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5 Key Trends in GI/Endoscopy

By Laura Miller

Industry experts discuss the big trends and developments in gastroenterology/endoscopy today and where they are headed in the future.

1. New technology in the field. Technology continues to evolve in several ways, according to Andrew Ross, MD, Section Chief, Gastroenterology and Medical Director, Therapeutic Endoscopy Center of Excellence, Virginia Mason Center, Seattle. One of the most important advances is the idea of "optical" histology.

"The concept is really using the endoscope and specialized accessories to make a tissue diagnosis without the need for a direct biopsy and histopathologic confirmation under the microscope," says Dr. Ross. "While this concept was introduced several years ago with the advent of technology such as 'FICE' and narrow band imaging, newer technologies such as confocal laser endomicroscopy really allow for visualization at the cellular level. Whether these devices will replace the need for true tissue biopsy remains a significant open question."

Another huge technological evolution for gastroenterology/endoscopy is minimally invasive surgical technique. Procedures once requiring open incisions and prolonged recovery times are now performed in endoscopy suites with less invasive procedures.

"The continued understanding of the submucosal space has allowed for the development and clinical implementation of procedures such as endoscopic submucosal dissection for the treatment of early-stage cancers of the GI tract and per-peroral endoscopic myotomy for patients with achalasia."

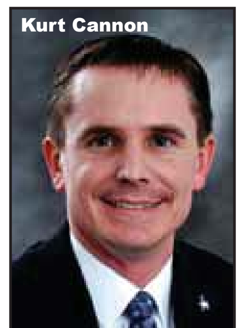
2. Proliferation of service agreements. More GI/endoscopy physicians are participating in multi-year service agreements with hospitals than in the past. These agreements should be carefully evaluated on individual merits and cost effectiveness.

"On the other hand, given the rapid pace that healthcare is likely to change over the next three to five years, locking into a fixed service agreement that does not change with technology or with economic pressures (that may come to bear on suppliers of those services) can work against you," says Barry Tanner, CEO of Physicians Endoscopy. "It is very much like airlines speculating on the future cost of fuel, depending on how much the market drives the price, it can either be a big win or very costly."

3. Appropriate cleaning, disinfection and sterilization. Cleaning, disinfection and sterilization are important for achieving good outcomes and quality service for patients.

"Consistent with professional organization guidelines including those from SGNA and federal agency recommendations (such as those described in the FDA/CDC/VA Safety Communication entitled Preventing Cross-Contamination in Endoscopy Processing issued November 2009), healthcare facilities should establish Quality Assurance and Safety Programs with an emphasis on endoscopy reprocessing," says Keith Nelson, Director, Infection Control and Product Development, Endoscopy Division, FUJIFILM Medical Systems U.S.A., Inc. "They should also develop institutional Standard Operating Procedures for the reprocessing and storage of flexible endoscopes based upon device manufacturer's instructions."

Dr. Andrew Ross


Kurt Cannon

Institutional quality assurance programs should include, but not be limited to:

- Identification of all staff involved in endoscope activities;
- Staff training;
- Annual competency review;
- Availability and dissemination of reprocessing procedures for all endoscopic equipment.

"Overall, we see that in facilities where strict adherence to training and education for dedicated cleaning, disinfection and sterilization exists, not only can additional efficiencies be found, but the frequency of product repair can also be reduced," says Kurt Cannon, Vice President, Sales, Marketing and Operations, Endoscopy Division, FUJIFILM Medical Systems U.S.A., Inc.

4. Electronic data gathering. Physicians and ambulatory surgery centers are now looking to incorporate electronic systems, for electronic medical records or other software for data gathering, which are expensive and take time and energy to implement. However, the right system can have a big impact on performance measurement.

"You need coordinated EMR so you can pull together the results of all the procedures and compare it to the pathology outcome," says Michael Weinstein, MD, Vice President of Capital Digestive Care and Managing Partner for the Metropolitan Gastroenterology Group Division. "If you don't have electronic records then you are doing a lot of manual data collection."

When ASCs and physicians have their data gathered, they can benchmark against industry standards locally and nationwide to see how they measure up and locate areas of improvement based on the comparison.

5. GI Benchmarking. The payment system of the future is moving away from fee-for-service and moving toward a value-based methodology, according to Tom Deas Jr., MD, Medical Director of Fort Worth Endoscopy Center and Past President of American Society for Gastrointestinal Endoscopy. "If you are paying for value, you have to define and measure quality. We are going to develop more advanced and sophisticated ways of doing that and we

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are going to rely on information technology more. There will be electronic data warehouses for clinical and claims information that can be analyzed and studied to measure and assess quality performance.

