Endoscopic Unit Efficiency
GI Outlook 2014

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Disclosures

- Chief Operating Officer – Ohio Gastroenterology Group, Inc.

- Accreditation Association for Ambulatory Health Care
  - Vice Chairman of the Board of Directors
  - Chair – Standards and Survey Procedure Committee
  - Chair – Audit and Finance Committee
  - Chair – Investment Committee
  - Faculty – Achieving Accreditation

- Institute for Quality Improvement
  - Member - Board of Trustees

- American Society for Gastrointestinal Endoscopy
  - Vice Chair – Practice Management Committee
  - Faculty - Improving Quality and Safety in Your Endoscopy Unit Course

… and now for something completely different …

Announcing the ASGE GI Histology/Pathology Benchmark for fiscal 2013

The Challenge

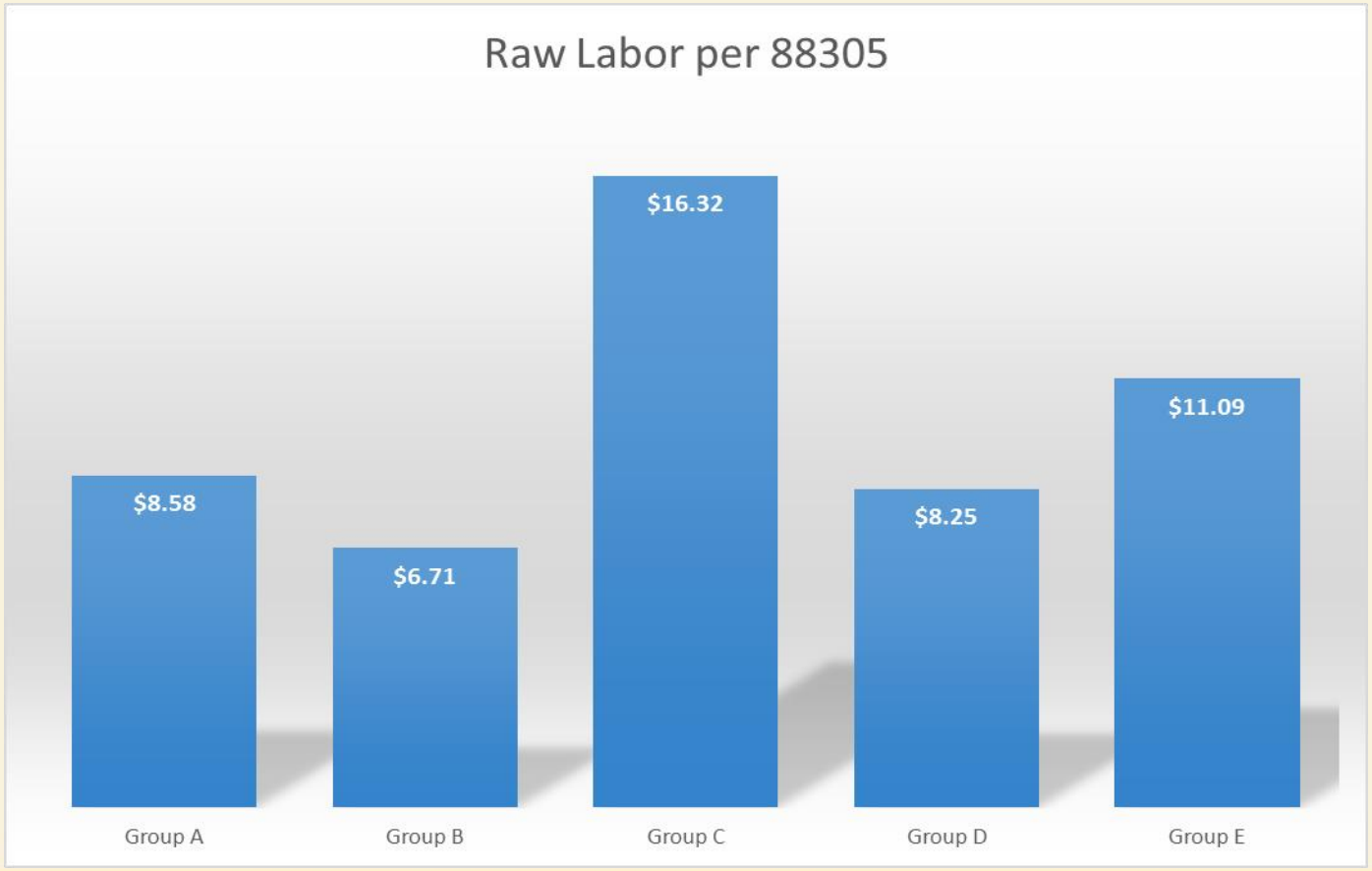
- Rapid adoption of in-house histology/pathology operations
- Heavy reliance upon consultants
- Not a great deal of in-house expertise in terms of efficiency
- “Norms” unclear
- Considerable growth still available

