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OBL Spotlight: Joint & Vascular Institute

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Vascular Disease Management recently spoke with interventional radiologist Osman Ahmed, MD, FSIR, FCIRSE, about the Joint & Vascular Institute, a new office-based lab (OBL) in Libertyville, Illinois, that he started with Mikin V. Patel, MD, MBA. Dr Ahmed was one of the first physicians in the U.S. to perform genicular arterial embolization (GAE), one of several minimally invasive procedures offered at the OBL. Before opening the Joint & Vascular Institute, he was a Professor at the University of Chicago and is also the cofounder of Flow Medical.

How long has the Joint and Vascular Institute been open, and what inspired you and Dr. Patel to launch your own OBL?

It has been only open a few months now, and the inspiration has been multifold. There is a desire to reconnect with the patient a little bit more, be able to be your own boss, and direct patient care in that sense. The outpatient space is becoming much more popular in the sense that a lot of the IR procedures that we are doing are probably better suited for that space, which is where my clinical interest and focus are. A lot of those factors contributed to us taking the plunge, to do it.

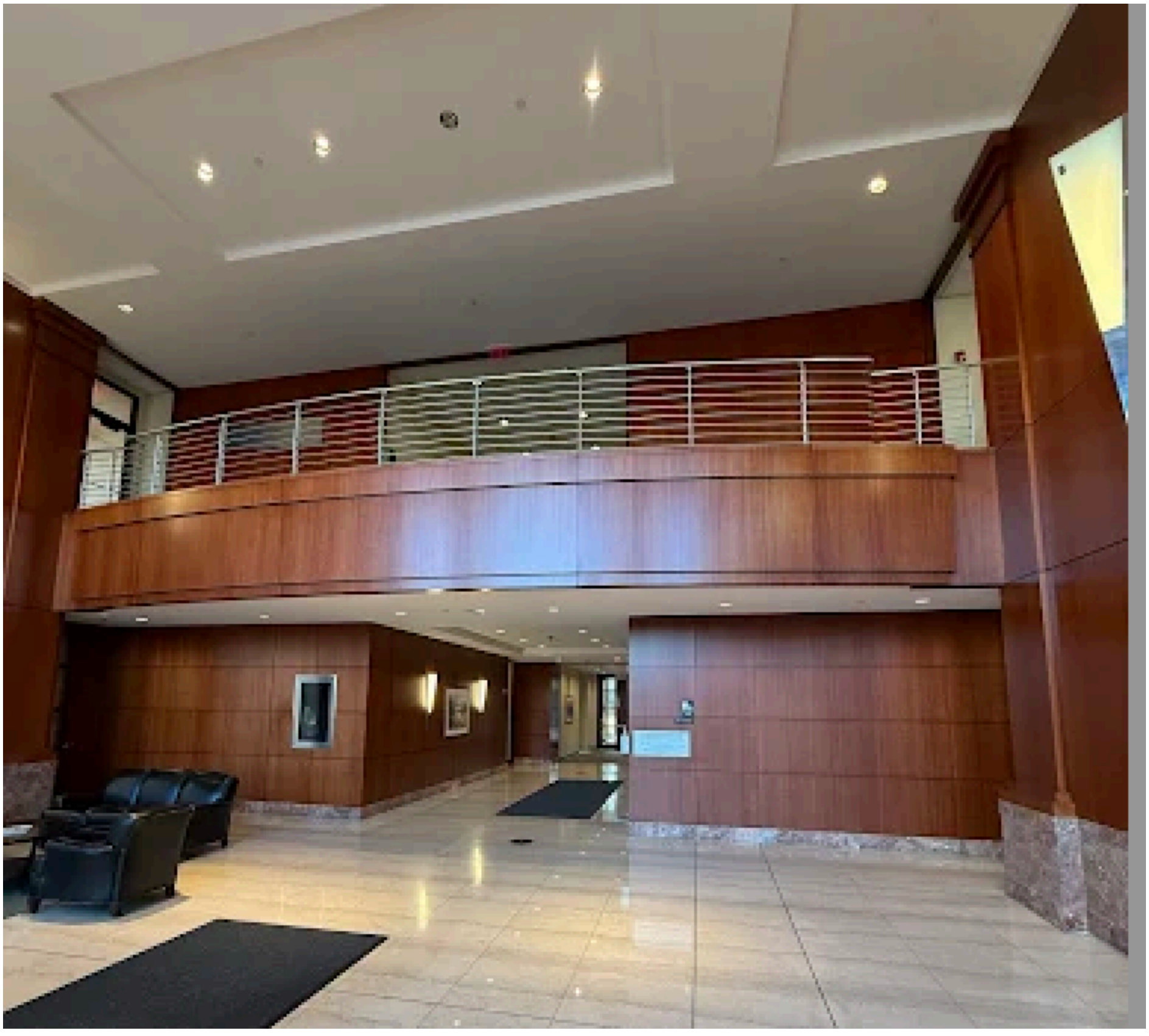
What makes your facility different from a traditional hospital-based interventional radiology practice, both from a clinical and patient experience standpoint?

