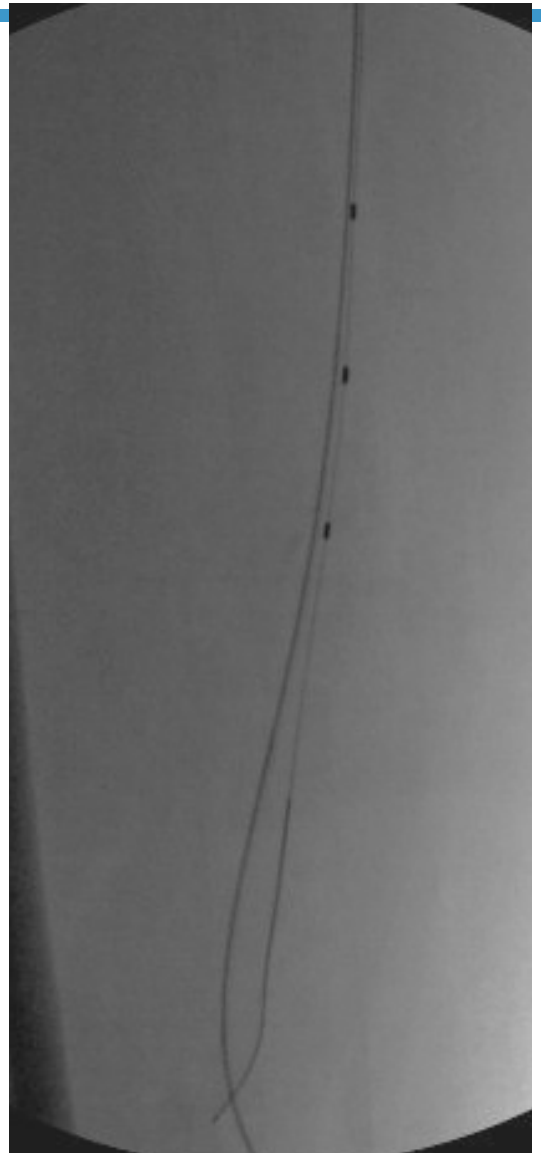


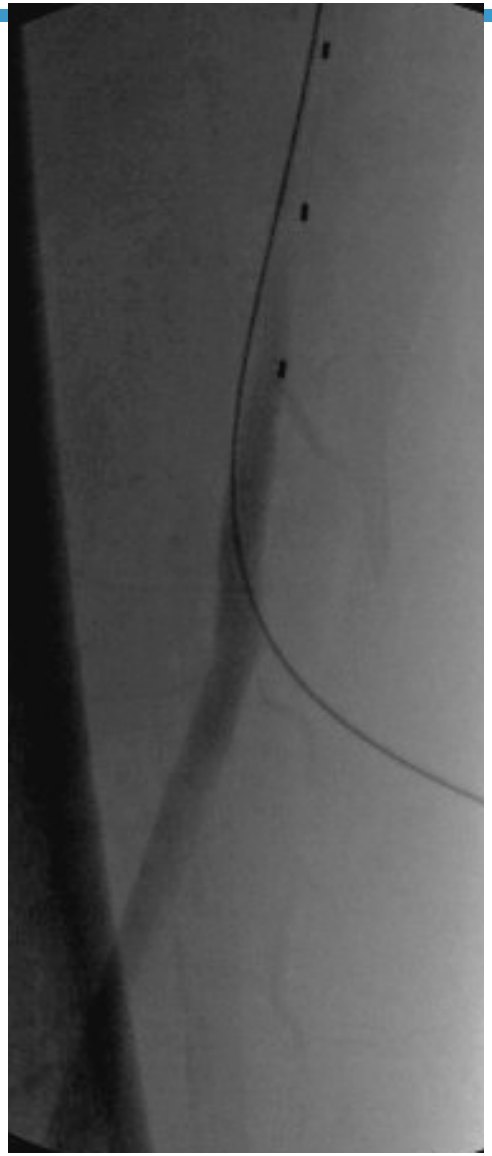


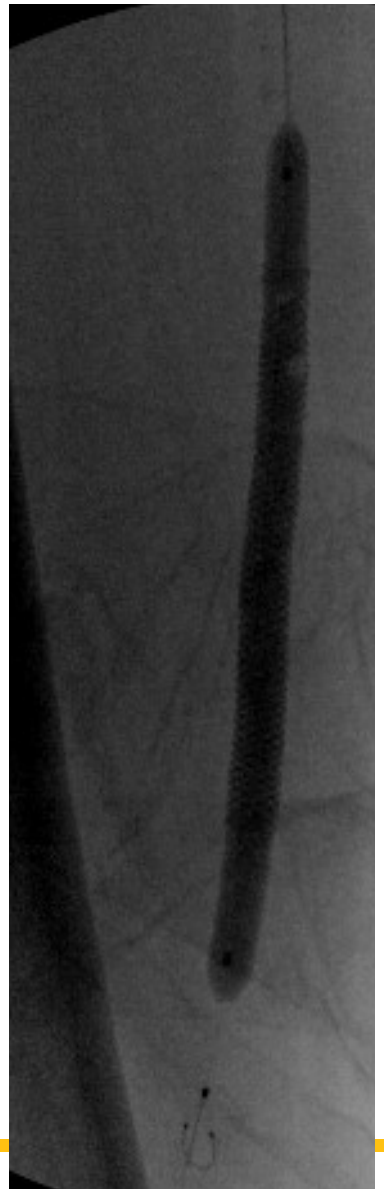


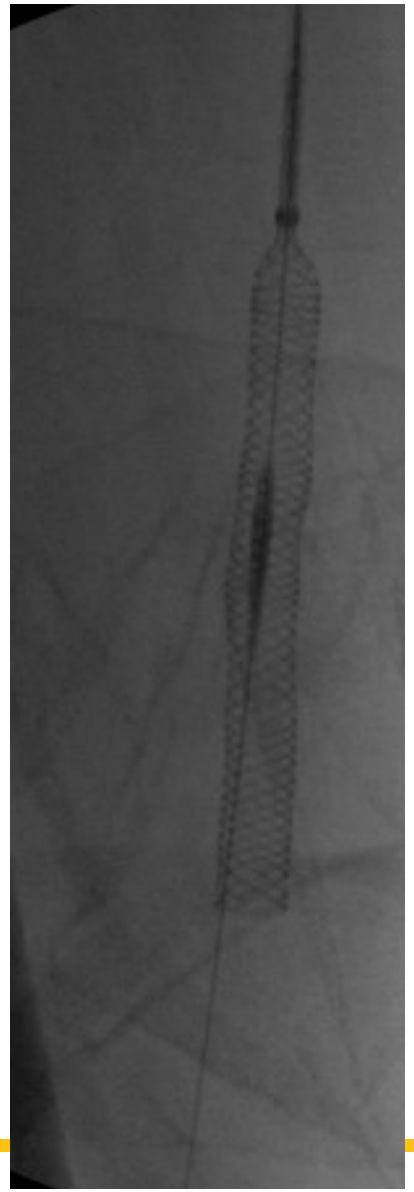
David Geffen School of Medicine

UCLA Health









UCLA Division of Vascular & Endovascular Surgery

Motivation for Establishing an Outpatient Lab

Potential Benefits of an Office-Based Interventional Suite

Patients

- ✓ Familiar care environment (avoids hospital)
- ✓ Fewer staff, residents, medical students
- ✓ Convenience for patients (physical, time)
- ✓ Focused attention / culture of safety

Office-Based Interventional Suite:
Motivation for Establishing an Outpatient Lab

Potential Benefits of an Office-Based Interventional Suite

Physicians

- ✓ Financial incentives (for owner/stakeholder)
- ✓ Convenience for physicians (physical, time)
- ✓ Improved access to devices
- ✓ Improved access to labs
- ✓ Autonomy and control (protocols, processes)