Histology Micro - Study

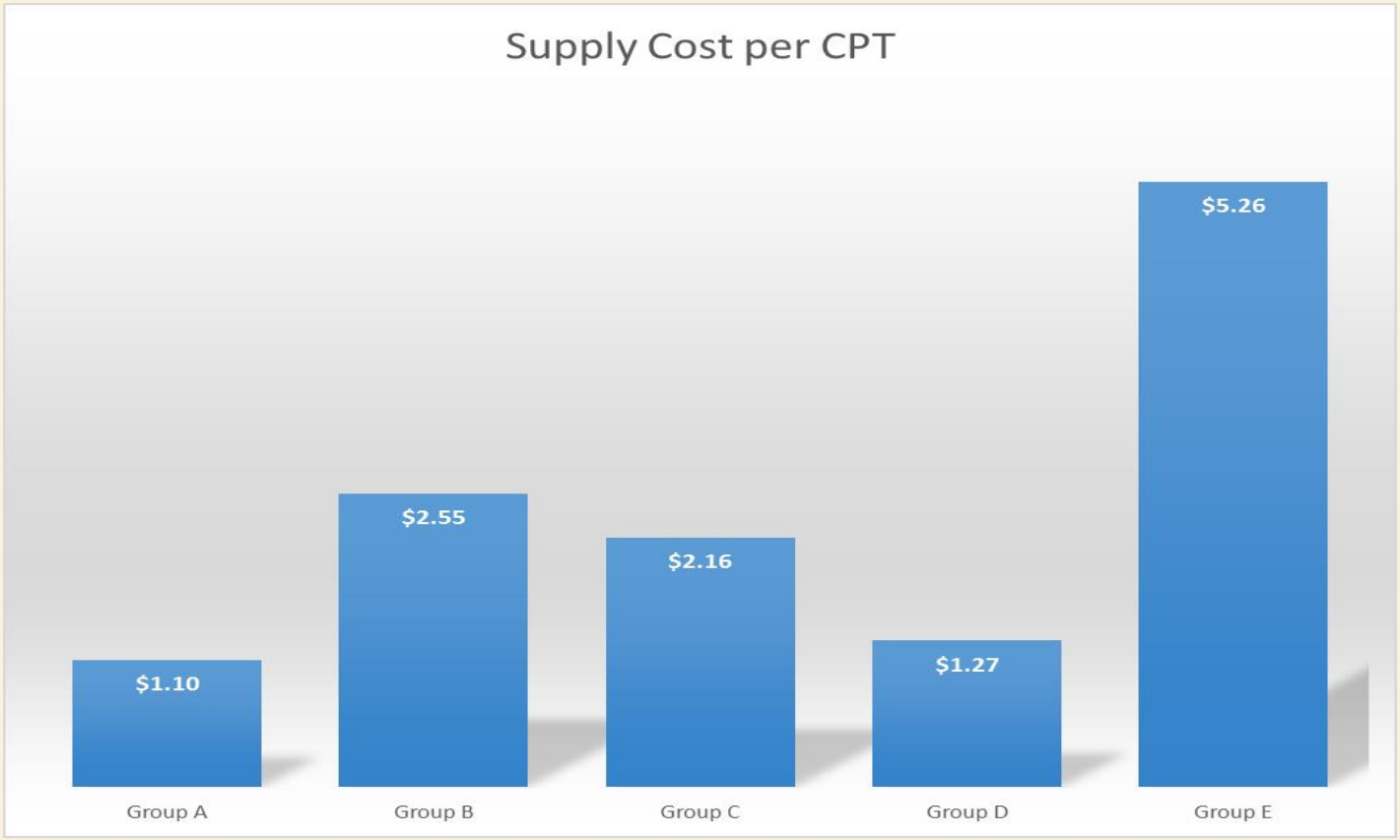
- 5 GI single specialty groups
- As few as 3 to over 20 physicians “feeding” the operation.
- Generating from 8,000 to over 19,000 88305’s
- 4 groups generating 88305, 88312, and 88313
- While 1 group generated only 88305 and 88312 but no 88313
- 1 of 4 employed a GI pathologist on staff
- 2 of 5 started their operation with some refurbished equipment