We obviously love hospital-based medicine, and have no problem with it, but there is a lot of bureaucracy and inefficiency in hospital systems. So one of our main focuses is, again, getting back to being patient-focused, or patient-centric, and trying to optimize the patient experience. If we are referred a patient, we try to get them in within, oftentimes, 48 hours, and then we often are able to accommodate their schedule in terms of the specific time that they want to have the procedure done; we even offer weekend appointments. We try to accommodate each patient's needs as opposed to saying, well, our next available appointment is a month from now for clinic, and then the procedure is another month after that. We try to streamline it make it simple and easy for patients navigate that whole process.

Can you describe the patient's journey at your lab from the initial consultation to recovery?

Whenever we get a consult or referral, we will see the patient, whether it is in-person or virtually, within 24 hours if they really want to get in. For better or worse, a lot of what we do in interventional radiology does not necessarily require a complex physical exam. It is more often than not based on imaging and history. We will do a pre-procedure clinic visit and work to get insurance preauthorization. As soon as we get that—and for most folks, if they have Medicare, for example, we can get them in very quick—usually within a week or two they come for the procedure. We have systems set in place to send patients automatic text reminders, email reminders, and then they will come in for their procedure.

The biggest delay that we have had on our procedure days so far is about 15 minutes. It is usually very timely in terms of start time, then they go home the same day after a short period of monitoring. Then, we typically do a routine clinical follow-up in person at 1 month and then virtual follow-ups at 3, 6, and 12 months; at 1 year, we will decide if they need additional follow-up.



A patient's first impression—the building lobby.

You are known for your work in GAE for knee OA. How has that shaped your practice, and are there any recent patient outcomes that really stand out to you?

My focus in GAE is a big reason that I took the plunge; I wanted to really focus on this. We are already doing maybe 20 or 30 GAEs a month now. That is already how many I was doing when I was at the university. This practice is allowing me to subspecialize and focus on that. We have the autonomy or freedom to use different tools a bit easier without having to go through a full validated assessment program process and things like that; there is nothing wrong with those things, but they just add time and what I think is unnecessary complexity.

I have a an academic-minded brain that I don't think I could ever turn off or leave behind. So, we have already started 3 registries, and we are going to be doing a clinical trial. I think it is really exciting because of the pace; I need a fast pace, I hate inefficiency, I hate being slowed down. So what I have found here is that the pace goes at my rate, not necessarily waiting on people or things to get done, which has been really fun. Already in a few months we been able to catch up to speed to what I was doing already in my prior institution.

What kind of equipment and imaging technology do you rely on to perform these procedures?

I would say that is a work in progress. I have a business background in economics but my partner, Mikin Patel, is an MBA, so he is a real numbers guy, whereas I am more of a strategy, big-picture person. The reality of the situation is you cannot start an OBL and have a $2 million machine. Economically, it can be risky. So for us, we have started very lean—we have a C-arm, and we have limited staff. Already, within a couple of months, we have plans to expand, to grow, and get what we call the final destination of a very nice, fixed unit.

A procedure room at the Joint & Vascular Institute.

What operational advantages come with being an OBL? How do those benefits translate into better care for your patients?

Operational advantages go back to what I was saying about how you get to control the pace, and smaller organizations have less bureaucracy because there are fewer people to sign off on things. It allows us to be nimble and swift. If we recognize an operational issue, we can essentially fix it on the spot or that day. For instance if, say, patients are complaining that they are getting too many text reminders, that same day we could change it so that they get fewer reminders. Or if they are forgetting their appointments, we can add a reminder the day before. What I like about it is that it's instantaneous. I really like the autonomy and the ability to make those decisions. I think that has been one of the best operational advantages. And that translates to a better patient experience, because they are getting the most up-to-date, efficient way of being taken care of.

