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November 22, 2022

Ms. Debra Savage, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Springfield Clinic – Springfield Ambulatory Surgery Center
Benefits of ASTC Setting of Cardiac Catherization – Project 22-027

Dear Chairwoman Savage:

As a physician at Springfield Clinic and in central Illinois, Springfield Clinic's application for a Certificate of Need to establish cardiac catherization services at our surgery center in Springfield will allow for catherization procedures to be done in a safe, timely, and economic manner.

Clinical Advancements in Cardiac Catherization

The landscape of vascular care has changed dramatically over the years. Many of the complex inpatient revascularizations that we once provided are now replaced with outpatient endovascular procedures, a change that has been decades in the making. Patients routinely opt for an outpatient endovascular solution when appropriate versus the inpatient surgical approach. Reasons for this include less pain, quicker recovery, lower infection risk without sacrificing durability. Parallel to this, has been the development of safer, smaller endovascular devices. Many of these procedures can be done through a 2.5 mm hole in the artery, with closure devices minimizing post procedure bed rest. As a result of this safety profile, many of these procedures are currently done in outpatient settings. The Society for Vascular Surgery has noticed this transition; and in 2019, created the Section on Outpatient and Office Vascular Care(SOOVC), which I am a member of, to help further develop this field. I have included several pertinent articles on patient safety below for your review. Springfield Clinic's wish to establish a Cardiac Catherization service is in line with these developments.

As been well outlined, the local hospitals suffer from overcrowding of the cardiac catherization laboratories leading to delays or rescheduling of elective procedures to accommodate emergency catherization cases. This is an inconvenience for ambulatory patients, many whom travel long distances to undergo endovascular intervention. Establishment of a Springfield Clinic Cardiac Catherization service will allow appropriately selected patients to undergo elective outpatient catherization in a timely fashion, minimizing disruption in the patient's and loved one's lives. The economic effect a procedure has on a patient can not be overlooked. Lost wages for time off, time for recovery, and loved ones taking time off for transportation and to help with recovery are real costs to any procedure that are compounded delays and rescheduling.

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Cost Savings to Patients

Healthcare expenses continue to rise and as a clinician I am mindful of the cost of the care I provide. I try to save my patient's healthcare dollars at every turn: cheaper medication alternatives, an ounce of preventive medicine to avoid costly surgery, and minimizing procedures expense when feasible are examples. Patients routinely ask how much a procedure will cost, which can be somewhat difficult to place a finger one. However a clear answer can be found at the Medicare.gov website: https://www.medicare.gov/procedure-price-lookup/ This site shows the overall cost of a procedure and the breakdown of the components. It also shows the savings the patient can expect by having a procedure done at an ASC versus the hospital, a savings typically around $300 out of pocket. It is also clear the Centers for Medicare & Medicaid Services (CMS) can save substantial cost by supporting the use of ASC for appropriate procedures, reducing overall health care cost by $3000-$4000 per endovascular case.

	Surgery Center (ASC)	Hospital Outpatient (HOPD)
RIGHT HEART CATHETERIZATION INCLUDING MEASUREMENT(S) OF OXYGEN SATURATION AND CARDIAC OUTPUT, WHEN PERFORMED	$313 Patient Pays (Average)	$890 Patient Pays (Average)
LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED	$334 Patient Pays (Average)	$911 Patient Pays (Average)
REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL ANGIOPLASTY	$664 Patient Pays (Average)	$1,092 Patient Pays (Average)

Source: CMS website

Positive Patient Experience

The path forward is clear. In March of this year, my partners and I have made the move to use our current ASC setup for routine low complex endovascular procedures for low-risk patients who meet our ASC admission criteria. Our patients' experiences have been great. We have been able to accommodate patients' schedules, save them hundreds of dollars, and reduce overall healthcare

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costs. A patient I have been treating for peripheral artery disease presented earlier this year with left leg pain. His treatment course may be illustrative. His passion is showing his vintage muscle car at auto shows. This requires walking far distances. His blocked left iliac artery was preventing him from participating in a qualifying auto show. We recommended iliac artery stenting but were unable to schedule it in a timely fashion at the hospital. He was a low-risk candidate and were able to proceed with iliac artery stenting done at our ASC. Upon follow-up he states that he made it to the auto show, walking pain-free, and qualified for nationals.

