VDM Vascular Disease Management

OBL CORNER

OBL Spotlight: Advanced Heart & Vascular Institute of Hunterdon

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Left to right: Kathryn Minikus, APN; Andrey Espinoza, MD, FACC, FSCAI, RPVI; Jamie Gatto, MA; Noel Baquilod, RT, RCIS

Vascular Disease Management recently spoke with interventional cardiologist Andrey Espinoza, MD, about this office-based lab (OBL) in Flemington, New Jersey.

What is the size of your facility, and how long has Advanced Heart & Vascular Institute (AHVI) of Hunterdon been open? How many staff members do you have?

I've been in the OBL space for about 8 years total; my physician-owned OBL, Vascular Center of Excellence, is about 2 and a half years old. The Vascular Center of Excellence at AHVI is up there with some of the most beautiful facility settings. We have 1 main procedural room, but it is a very large room, which is atypical for an OBL. It's almost the size almost of a hybrid surgical suite.

Our OBL space is connected to our main office suite; we basically knocked a wall down. It's one contiguous cardiovascular center, so to speak. But the OBL area itself has 3 bays for recovering patients. We have a separate office for our lead radiation tech (RT), and we have a nurse practitioner (NP) who was a cardiac catheterization lab nurse—she's an NP during the day and during her free time comes over and does the OBL. We have a whole series of support staff, from our prior authorization specialists to other medical assistants who help us not only bring patients into the suite but also help us recover patients and get them discharged home.

What made you decide to open your own OBL?

Having been in the hospital space for almost 3 decades now, and especially with the current health care environment and the way hospital systems have behaved—for physicians now, not universally, but hospitals can be hostile environments. Having been a cath lab director and an endovascular director, you get to a point in your career where, at least for most physicians, it's always about caring for patients and the quality that we provide. When you start to see that break down for no other reason than pure economics, for administrative reasons, political reasons, for all the wrong reasons, you realize that first of all, this is insane. And second, we can do this better. We can do it more efficiently. We can improve quality, but also that one thing that everybody loves to talk about is patient satisfaction. If you ask any patient in today's environment, *Do you want to go to the hospital?*, it's the last place in the world they want to be. The only reason they go there is because their physician is there, they go there for the team, not for the facility. For our OBL space, they come for both; they come there because we're there, but the reality is we also provide a service that we truly view as a service. So even though I don't like the concept that medicine is a business, it is, and we are providing a service and it can be done as a white glove service in a very professional environment that's clean, that's efficient, and that I would argue is much more cost effective. And the outcomes are arguably, I would say, if not equal, much better because we control everything that happens. We choose the equipment, we choose the time, we choose the place, we choose the staff. And the good thing about having your own OBL is that nobody gets to tell me or my team if there's a better way to do something. We already know—I have professionals with a combined total of over 120 years of experience in a lab. I've got the best nurse, the best radiology tech. You can't go wrong when you have the best people. And ironically enough, we steal them all from the hospital, so it's not as though the hospital didn't have access to these people. We just decided to take them outside. They leave of their own free will because they know. They know what to expect and they know that the patient will come first.



What procedures are performed at your facility and approximately how many are performed each week?

We keep it to 3 procedures on Tuesdays and 3 procedures on Wednesdays. Obviously, if there is need on an urgent or emergent basis, for a cold leg or somebody with limb ischemia, we're looking to get them in as quickly as possible. And the reason we do that is I own my own solo practice. I was part of a large cardiovascular group for 18 years. I went out on my own and I have all the responsibility. I'm an interventionalist, endovascular specialist, and cardiovascular specialist. I do everything from reading ECGs, performing nuclear stress test, reading ECHO, seeing patients and all my other non-OBL procedures. I also do my outpatient cardiac caths and carotid work at 2 other facilities. So we control the environment.

Having a very set schedule in our OBL, our staff knows exactly what to expect. None of our patients are home any later than the early afternoon. Patients are not sitting there late at night. We're not keeping staff after hours for no reason. We could schedule 5 on Monday, 5 on Tuesday, and so on, but we don't want that because it overburdens the system.