Office-Based Interventional Suite:
Motivation for Establishing an Outpatient Lab

Potential Benefits of an Office-Based Interventional Suite

Physicians in Academic Medical Centers

- ✓ Exposure of trainees to this important practice setting
- ✓ Opportunities to be involved in researching safety and appropriateness of this new site of care
- ✓ Shared supply resources with hospital system
- ✓ Shared staff resources with hospital system
- ✓ Proximity of hospital & admitting privileges for management of urgent complications

UCLA Division of Vascular & Endovascular Surgery

UCLA Gonda Ambulatory Procedure Unit

INSERT PICTURES OF APU

- ____ square foot space; opened in _____
- Reception & waiting area
- Venous & Arterial Procedure Rooms
- Recovery / sclerotherapy room

UCLA Division of Vascular & Endovascular Surgery

UCLA Gonda Ambulatory Procedure Unit

- Case Distribution
  - Hemodialysis
  - Venograms & deep venous interventions
  - Arterial interventions (lower extremity)
- Procedures:
  - 201_ to 201_ - ___ total procedures (one operator)
  - 201_ - ___ total procedures (two operators)
  - 201_ - ___ total prodedure (4-5 operators)

UCLA Division of Vascular & Endovascular Surgery

UCLA Gonda Ambulatory Procedure Unit

- Case Example : SFA retrograde case with DCB
- Case Example : venous stent case

INSERT THESE CASES HERE

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

1. **Start-up Issues**

- Hospital administration and CEO
- Dean and Department of Surgery / Medicine / Radiology
- Wide array of hospital politics

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

2. **Ongoing Operational Issues**

- Integration of fellows and residents
- Maintenance of hospital case volume
- OBL management in absence of "business-minded physicians or Division staff
- Lack of group "buy-in" when incentives are less than other practice settings / private practice groups
- Lack of comfort / skill set required w/outpatient intervention
- Competing priorities (teaching, research, etc)

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

3. **Optics Issues**

Perception of OBLs in academic circles

- Financial motivation
- Lower standards for devices, products
- Differential practices (hospital vs OBLs)
- Lesser degree of oversight
- Concerns regarding patient safety

Office-Based Interventional Suite:

Barriers to OBLs in Academic Environments

The New York Times | http://nyti.ms/1BAAIL1

BUSINESS DAY

Medicare Payments Surge for Stents t Unblock Blood Vessels in Limbs

By JULIE CRESWELL and REED ABELSON JAN. 29, 2015

At a time of increasing scrutiny of procedures to open blocked heart arteries, cardiologists are turning to — and reaping huge payments from -- controversial techniques that relieve blockages in the arms and legs.

Unlike heart procedures, which must be done in a hospital or outpatient facility, where oversight is typically more intense, the opening of the peripheral arteries and veins of the arms and legs can be done in a doctor's office.

Medical experts are questioning the necessity of some of these treatments, a many believe the condition is more safely treated with drugs and exercise. Nonetheless, some of the nation's most highly reimbursed cardiologists are mak millions of dollars from Medicare for performing these procedures, as payments for relieving blockages in the heart have fallen.

Earlier this month, the Justice Department said it joined two whistle-blowe lawsuits accusing one of these doctors of performing unnecessary procedures, including placing a stent in the leg of a patient who later died of complications.

The cardiologist in question, Dr. Asad Qamar of Ocala, Fla., was paid $18 million by Medicare in 2012, making him the top-billing cardiologist in the country, according to an analysis by The New York Times of Medicare data. Dr. Qamar was also the leader in billing for procedures to treat peripheral blockages

http://www.nytimes.com/2015/01/30/business/medicare-payments-surge-for-stents-to-unblock-blood-vessels-in-limbs.html

PRESIDENTIAL ADDRESS

From the Society for Vascular Surgery

"Better" (sometimes) in vascular disease management

Peter F. Lawrence, MD, *Los Angeles, Calif*

In January 2015, *The New York Times* reported on a physician in Florida who collected $18 million in 1 year from Medicare, of which $13 million was received for performing arterial interventions on legs. The reporters questioned whether the lack of oversight in office-based procedural centers was leading to patients being subjected to too many vascular procedures, both venous and arterial.[1] Of course, that physician denied there was any relationship between the lack of oversight and overtreatment, using as evidence that he had the lowest amputation rate in the entire country. He completely missed the point—this article was not about his technical skills or outcomes—it was about the appropriateness of his indications and whether he was overtreating patients with a high-cost procedure, when they may only have needed an exercise program—or even nothing. It's easy to get great results in a patient who needs nothing done!