"Then we can compare performance against guidelines and see whether physicians completed the guidelines appropriately. They must administer the right tests and medication for diseases and coordinate follow-up and blood work according to the protocols. It's fairly easy to take claims data and EHR data and determine if treatment was given in an automated way rather than doing chart searches to sort everything out.

"Additionally, we will begin to take this same approach for endoscopic operations. We will look at what it costs to provide various services and benchmark individual performance against others to determine whether we are achieving the highest level of efficiency for the resources spent." ■

How ASC/AECs Can Survive Coming Healthcare Changes: Q&A With Barry Tanner of Physicians Endoscopy

By Laura Miller

Q: What are the biggest changes coming for ASC/AECs as a result of the current healthcare environment?

Barry Tanner: I think that many of the most significant changes are yet to be determined. It seems clear that pricing pressures will continue, especially on the professional practice side. Beginning in 2014, we anticipate seeing the start of an influx of newly insured patients. However, what we don't yet know is how to determine the change that will occur in the overall payer mix.

Clearly many more patients will have access to healthcare. That is a very good thing. Providers will be strained from a service perspective. Many providers will likely have increases in government-like reimbursements. The big question is how many patients will be migrating from third-party payer plans that actually support provider operations and survival to the health exchange plans.

It seems clear that there is likely to be continued movement toward population management and a bundled type of reimbursement and as a result of that pressure data gathering and data management will play an increasingly larger role in healthcare delivery.

Q: What can physicians and ASC/AEC administrators do to prepare for those changes as best as possible?

BT: The best thing we can do is to be extremely diligent on documenting our quality of care and the costs associated with that care. Shifting more payment reimbursement to the consumer is going to increase the need for transparency and will increase healthcare shopping. Physicians and providers in general need to change toward making their quality and costs fit that mold.

> ***"All ASCs will need to grow the area of data gathering and data management. We know that AECs deliver extremely high quality care at the lowest possible cost. We need to work very hard to make sure that fact is widely known and appreciated."***
> — Barry Tanner, Physicians Endoscopy CEO

Q: What core concepts in healthcare reform should gastroenterologists/ endoscopists grasp for success down the road? What are the biggest opportunities for success?

BT: For gastroenterologists, the greatest opportunities I believe lie in quality, service and cost. Overall, GI service line management, meaning tight management across the entire healthcare delivery spectrum, is going to be key. Patient experience is going to play a bigger role, again due to the healthcare shopping effect and once again transparency will be key. Consumers will be much more knowledgeable about healthcare in the future and we need to change to meet that need.

Q: What areas of growth do you feel will be important for all ASC/AECs in order to survive into the future?

Barry Tanner

BT: I believe that AECs and the physicians who own or participate in them need to focus on fully integrating the AEC into the local delivery system. Being an island and working in the same fashion isn't going to be successful. Look to have professional management both for your practice and your AEC.

All ASCs will need to grow in the area of data gathering and data management. We know that AECs deliver extremely high quality care at the lowest possible cost. We need to work very hard to make sure that this fact is widely known and appreciated. Find ways to work with the payers on cost reductions in exchange for better patient management. These are key focus areas for growth. ■

Budget-Friendly Tips for Acquiring New Technology

By Carrie Pallardy

It is no secret that healthcare is changing, but the full impact these changes will have on providers is still unknown. Surgery center leaders are constantly looking for ways to remain competitive in this changing market, and new technology is one way to attract patients. However, it can be an expensive proposition for surgery centers to stay on the cutting-edge in a time of declining reimbursement and financial pressure.

Tom Sakovits, Director of Financial Services, Endoscopy Division FUJIFILM Medical Systems U.S.A., Inc., discusses the challenges surgery centers face and budget-friendly tips for acquiring new technology in an age where every dollar counts.

1. Figure out where new technology fits into the budget. As the implementation of the Affordable Care Act grows nearer, healthcare providers will increasingly have to make the shift to high-quality, low-cost patient care. As this paradigm shift occurs, providers must also contend with a decrease in reimbursement and a rise in financial obligations.

"Financial pressure is not limited to reimbursement rates. Mandated investment in electronic medical records is expensive. Approximately 33 percent of capital dollars are being consumed by IT," he says. As a result, cost savings will now be one of the main drivers in provider strategy. Pay close attention to how new technology will fit into the ASC's budget before you begin exploring acquisition and financing opportunities.

2. Locate a vendor that understands an ASC's place within the healthcare market. New technology is in constant demand in healthcare. Equipment becomes out-dated or providers simply need additional technology to address patient needs. Even though this has not changed, the means of acquiring this technology has become a much greater concern.