Histology Micro - Study

Histology Micro - Study



Histology Micro - Study



Histology Micro - Study

Survey should be open for participants soon.

Please participate, when survey is available.

ASGE Endoscopic Operations Trends

First case of the day is starting earlier

- In 2008 most frequent start time was 8:00 am
- In the 2012/2013 data = 7:00 am 1st and 7:30 am 2nd
- There were more 6:00 am and 6:30 am cases than 8:00 am

… but there is hope for physicians who need their sleep as Kazakhstan starts at 9:00 am and Kiev starts at 9:30 am

ASGE Endoscopic Operations Trends

Endo Days are Getting Longer

- In 2008, most frequent "day" was 8:00 am until 03:30 pm
- 3:00 pm to 3:30 pm is still the most frequent last case
- Those units starting prior to 7:00 am have their last case between 1:30 pm and 2:30 pm

ASGE Endoscopic Operations Trends

Is Flex Sig Disappearing as a Procedure?

- For respondents providing annual 2012 data, 82% indicated they performed no flexible sigmoidoscopies during that period.
- For respondents providing annual 2013 data, 87% indicated they performed no flexible sigmoidoscopies during the period.
- No hospital units reported flex sigs, 1 medical school did, 1 office operation did, a small minority of ASCs did.

ASGE Endoscopic Operations Trends

Decline of "Conscious Sedation" only …

- For respondents providing annual 2012 data, 30% reported that their unit did not offer deep sedation.
- For respondents providing annual 2013 data, 23% reported that their unit did not offer deep sedation.

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Key Indicator of Profitability

Encounters per Room per Day

- Average EpRpD for 2013 respondents = 11.05
- Average EpRpD for 2014 = 9.7

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In Room Staffing

- All hospitals reported staffing a room with at least 3 staff.
  - Typically – CRNA, RN, and a tech.
- Office Operations were most likely to staff with a single RN.
- In ASCs, when a CRNA was present, the most recent data shows that 62% of the time an RN was also present (38% of the time the RN was replaced with a tech.).