Representing the views of the Society for Vascular Surgery (SVS), I provided a 175-word statement to *The New York Times*.[2] We decided to take on the elephant in the room—the current system that fosters unnecessary and inappropriate vascular procedures, and we pointed out that some of us, including vascular surgeons, are tempted to perform unnecessary care because the environment and incentives are wrong. The letter received more responses from SVS members than any communication in the history of our society—over 500; you asked that this issue not be swept under the rug, so I am continuing that process today and have incorporated many of your thoughts and suggestions into my talk.

I will discuss the extent of the problem, the possible causes, and then some proposals for reducing the frequency with which inappropriate care is provided to vascular patients. What surprised me most was the consistency of our SVS members' responses to the *New York Times* article—not a single person disagreed with the basic point of the letter, even some whom I knew were occasionally performing "unnecessary" procedures! They seemed to be asking us to help develop a better system. Some thought that I should have been more critical, some wanted the letter more nuanced, and most wanted it longer—not realizing that it would not get published in *The New York Times* unless it was fewer than 175 words, which is not much space to address such an important issue.

This article brought to mind a very thought-provoking book by a fellow surgeon and MacArthur genius, Atul Gawande: *Better: A Surgeon's Notes on Performance*,[3] in which he discusses how some of the most challenging health care problems have been solved, areas where we have become "better." For those of you who, like me, started practicing in the 1980s, you know that there has not been a field of medicine with more progress than vascular disease management. But, you also know that at the same time that we have developed the capability to treat vascular patients "better," we, meaning the global community of vascular specialists, have also treated many patients "worse"—by overtreating them with procedures that they do not need, just because we have the technology; for example, patients with mild claudication with superficial femoral artery occlusions undergoing angioplasties or atherectomies, patients with minimal venous reflux undergoing ablation of multiple veins, and patients with small asymptomatic aneurysms being treated with endografts. Some of these procedures are not durable, so that patients, once treated, often require repeated procedures. These unnecessary and nondurable procedures have led to huge costs for our health care system, occasionally cause complications for patients, and many are done primarily for our own personal economic gain. So, my talk today is "'Better'

From the Division of Vascular and Endovascular Surgery, David Geffen School of Medicine at the University of California, Los Angeles.
Author conflict of interest: none.
Presented at the 2015 Vascular Annual Meeting of the Society for Vascular Surgery, Chicago, Ill, June 17-20, 2015.
Correspondence: Peter F. Lawrence, MD, Division of Vascular and Endovascular Surgery, David Geffen School of Medicine at the University of California, Los Angeles, Los Angeles, 200 Medical Plaza, Ste 510-6, CA 90095 (e-mail: pflawrence@mednet.ucla.edu).
The editors and reviewers of this article have no relevant financial relationships

Office-Based Interventional Suite:

Barriers to OBLs in Academic Environments

Recent Increase in Percutaneous Arterial and Venous Interventions

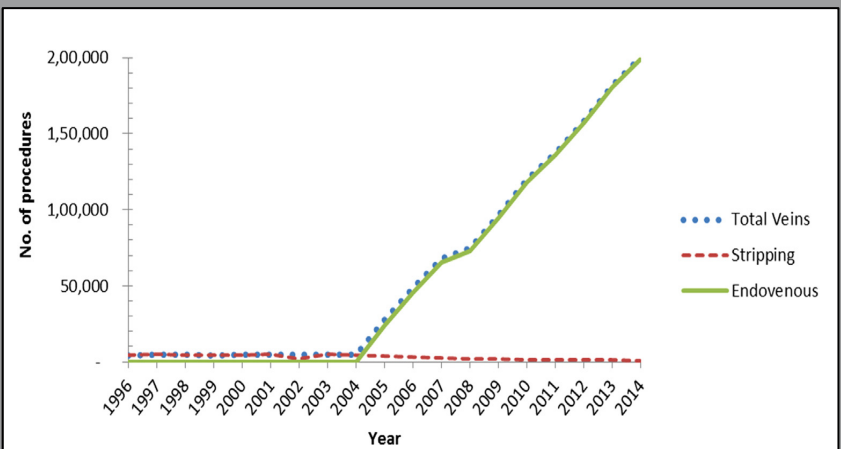


Fig 2. Venous procedures performed in the U.S. (1996-2014).

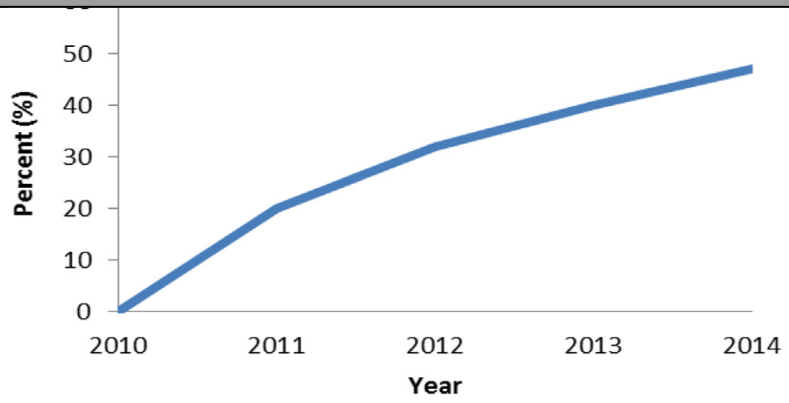


Fig 3. Lower extremity atherectomies, percent performed as office-based procedures (2011-2014). Collection of data began in 2011.

Venous Ablations

Outpatient Atherectomy

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

From the Vascular and Endovascular Surgery Society

The disproportionate growth of office-based atherectomy

Dipankar Mukherjee, MD, FACS,[a] Homayoun Hashemi, MD, FACS,[a] *and* Brian Contos, BS,[b]
Falls Church, Va; and Washington, D.C.

ABSTRACT
Objective: The purpose of this study was to evaluate the trends in procedure volume, clinical sites of care, and Medicare expenditure for peripheral vascular interventions (PVIs) for lower extremity occlusive disease since the Centers for Medicare and Medicaid Services instituted reimbursement policy changes that broadened payment for procedures performed in physician-owned office-based laboratories (OBLs).
Methods: We analyzed fee-for-service Medicare claims data fro
type, care setting, and physician specialty. We also assessed char
Results: There was a 60% increase in atherectomy cases among
the same period, OBLs experienced a 298% increase in atherec
settings and an 11% decrease for inpatient hospital settings. In 2
tomy. Nonatherectomy PVIs grew more modestly at just 3% but
and cardiologists accounted for the majority of office-based PVIs i
2011 to 2014. Hospital inpatient costs declined 1%, whereas cos
physician office costs increased by 258%.
Conclusions: The migration of revascularization procedures fo
continues from the inpatient to the outpatient setting and es
segments of the lower extremity arterial system has been observ
the literature of increased efficacy compared with standard an
reimbursement for in-office atherectomy procedures is likely co
2017;65:495-500.)

After years of rapid growth, today approximately 80% of peripheral vascular interventions (PVIs) are catheter based.[1,2] The rapid growth in PVI utilization corresponds to a similarly dramatic increase in health care costs to treat peripheral arterial disease (PAD). In 2014, Medicare paid more than $22 billion to hospitals for medical claims with a diagnosis of PAD.[3] In a seminal publication by Jones et al,[4] the study authors showed that between 2006 and 2011, there had been a minimal increase in the annual rate of PVI. However, there was a dramatic shift in the location of these interventions from the inpatient to the outpatient setting. Specifically, they noted