"Financial solutions used to be an afterthought, but now this is the first thought. You must have an economical way to acquire needed equipment," says Mr. Sakovits. "On the financial services side, the industry is transforming itself because it needs to."

Surgery center leaders need to find a vendor that will better serve and support a cost-conscious strategy. Companies, such as Fujifilm, can provide practical financial strategies and solutions for equipment, as well as anything a surgery center may need from beds to a new space.

3. Build an individualized strategy. Though all surgery centers and providers are facing the challenges of the shifting healthcare environment, there is no one way to address these pressures. Surgery center leaders need to become savvier as the marketplace changes. "Capital is not as readily available," says Mr. Sakovits. "You can predict patient volumes, but not where funding will come from."

When considering the acquisition of new technology, surgery center leaders need to understand that there is not a "one-size-fits-all" solution. They should find a technology company

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that is capable of and willing to create a customized financial solution.

"At Fujifilm, we incorporate a certain degree of creativity that allows our customers to keep pace with the rapid changes in technology, all in a way that is based upon a budget and available dollars," says Mr. Sakovits.

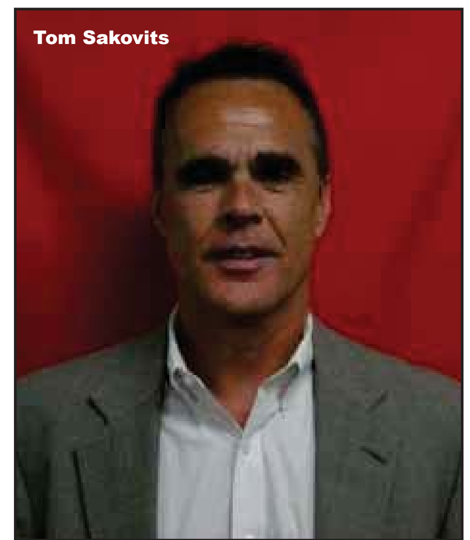
4. Find creative financial solutions. The need for capital exceeds its availability. The need can be four or five times what is available. Though this is often the case, surgery center leaders can enter into feasible financial arrangements that allow for the acquisition of new technology without breaking the bank. "At Fujifilm, our goal is to keep our financial services affordable, creative and simple," says Kurt Cannon, Vice President, Sales, Marketing and Operations.

Surgery center leaders must be upfront and honest about their budgets. This is the only way to establish a productive, lasting relationship with a vendor. "If a customer has money, but not enough to afford a major piece of equipment upfront, we will have, for example, interest only offerings. We create a firm repayment plan that their capital budget allows," says Mr. Sakovits.

A tiered repayment structure is another example of a creative solution. "The payment escalates and then plateaus into a friendly stream of repayment as the equipment generates revenue," says Mr. Sakovits. "Appealing to surgery center leaders, we provide 100 percent financing. There are no down payments, whereas a standard banking solution will want to see a 20 to 25 percent down payment."

5. Calculate the potential return on investment. If surgery center leaders find a piece of equipment that will provide a significant return on investment coupled with a financial solution that works for their center, there is nothing stopping them from acquiring much needed technology.

"Cutting-edge equipment and cutting-edge financial solutions go hand in hand," added Mr. Sakovits. "If a surgery center is a prospective or established customer that can build a mutually valuable and constructive relationship with the vendor, there should be nothing off the table in terms of solutions." ■


Tom Sakovits

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8 Benchmarks to Improve Profitability at GI-Centers

By Rachel Fields

GI ASCs suffer from low reimbursement, so keeping costs down is a priority. If surgery centers can keep turnover times and case times short and target the right patient populations, they can make a significant profit from GI. Lindsay Allen, Special Services Coordinator at the Borland-Groover Clinic, discusses eight statistics every GI-driven center should track.

1. Population growth. Ms. Allen says the Borland-Groover Clinic's executive team routinely reviews regional economic data on population growth that is prepared by a local economist. She says it is helpful for ASCs to understand how the population of the region is changing. For example, if the population is growing, the ASC might focus heavily on physician recruitment; if the population is staying stagnant or shrinking, it may be wiser to focus on direct-to-patient marketing in order to capture valuable market share.

2. Median age. According to Ms. Allen, GI-driven centers should pay particular attention to population demographics because the patient base is generally age-specific. Patients coming to the surgery centers for colonoscopies are likely to be 45-50 years old, so the center should know whether the average age of the community is increasing or decreasing. As the population ages, it is likely that there will be a significant increase in the number of patients requiring colonoscopies. Benchmarking age demographics can help the center understand which procedures to highlight in direct-to-patient marketing.