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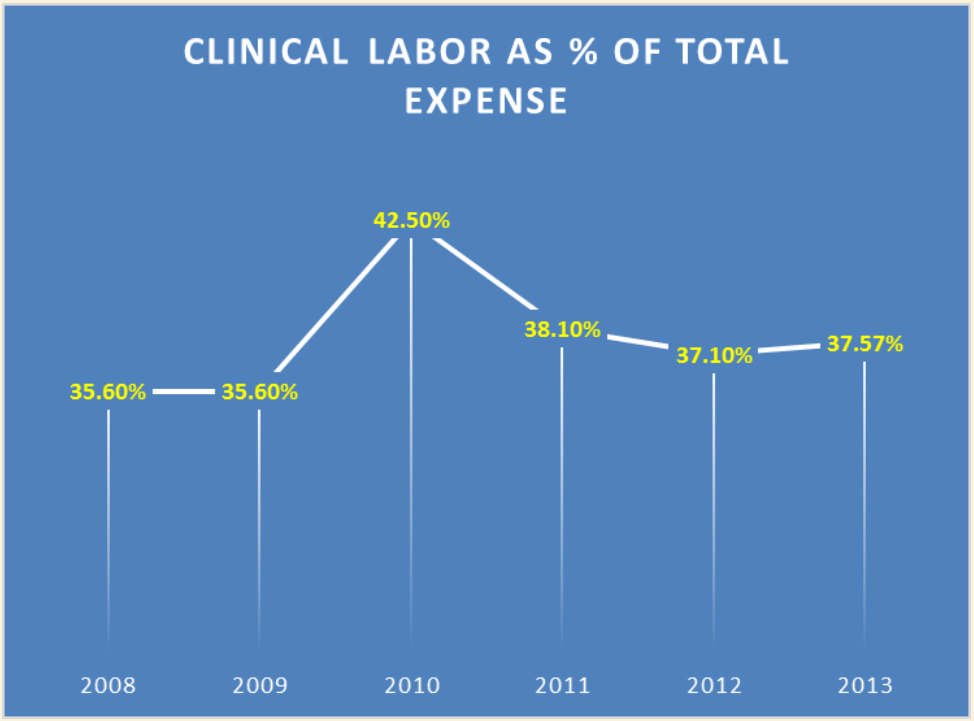
Clinical Labor as a % of Total Expense



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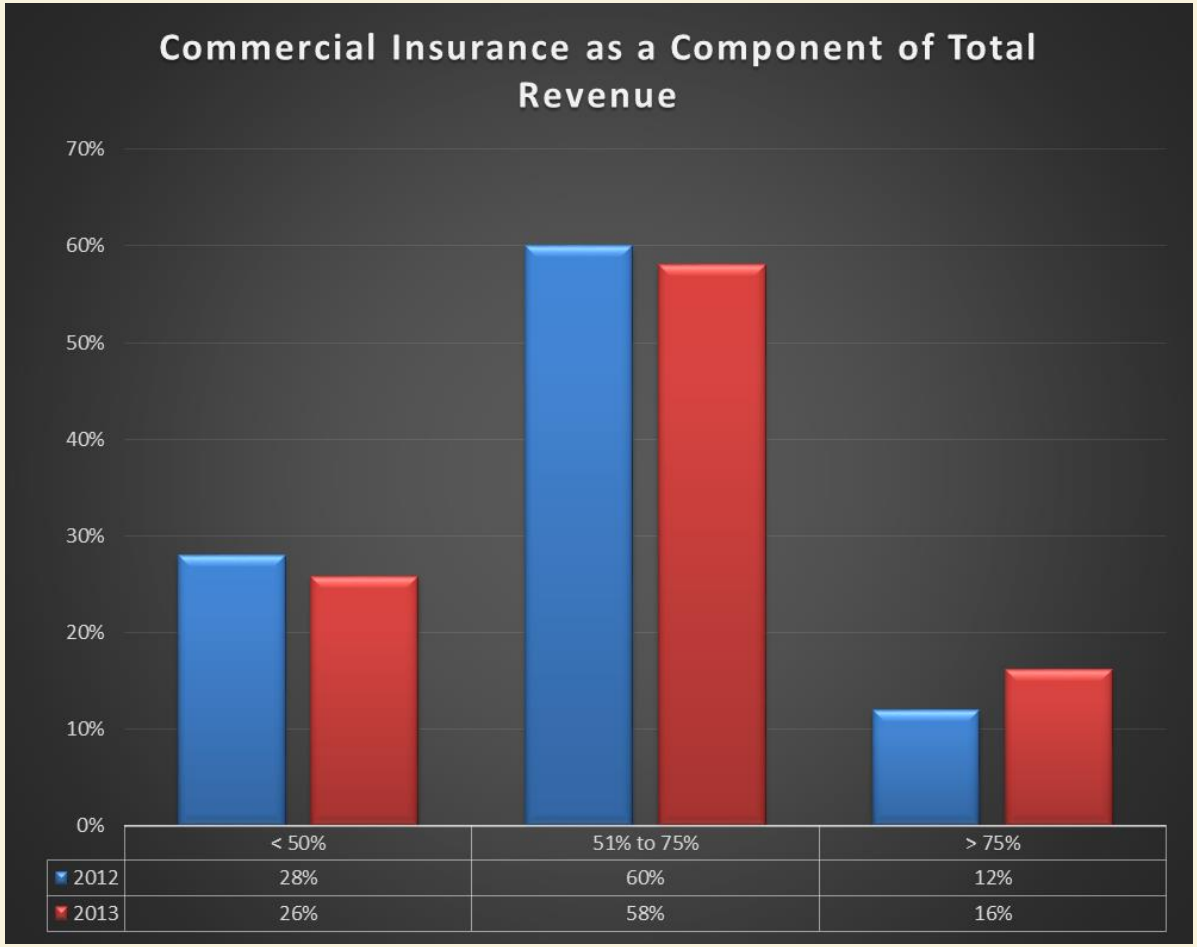