There’s a lot that goes into the process including prior authorization, making sure we have all the appropriate equipment on the shelf, and so forth. We keep it to a very controlled environment where I'm only in the OBL 2 days a week. And the beautiful thing is most of our work uses ultrasound guided pedal access. We'll do a patient at 7:00 am and they're home by 10:00 am, literally walking out of there. It's a really nice thing. Then I just walk next door and I start seeing patients all day. I periodically will go back re-evaluate patients, but I also have my NP and my RT there. So we're pretty much covered, but I'm never more than 15 feet away from the patients even when not physically in the lab.

What types of equipment are commonly used in the lab? What imaging technology do you use?

We have a Philips Zenition 70 Mobile C-arm flat panel system that we purchased from Philips, and we participate in their SymphonySuite program. The program allows the physician to at least in part purchase not all but the predominance of the equipment through them at better economic price points. We have intravascular ultrasound, and 85-inch televisions on either side of the patient for operator viewing preference, and we also have the smaller screen that comes with the flat panel equipment. It's a nice setup.



What is a typical day like in your lab?

Patients usually will arrive at 6:30 in the morning. That's when the day begins with their check-in process and procedural case preparation. We usually will start the first case at 7:00 or 7:30, depending on what the case is, how long we think it will take. Every patient is scheduled on the hour immediately after that. Most of our work is done with ultrasound guidance, and I would say about 85% of our work done is with pedal access. We don't go generally radial unless there is an absolute necessity; I'm not a big fan of that, so we mostly stick to the pedal vessels. If we need to go femoral, then we do that as well, but everything is ultrasound guidance so we keep the access sites as safe as possible. We are able to move quickly, safely, and efficiently with our procedures as we really have an experienced and talented team. I would say most cases are completed in an hour; an hour would be a long time for procedures, mainly because we don't do diagnostics. We don't bring people in who are going to have a diagnostic procedure. All our patients have had some form of advanced imaging, whether it be duplex, computed tomography angiography, or magnetic resonance angiography. Imaging guides us. We have our own accredited vascular lab upstairs from our suite where we do all our noninvasive imaging: ankle-brachial indexes, vascular ultrasound, and such. Routinely the day before the procedure, I will send an email to the team that's responsible for caring for the patient and anybody who’s going to touch the patient either before, during, or after, including our ultrasound team because they're always very heavily involved. Everybody knows the plan. I perform a case review: this is the plan, this is the access approach, this is the equipment we're planning on using, and this is what we'd like to accomplish or achieve at the end of the day. Everything's done in a very systematic fashion, so when the team walks in the next day, everything is clear. Once the procedure is complete, the patient goes to the recovery room. As I said earlier, if it's tibial the recovery is fairly quick and benign; if it's femoral, most of the patients get a closure device if appropriate, but not all. We monitor as we normally would in any postprocedural environment. Then the patient is discharged home at the earliest possible, safe time frame for hemostasis.

Is your lab involved in any clinical research?

Yes. I've been doing research for 30 years and have been involved in an excess of probably over 50 clinical trials. Unfortunately, the COVID pandemic kind of put the kibosh on a lot of that; research slowed to a screeching halt, which was disappointing. So now we're getting back into the “Institute” side of things.

We’ve now participated in 2 clinical trials. One was a Philips postmarket approval study for their Tack MicroStent. We also just participated in the DEEPER Reveal trial, which is a retrievable stent technology. We will likely be participating in the TANGO 3 study, which uses the Bullfrog device from Mercator MedSystems. It's a periadventitial drug administration device, and we were part of the safety study about 10 years ago, and now they're doing a trial targeting anti-restenosis therapy.

We love the research part of it. My team has been doing research for as long as I have, and we love, love, love doing research. Most of it is not necessarily physician-driven; it's usually either national or international trials.



How does your lab compete for patients? Have you formed an alliance with others in the area?