3. Wait times. It is important for GI-driven centers to benchmark wait times to determine how long patients have to wait for a surgery appointment at the surgery center. John Gol, Executive Director of Finance for the Borland-Groover Clinic, says, "Historically, if a patient has to wait more than three weeks for a procedure, they will go elsewhere."

Borland-Groover Clinic uses its practice management system to produce a report on patient wait times, and then each center tries to stay below an established benchmark. "If our wait times are growing past a certain point, the center looks at the possibility of hiring another physician," Ms. Allen says.

4. Costs-per-case. Ms. Allen states that her centers use costs-per-case to determine where cost-cutting opportunities might exist. She says physician preference is the biggest cause of outliers when it comes to case costs in a GI center.

"A physician will request [a certain supply], which can cause our costs-per-case to increase," she says. "Usually by showing them the difference in costs, the physician is agreeable to using a more cost-effective item." She says tracking case costs has enabled the ASCs to notice opportunities to cut costs by identifying both the peaks and valleys in the case costing trends.

5. Staff hours per case. Benchmark staff hours for GI cases separately from OR cases, Ms. Allen recommends. "We keep the calculations separate because it does seem like supplies and staffing for GI are pretty standard, so we keep them separate to monitor the difference in our OR staff hours." She says Borland-Groover tries to keep staff hours per case at an internal benchmark of five hours per case for its GI cases.

"Sometimes it can be as high as seven or eight, in which case we look at the difference and try to determine what happened," she says. "For example, maybe we had more people in the PACU than we needed."

She says benchmarking staff hours per case is useful because it makes staff aware of their time on the clock. "Charge nurses are a little bit more aware of getting people out of there," she says.

6. Polyp detection rates. Borland-Groover's Quality Development department benchmarks physicians' polyp detection rates — that is, the number of polyps found during a colonoscopy compared to the withdrawal time of the scope. She says they compare their physicians' rates to national

benchmarks, which suggest that 15 percent of women and 25 percent of men will have one or more polyps detected during a colonoscopy.

Jack Groover, MD, CEO for Borland-Groover Clinic, says, "There is a direct correlation between rapid withdrawal times and lower polyp detection rates." Borland-Groover researches and tracks these rates for each of their physicians and counsels physicians who fall below the national benchmarks.

"GI-driven centers should pay particular attention to population demographics because the patient base is generally age-specific. Patients coming to the surgery centers for colonoscopies are likely to be 45 to 50 years old, so the center should know whether the average age of the community is increasing or decreasing."

7. Patient transfer rate. Ms. Allen says Borland-Groover's GI centers also track patient transfer rates to determine how many patients are sent to the hospital because of a surgical complication. She says benchmarking these rates has led the centers to implement a pre-admission testing process for GI patients as well as surgical patients.

"Our surgery center used to do PAT for OR cases only, and we will be doing PAT for our GI patients now, to hopefully improve our patient transfer rate," she says. Tracking the number of patient transfers is important for surgery centers to understand whether they are admitting patients who are inappropriate for outpatient surgery.

8. Block time utilization. GI-driven centers should track physician block time utilization to make sure surgeons are using their time effectively. Because GI centers thrive on efficiency, patients should be seen in a timely manner. "We use our practice management system to run a report, accounting for any vacation and on-call days," states Ms. Allen. "The report helps us determine who might need more block time and who may need a little less, to make sure that patients are being seen in a timely manner."

She says every patient should be able to schedule an appointment within three weeks. Borland-Groover leaders look at block time reports monthly and adjust schedules if they see an issue. ■

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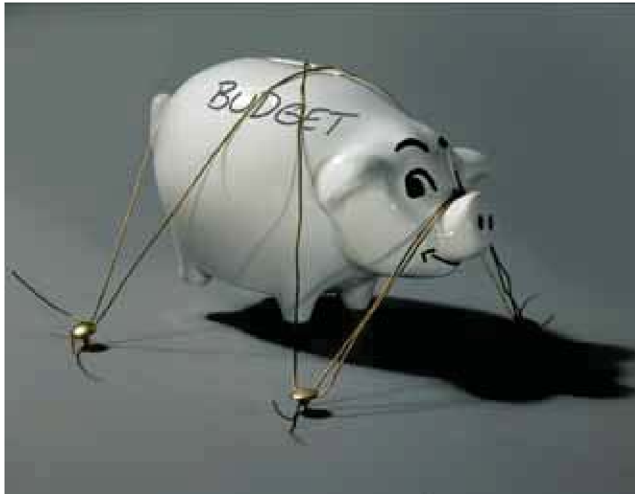

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