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Have recent Medicare changes led to modification in your scheduling process?

2012 = Yes 3.4%

2013 = Yes 5.9%

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In-house Histology or Pathology

After removing hospital and medical school participants, those ASC and office participants with in-house histology or pathology for 2012 and/or for 2013 represented less than 31%

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Adoption of EMRs in the ASC

- 34.5% of 2012 participants had deployed an electronic medical record in their ASC
- 47.1% of 2013 participants had deployed an electronic medical record in their ASC

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Participation in a registry?

- 13.8% of 2012 participants participate in a registry
- 8.8% of 2013 participants participate in a registry

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Homework

Most unit's cost curve is unsustainable. You must find ways to change some component of your cost.

Typically your largest cost is clinical labor, with the cost of equipment (primarily endoscopes) coming second.

ASGE Endoscopic Operations Trends

Homework

Review your labor mix.

The best method is to review the work required in an endoscopic unit and then match licensed staff to those work components that require licensure. For all other work, seek non-licensed staff when appropriate.

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Homework

Review how you schedule patients.

Disconnect your scheduling process from a prediction of how long a procedure takes and focus on having a patient ready for the physician.

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Homework

- Your two largest costs (clinical labor and equipment) are fixed over an 8-hour period. The only way to reduce average cost per case is to do more EpRpD.

- Encounters per Room per Day
- Average EpRpD for 2013 respondents = 11.05
- Average EpRpD for 2014 = 9.7

Seek increased throughput.

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Homework

Think about starting 30 minutes earlier.

1 additional case per room is typically 253 additional cases per year for each room.

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Homework

If you have multiple rooms, consider staggering starts.

If all your rooms start at the same time, they typically empty to recovery at roughly the same time. Peak and trough activity makes it seem to your recovery team that they are busier than they are.

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Homework

Consider adding Histology/Pathology Services

Just as the ASC provides greater control over the quality of the operation, the control over the quality of the histology/pathology service and the ability to prioritize cases of concern is the primary reason to bring these services in-house.

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Homework

Consider participation in a registry

Prepare for transparency in terms of quality. The best method of competing against surgeons and primary care physicians performing endoscopy is to track and publish your own quality metrics.

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Thank You!

Questions?

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