We never view ourselves as a competitor, more of an option for people. We try to market ourselves as being or at least understanding that there are a number of really talented people out there. We just want you to be in the best hands based on your situation. If we do market, we usually will market to the wound center environments, to the podiatrists. I have shifted gears away from primary care physicians; having given hundreds of lectures to them, they just still don't get it or are too busy focusing on other non-vascular screening. It's really challenging. I've moved toward endocrinologists who, I find, are very savvy and very aggressive about the care of their diabetic patients. The savvy ones are very interested in the fact that they know these people develop vascular disease, not only coronary disease, but peripheral vascular disease. We've developed some nice alliances with the endocrinology community. Hunterdon County, where we're located in Flemington, New Jersey, is a geographically isolated area. One vascular surgeon at the 1 small community hospital that we have, I know him well. We've worked together for decades. He's toward the later part of his career and doesn't have endovascular skill sets. So we're kind of the only endovascular skill set game in town, which is nice. But we're also very appreciative of the fact that this is a collaborative approach to patients. This is not something that's occurring mutually exclusive of the endocrinologist, the family doctor, the wound care specialist, the vascular surgeon. We work very closely with the vascular surgeons at other tertiary care centers, and we always do what's in the best interest of the patient. Most of our work is endovascular, but there are times when people need some form of advanced surgical procedure with a good surgical operator, and we have those established relationships as well.

Is there a clinical problem or a challenge your lab has faced, and how was it addressed?

The beautiful thing is we have a big practice, about 15,000 patients. The good thing about now, as opposed to 5 or 10 years ago with the advent of the internet and social media, even though there are potential competitors in the area or other options, patients are pretty savvy. They do research on their own and they're able to go to a website or hear about us via word of mouth. I've been in the community now for 21 years, so we've got a really good reputation. Having and owning a small practice alleviates a lot of the challenges of being in a larger practice. If anything, I would say we haven't encountered much in the way of challenges more so than being able to accommodate all the patients who are looking or seeking for medical attention.

Do you do any community events or outreach?

Yes! We always celebrate Peripheral Arterial Disease Awareness Month. Last year it fell literally on the weekend when a hurricane hit, but we still had a massive event. People still showed up. This year, we're doing a “Walk for Your Life” event at a local public park, which is in Hunterdon County, we're going have a DJ, refreshments, and education, and it's all about PAD awareness. Myself, my team, and hopefully hundreds of patients will be there to do about a 2-mile walk just to get people accustomed to what 4,000 steps looks like, and we'll speak at the beginning and get people motivated. The DJ will be playing every song that has the word “walk” in it. It's going to be a lot of fun.



Left to right: Sylvia Barrantes; Bianka Suarez, MA; Rebecca Nagel, MA; Laura Garcia, MA; Amy Padula, MA; Andrey Espinoza, MD, FACC, FSCAI, RPVI; Kathryn Minikus, APN; Denise Kaczanowski, MA; Jamie Gatto, MA; Margaret Herman; Lauren Verran, RVT, RCS

How do you reassure patients who might be uneasy undergoing a procedure outside of the hospital?

It’s a big shift, mentality wise, because everyone's used to being in the hospital. I explain to them right out of the gate, listen, you're getting the same doctor, you're getting the same nurse, you're getting the same RT, and you're getting the same technology that we would use in the hospital. If anything, I would argue we have more flexibility with technology to put on the shelf because hospitals have these ridiculous committees that spend half of their time with non-vascular physicians telling me the most appropriate stent that I should be using to fix somebody's artery. That’s the beauty of an OBL, we don't have any of that red tape anymore. If any patient has a doubt, we always walk them through the facility. At the end of the encounter in the office, we'll say, listen, why don't you come over and take a look at the lab. The second they walk in they see that this rivals any hospital-based setting and they realize that we take a lot of pride in what we provide. It's very clean, and you really feel like you've just been transported into a hospital. It starts to quell their fears. There's always a patient who says, hey, listen, I'm just nervous if something happens; they would feel more comfortable in that setting. That’s fine. We want people to be comfortable. But thankfully, most of the patients feel pretty confident, especially after they've seen the facility. If they've experienced it one time, they usually say, I don't want to ever go back to the hospital! And you don't have to.

What would you say is unique about your lab in comparison to others that you've visited?