From the Department of Surgery, Inova Fairfax Medical Campus, Falls Church[a]; and The Advisory Board Company, Washington, D.C.[b]
Author conflict of interest: none.
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Correspondence: Dipankar Mukherjee, MD, FACS, Department of Surgery, Inova Fairfax Medical Campus, 3300 Gallows Rd, Falls Church, VA 22042 (e-mail: muk1953@aol.com).
The editors and reviewers of this article have no relevant financial relationships to disclose per the JVS policy that requires reviewers to decline review of any manuscript for which they may have a conflict of interest.
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Trends in Settings for Peripheral Vascular Intervention and the Effect of Changes in the Outpatient Prospective Payment System

W. Schuyler Jones, MD,*† Xiaojuan Mi, PhD,* Laura G. Qualls, MS,* Sreekanth Vemulapalli, MD,*†

ention (PVI) is an effective treatment option for patients with peripheral
dified reimbursement rates to encourage more efficient outpatient use of PVI
as to evaluate trends in the use and clinical settings of PVI and the effect
Medicare fee-for-service beneficiaries from 2006 to 2011, we examined
type of procedure, clinical setting, and physician specialty.
neficiaries underwent revascularization for PAD between 2006 and 2011.
om 401.4 to 419.6 per 100,000 Medicare beneficiaries ($p = 0.17$), but the
clined in inpatient settings from 209.7 to 151.6 ($p < 0.001$), whereas the
.7 to 228.5; $p = 0.01$) and office-based clinics (6.0 to 37.8; $p = 0.008$).
outpatient hospital settings and 50-fold in office-based clinics during the
cedures were similar across all types of PVI, whereas mean costs of
office-based clinics exceeded those of stenting and angioplasty
all rates of PVI increased minimally. However, after changes in reimburse-
cilities and office-based clinics increased dramatically, neutralizing cost
ossible unintended consequences of coverage decisions. (J Am Coll Cardiol
ollege of Cardiology Foundation.

rsity School of Medicine, Durham, North Carolina; and the †Department of
, North Carolina. This project was funded by American Heart Association
nt #14CRP18630003. The content is solely the responsibility of the authors
f the American Heart Association. Dr. Jones has received research grants
ibb, the American Heart Association, and Daiichi Sankyo. Dr. Vemulapalli
r. Peterson has received research grants from American College of Cardi-
sen Pharmaceutical Products, Society of Thoracic Surgeons; and serves as a
er AG, Boehringer Ingelheim, Janssen Pharmaceutical Products, Merck &
from AstraZeneca, Johnson & Johnson, Maquet, the National Heart, Lung,
consultant/on the advisory board for Baxter, Bayer, Genzyme, and Ortho-
m GlaxoSmithKline, Boston Scientific, Novartis, and Amgen. Drs. Mi and
elevant to the contents of this paper to disclose.
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ACC Editor-in-Chief Dr. Valentin Fuster.
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OCTOBER 13, 2015:1738–46

Era of Change in Sites of Service for Peripheral Vascular Intervention Requires New Ways to Look at Costs

I read with interest the article by Jones et al. (1) in the March 10, 2015, issue of the *Journal*. I am concerned that, based on the methodology and data presented, the conclusions may be misleading and suggest that interventionalists are making treatment decisions for peripheral vascular interventions (PVIs) and the choice of atherectomy, particularly, based on financial remuneration rather than on scientific evidence, depth of clinical experience, and interest in improving outcomes for patients.

The article presented data for Medicare fee-for-service beneficiaries between 2006 and 2011, showing no statistical increase in overall rate of PVIs, but with significant shifts in site of services from inpatient hospitalization to outpatient and office settings. Additionally, increases in atherectomy procedures during that time period were presented as two-fold in the hospital outpatient setting and 50-fold in the office setting. The authors concluded that changes in reimbursement intended to result in cost savings to Medicare inadvertently drove the shift in PVI site of service and the increase in atherectomy procedures in outpatient and office settings, thereby neutralizing cost savings. However, several points of clarification are necessary for accurate interpretation of the presented data.