Can you share a specific case where a minimally invasive procedure made a significant difference in someone's quality of life?

Oh yes. We are an embolization-focused practice; that is my area of expertise, as you mentioned, along with Dr. Patel. We have already done some fibroid embolizations, for example, which in this sort of renaissance of embolization is kind of forgotten a bit. It is by far one of the best procedures that we offer our patients in terms of improvement in quality of life; it is minimally invasive and, obviously, uterine sparing. Doing this in the outpatient space has really opened to my eyes to just how minimally invasive this is. In the hospital, some clinicians use anesthesia, and it can take hours, so even though it feels like it is minimally invasive, it is still kind of a big ordeal in the hospital. But now having it done it in the outpatient space, a patient comes in, we do it, do a nerve block, they go home, and it really changes their life. We have had a few patients who, with fibroid embolization specifically, have said, “I've been suffering for X number of years, and I never knew that this was an option.” Once they find it, it is game changing for them. So that has been particularly rewarding.

We have seen similar success stories already with (MSK) musculoskeletal embolization and prostate embolization. We are also doing hemorrhoid embolization, which I think is a unique game changer for patients; it is kind of a taboo subject, and it's a sensitive area to have surgery in as well.

How do you and your team educate patients who may not be familiar with image-guided treatments like embolization?

That’s a great question. I would say almost every single consult starts with telling patients what an interventional radiologist is, because at the end of the day, we have not historically done a good job of educating patients. We are getting better at educating other providers about who we are, but for patients there is still a way to go.

This is a method of practice or site of service that lends well to education because we are very patient facing. Every consult starts with, “What is an interventional radiologist? Who am I? What's my experience? How can I help you even though I am not necessarily the master of that specific system?” For example, if I see a patient with benign prostatic hyperplasia, they historically associate that with the urologist, and rightfully so, as they have been doing this for decades and we have only been doing this for maybe 1 decade. So, I use it as an opportunity to educate and increase awareness. Honestly, what I have found is a lot of times it leads to more interventions and improved quality for the patients. They often say, “Oh, you can also treat knee pain? That's crazy, and I have arthritis”, but without educating them, they would have never known that.

Are you doing any outreach or partnerships in the community to build awareness and access? What is your approach to increasing your patient base?

We are still new, so we are still in that phase of throwing everything against the wall, but we are trying to figure out which things to throw against the wall first. We absolutely have been doing some outreach. What I have found is, obviously, just knowing people in the community, finding 1 or 2 docs who are friendly and sympathetic to what we are trying to do, helps a lot. We have plans to do some community health fairs, go to the local YMCA, things like that. In big institutions you don't have the time nor do you really even need to do those things because the patients already know those exist. But here, it is an opportunity to really connect with patients very much on an individual level.

You mentioned that you are also doing some research at your lab, can you tell me a little bit more about that?

We have started a few registries, we are doing an embolization registry, a GAE registry, and a non-GAE MSK embolization registry. I am working on a global registry with Dr. Mark Little that I am very excited about, and we will probably join that as an institution or a practice.

Then I am doing some industry-sponsored things with a few companies. It's really exciting. I even have a research fellow, which again speaks to the ability to make swift, easy decisions without having to get 100 people to sign off. Having him has been a godsend and it's been fun. It lets me stay connected to that part of medicine that I think otherwise I would very much miss.

Looking ahead, what are your goals—adding new procedures, expanding the team, or reaching more patients in Chicago and beyond?

I would say it's all those things. I have big philosophical goals; I would love to potentially redefine the model of care that is being done for interventional radiology. There are pioneers ahead of me, like Dr. Golzarian, Dr. Arslan, a lot of people who I take inspiration from, and I want to continue those efforts to say, look, interventional radiologists can have their own practice, they can work in the hospital, they can do both—you can have your cake and eat it, too.

Fundamentally, on a big picture scale, that is what I am trying to do, but also in the process I would love to increase access to care, make these minimally invasive procedures much better recognized and available to all our patients, and hopefully help contribute to the evidence needed to get them into guidelines.

I have a lot of goals, so we'll see what happens. But that’s what motivates me on a daily basis. ■