I would say the uniqueness, probably from a logistical point, is definitely the size of the room. I understand that it's difficult when you're building a facility and you're trying to not necessarily cut corners more so than control cost. OBLs can be very costly. My lab cost over $1 million dollars to shell out personally without any hospital support. It's a big infrastructure investment. So when you have the ability, thankfully, to spare no expense, whether it's because you have the money or whether it's because you just feel committed to the fact that this is the appropriate thing to do, it makes it easy to partake in that. I don't think that we really have any challenges.

We’re also very open with our industry partners in a sense that we don't keep the lab on lockdown; we use equipment from just about every vendor that's out there if it's the equipment we need. We're not specific to 1 vendor, we're not beholden to anyone. We make our decisions based on what's in the best interest of the patient, which I also think is somewhat unique. A lot of labs get 1 vendor, and they do save money, but the reality is, sometimes they may not have the appropriate equipment to do the procedure. We're happy to spend more or stick our neck out a little bit more economically in order to do so.

We also take care of patients who have no insurance. We will ask the vendors for equipment and ask them to do the best they can so we can cover costs so we don't turn people away. Whether they have Medicare or Medicaid or are self-pay, if it's somebody with a wound and we know the consequences of that, we do everything we can not to send them to a hospital that we know doesn't have the capacity, the operator talent, the skill sets, or the equipment needed. We decide we're just going to do the procedure. Yes, it is going to end up costing us money, but that's not what it's about for us. I think we have some unique approaches to how we care for

people because there are always enough paying customers to help us get through those times where we're going to have to eat a case every now and then. And that's okay, because I do this to help people. I mean, we all have a good job, make a good living. My goal is to make sure that my skill sets, my team's skill sets, are applied to everybody across the board.



Is there a memorable case from your lab that you can talk about?

In the last 2 years, we had a really nice case. I had sent the patient to a vascular surgeon at New York University for a very complex, rarely performed, axillofemoral bypass, an axillary artery femoral bypass for a limb ischemic patient. The patient did really well for a duration of time, and we had been following them with surveillance. And then the graft itself began to fail and it had a stenosis at the anastomosis of the axillary tie-in site, and distally. So we did a nice radial case, went in up into the subclavian artery, got into the axillary graft, treated the proximal segment of the graft and went distally, treated the distal segment of the graft, and the patient's done beautifully ever since. When we work with high-risk patients with high-risk anatomy who have already undergone surgical procedures, we love those because it illustrates that again, it's not about where you do it as much as the people who are taking care of you and their skill sets that we are able to apply, even in an office setting. That case took maybe a half an hour. Even though it was technically complicated on paper, the reality is you can do it in a very sophisticated, safe fashion where people say, "Oh my God, you have to take that person to the hospital, what if something happens?" Well, we have the ability to handle everything that could possibly happen. In the hospital, sometimes you can be in the same situation and there's nobody there to help you. I thought that was a unique case where I would say, I'm not necessarily shy of doing any complicated procedure. But an axillofemoral bypass in a limb ischemic patient, having to go through the arm, it's highly advanced stuff but we do it all the time. So I was proud of that one.

Is there anything else you wanted to say about your facility that we didn't cover?

I think most operators who are in my position feel the same way—that we are only going to be as good as the team we work with. I truly feel, every single day, that I am surrounded by some of the most talented people, and that allows me mentally to never have to think about what it is that I'm doing because they know exactly what needs to be done. They're such a talented team. They're extremely savvy. They know when to have a conversation with me about something that they don't necessarily feel particularly comfortable about. The take-home message is always that you're only as good as the team you're surrounded with. When you're blessed to have a team like I have, as an operator, you almost feel invincible, there's nothing that you can't do. You know that even in the event something does arise, which may not be anything other than just a bad complication, you're with all the people around you that you need to resolve the issue. That's the calm that I have in the deepest part of my heart. When I've got my team with me, my NP, my nurse, my RT, and everybody else surrounding me, I know that no matter how nervous they may be or a little bit uneasy about a certain case or what we may be doing because it's risky, I know from the bottom of my heart that it's okay, because if the worst-case scenario arrives, I have the best people to handle it. ■