First, the article presents an increase in atherectomy procedures up to 50-fold in the office setting during the study period. However, unlike percutaneous trans-
2011 represented only 16% of the total number of atherectomies performed for that year in all 3 settings.

Second, mean costs of atherectomy procedures are presented as exceeding those of stenting and PTA procedures during the study period. However, in the hospital outpatient setting, atherectomy was reimbursed at the same level as PTA until 2008, and less than or equal to stent procedures since 2008 (Table 1). In addition, the utilization and costs of atherectomy are likely overestimated relative to those of stenting as the PVIs in the article were categorized as angioplasty, stenting, or atherectomy, without regard to procedures involving more than one treatment modality, and the costs of procedures using both atherectomy and stenting were only attributed to atherectomy in the analysis.

Third, the analysis excluded patients undergoing expensive surgical or hybrid revascularization procedures ($n = 8{,}901$ [20.6%]) from the entire pool of 39,339 patients who underwent revascularization. Therefore, the conclusion about the erosion of savings due to shift in site of service and outpatient reimbursements is based on incomplete information that ignores the substantial reduction in the rate of surgical bypass procedures (33%; $p < 0.001$) during the study period. Considering that lower extremity bypass surgery is an expensive, inpatient-only procedure typically requiring a 3.8- to 10-day length of stay (LOS) and with Medicare costs ranging from $17,215 to $28,983 per bypass procedure (FY 2011 rates), the significant reduction in surgical procedures which likely resulted in significant cost savings to Medicare is not represented fairly in this analysis. (Medical provider analysis and review data for fiscal years [FY] 2009–2012, and FYs 2011–2014 Final Rules also are available at the Centers for Medicare and Medicaid Services website.)

Fourth, the patients treated with atherectomy in the study represented a sicker population than those

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Perception of OBLs in academic circles

- Financial motivation
- Lower standards for devices, products
- Differential practices (hospital vs OBLs)
- Lesser degree of oversight
- Concerns regarding patient safety

Are these all fair criticisms and true concerns???

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

How do we navigate these challenges, barriers, and biases in the academic environment in order to provide the benefits of high-quality outpatient based care?

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Integration of fellows and residents

- Viewed as simply another one of multiple practice sites (like OR, cath lab, etc)
- Particularly valuable training experience for graduating fellows and 0+5 residents
- Emphasis on meticulous detail to reduce complications (our teaching is better in the OBL!!!)
- Residents and fellows keep you honest
- M&M process, Weekly pre-op conferences

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Maintenance of hospital volume

- Potential area of conflict with CEO / cath lab administration
- No conflict when running at 110% capacity
- Offloads high-resource hospital-based sites for more complex procedures (fenestrated EVAR, TAVR, peripheral thrombolysis, etc)

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

OBL management issues

- Remains a problem for us
- Distribution of roles among stakeholders
- Some reliance on Departmental resources
- Has by necessity resulted in us becoming more knowledgeable about health care economics and care processes (which are ultimately critical as health care delivery continues to evolve)

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Lack of group “buy-in” when incentives are less than other practice settings / private practice groups

Lack of comfort / skill set required w/outpatient intervention

Competing priorities (teaching, research, etc)

- Also a problem for us, only 3 of 11 interventionalists in our group use the office-based space regularly
- Mentoring of those that are not as comfortable
- Recognition that it is not for everyone
- Realization of opportunities for improved teaching, research, and patient care advantages

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Perception of OBLs in academic circles

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Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Perception of OBLs in academic circles

- Difficult for those who have not experienced the benefits of the outpatient care setting to see OBLs as anything but financially driven
- Easier in the academic setting by default
  - ✓ Decreased financial benefit (vs other centers)
  - ✓ VQI Registry, M&M process
  - ✓ Site neutral patient care
  - ✓ Resident involvement
  - ✓ Site Accreditation

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Perception of OBLs in academic circles

- Shouldn't be too much harder for free-standing labs
- Requires commitment to the same principles our group uses and the OEIS advocates