Approval of establishing cardiac catherization services at our surgery center in Springfield will allow for us to have a dedicated ASC Endovascular Lab, with a dedicated team, dedicated nursing staff, and dedicated imaging to ensure that our catherization procedures will to be done in a safe, timely, and economic manner.

Thank you for your time and consideration.

Very truly yours,

Andrew Lambert, MD

cc: John Kniery, Administrator

Enclosure(s):
Article: Safety of vascular interventions performed in an office-based laboratory in patients with low/moderate procedural risk

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Journal of Vascular Surgery SVS Society for Vascular Surgery

CLINICAL RESEARCH STUDY OFFICE-BASED LAB | VOLUME 73, ISSUE 4, P1298-1303, APRIL 01, 2021

Safety of vascular interventions performed in an office-based laboratory in patients with low/moderate procedural risk

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Abstract

Objective

An exponential increase in number of office-based laboratories (OBLs) has occurred in the United States, since the Center for Medicare and Medicaid Services increased reimbursement for outpatient vascular interventions in 2008. This dramatic shift to office-based procedures directed to the objective to assess safety of vascular procedures in OBLs.

Methods

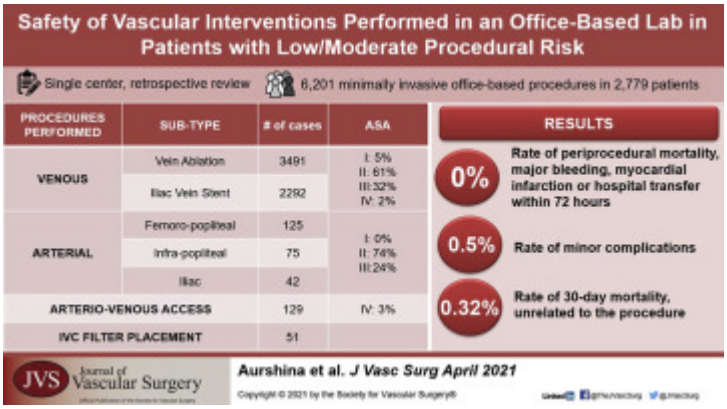
A retrospective analysis was performed to include all procedures performed over a 4-year period at an accredited OBL. The procedures were categorized into groups for analysis; group I, venous procedures; group II, arterial; group III, arteriovenous; and group IV, inferior vena cava filter placement procedures. Local anesthesia, analgesics, and conscious sedation were used in all interventions, individualized to the patient and procedure performed. Arterial closures devices were used in all arterial interventions. Patient selection for procedure at OBL was highly selective to include only patients with low/moderate procedural risk.

Nearly 6201 procedures were performed in 2779 patients from 2011 to 2015. The mean age of the study population was 66.5 ± 13.31 years. There were 1852 females (67%) and 928 males (33%). In group I, 5783 venous procedures were performed (3491 vein ablation, 2292 iliac vein stenting); with group II, 238 arterial procedures (125 femoral/popliteal, 71 infrapopliteal, iliac 42); group III, 129 arteriovenous accesses; and group IV, 51 inferior vena cava filter placements. The majority of procedures belonged to American Society of Anesthesiology class II with venous (61%) and arterial (74%) disease. A total of 5% patients were deemed American Society of Anesthesiology class IV (all on hemodialysis). There was no OBL mortality, major bleed, acute limb ischemia, myocardial infarction, stroke, or hospital transfer within 72 hours. Minor complications occurred in 14 patients (0.5%). Thirty-day mortality, unrelated to the procedure, was noted in 9 patients (0.32%). No statistically significant differences were noted in outcomes between the four groups.

Conclusions

Our data suggest that it is safe to use OBL for minimally invasive, noncomplex vascular interventions in patients with a low to moderate cardiovascular procedural risk.

Graphical abstract



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Keywords

• Vascular interventions • Minimally invasive • Office-based procedures • based laboratory • OBL • Outpatient labs

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