Office-Based Interventional Suite:
Barriers to OBLs in Academic Environments

Five Pillars of Quality

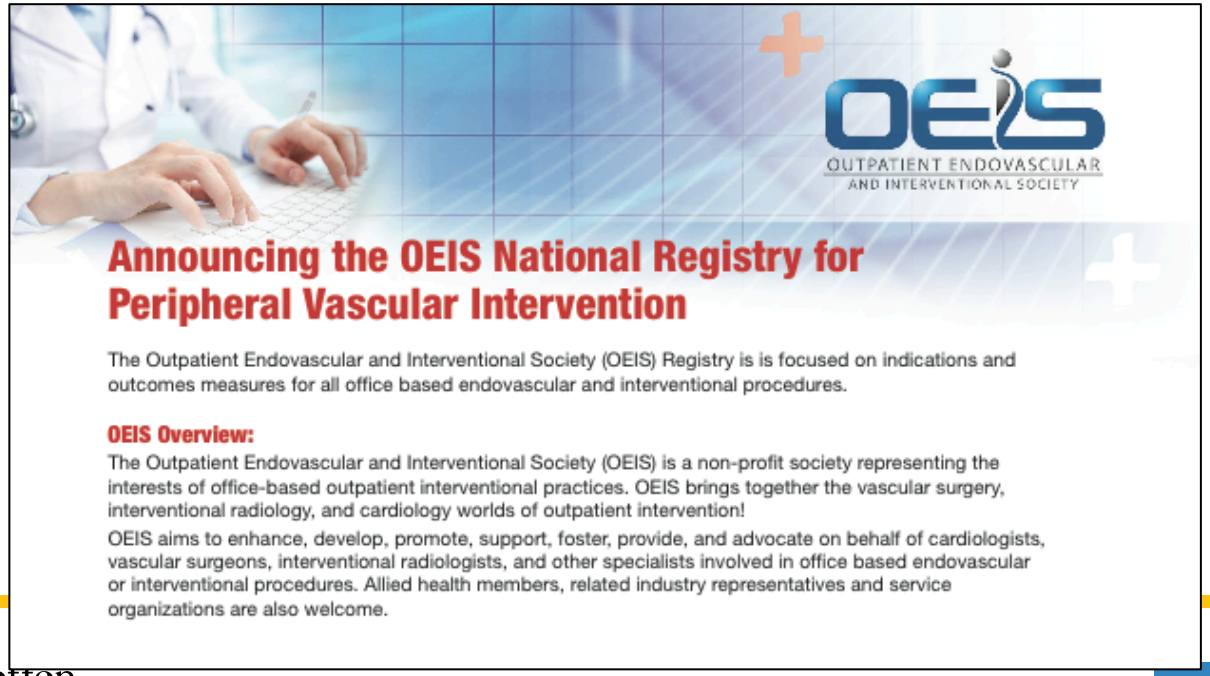
- Commitment to patient safety and quality
- Commitment to excellence in outcomes
- Commitment to selecting and performing clinical appropriate procedures in all cases
- Commitment to continued education
- Commitment to fiscal responsibility and transparency

Office-Based Interventional Suite:

Barriers to OBLs in Academic Environments

OUTPATIENT ENDOVASCULAR AND INTERVENTIONAL SOCIETY

Five Pillars of Quality



Office-Based Interventional Suite:

Lesson we have learned through our office-based lab experience at UCLA

- Improved Patient Care
  - ✓ Increased attention to detail
  - ✓ Zero tolerance for complications
  - ✓ Decreased anesthetic complications
  - ✓ Improved focus on patient experience

- Improved Teaching
  - ✓ Increased vigilance regarding resident participation, generally meaning improved focus on endovascular technique and increased faculty involvement

Office-Based Interventional Suite:

Lesson we have learned through our office-based lab experience at UCLA

- Improved cost-effectiveness of care extends to other settings of care
  - ✓ Choice of stents, atherectomy catheters, and DCB based on best published evidence rather than cost
  - ✓ Select use of these devices in scenarios where they have been shown to be effective, and not used outside of areas where evidence supports their use
  - ✓ Use considerations carry over to the hospital, and has made us more evidence-based in our practices there too