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PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Hospital-Physician Joint-Ventures: Current Tips for Success

By Stephanie Wasek

Physicians and hospitals, it would seem, can complement each other in many ways that would benefit both parties. For example, for physicians, running an ASC is more difficult than ever: Competition is stiff, regulatory and legal issues are more complicated than ever, and the reimbursement climate is difficult, to say the least. At the same time, hospitals are looking to expand market share and revenue streams, and their administrations have expertise in managing facilities and navigating bureaucracy. So what hampers such projects?

"All start out with varying levels of misunderstanding and even some acrimony," says Todd Flickema, senior vice president of development and operations at Surgical Management Professionals.

But as the healthcare market becomes increasingly difficult to survive in, "We're going to see more three-way partnerships with hospital systems, physicians and management companies," says Kenny Hancock, the chief development officer at Meridian Surgical Partners. "It's part of an evolution of thought, as it relates to the administration of healthcare systems; you absolutely have to have a motivated healthcare system that recognizes the need to partner with physicians, and vice versa. Otherwise, you waste a lot of time."

So how can tensions be eased and true partnerships formed so that physician-hospital joint-ventured

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Four Tips for Profitable Endoscopy in ASCs

By Stephanie Wasek

By all accounts, GI as a specialty — and especially single-specialty GI ASCs — will be hit the hardest by CMS's restructuring of the ASC payment system. But despite a 4.3 percent average cut for GI procedures, the situation is not as dire as it may seem at first glance, nor is it impossible to increase profitability in the new market.

"We performed a site-by-site analysis to determine the impact at each facility," says John Poisson, the executive vice president at Physicians Endoscopy, which works exclusively with GI-focused facilities. "You really need to look at all your payers and not just Medicare in determining what will be the real impact on your center."

And according to Physicians Endoscopy's calculations, "not taking into account payment increases from non-governmental payers over the next couple years, we're seeing an impact of only about 1 percent per year average reimbursement per procedure," says Mr. Poisson. For a center that does 11,000 procedures annually (34 percent of them being Medicare and commercial Medicare patients), the bottom-line impact is only $60,000 total (see "Breaking Down GI Cases").

"That's only three endoscopes in the grand scheme of things," he notes.

Based on Physicians Endoscopy's analysis, Mr. Poisson lists four key steps you can take to compensate for the Medicare cuts' estimated hit, and to help increase the profitability of GI in your ASC.

1. Stay on top of third-party payors. Looking first for ways to enhance your reimbursement is a far more efficient route for boosting the bottom line than trimming "fat" from operations or supply costs, for example, could be. As a result, examining your contract with third-party insurers is a good place to start.

"In terms of managed care contracting, we haven't seen any negative from Medicare interpretation from the private payors, so that has been encouraging to date," says Rodney H. Lunn, the CEO of Surgical Health Group in Brentwood, Tenn. "If you're concerned about [private payors' rates] going down, I think looking at contracts for three years is a wise decision. I think especially when you're looking at cuts from Medicare, it probably would be smart to because I think ultimately there will be cost pressure or payment pressure."

He notes that it's best to deal with contracts as they expire, however.

"We haven't had too much success between contract periods," says Mr. Lunn.

Mr. Poisson recommends renegotiating with non-governmental payers every 18 to 24 months.

"The vast majority will provide rate increases," he says. "It may be 3 to 5 percent, though in some cases up to 10 percent, but any rate increases will help offset increases in expenses and decreases in governmental reimbursement."

Any increase will help — just $15 more per procedure equates to $105,000 pure profit in a center that

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Four Tips for Profitable Endoscopy in ASCs (continued from page 1)

performs 7,000 procedures annually — but there's absolutely no reason to accept a decrease.

"We're negotiating contracts and we are emphatic about not allowing Medicare cuts to be transferred over to third parties," says Bergein "Gene" Overholt, MD, FACP, MACG, of Gastrointestinal Associates in Knoxville, Tenn., and a past-president of the American Society for Gastrointestinal Endoscopy and the American Society of Outpatient Surgeons. "They are trying and they are testing the water, and we are just flat rejecting that approach. We won't discuss that. We'll walk.

2. Bring in the cases. "If you can increase your volume, that will go a long way to offset any bottom-line discomfort," says Mr. Lunn. There are several areas to mine in order to ensure you're getting a maximum number of cases referred to your center.

"Not everybody's compliant with getting their colonoscopies when they reach the appropriate age. As a result, I think there are a whole lot of people out there who need and could be having procedures done, but who aren't. You need to make sure your physicians are doing everything they can to recruit new physicians or bring more volume into the center. In-servicing your primary care physicians to make them aware and community awareness programs are both important."

For example, he says, "a lot of women go almost exclusively to their GYNs. Are these physicians fully aware that maybe their patients need to have screening colonoscopy done? That might be an area that is neglected in terms of education from a colon cancer standpoint."

The schedulers in the physicians' practices are possibly the biggest factor in bringing in cases to your ASC, so it's important to network with them and make their lives as easy as possible, especially if the physicians are utilizers but not owners.

"Provide schedulers with a script that lists what to say and where to say it. The schedulers truly want to do a good job, but it's very easy to fall back into scheduling patients at the hospital because it's less work and less challenging," says Mr. Poisson. "We encourage the physicians to monitor the scheduler's interactions with patients frequently in the first few months — you need to trust they are doing what they've been asked to do, however, verification by management is critical."

Further, it's key that you communicate with schedulers (and their physicians) the importance of early notice of vacations or other planned time off that might leave blocks open in the future. Physicians Endoscopy has found that the success rate of filling a block with at least 30 days' advance notice is greater than 85 percent in its partnered centers; it's less than 15 percent for less than 48 hours' heads up. Estimating average reimbursement of $500 per case, leaving one room open for just one day costs an ASC $7,500; one open block weekly for a year costs $390,000 in revenue, says Mr. Poisson. He advises using a three-step open-slot process that highly involves the schedulers at the physicians' offices to help fill every patient block within each daily physician block.

- Patients evaluated in office are scheduled normally for a procedure in the ASC and asked if they wish to be placed on a priority list if availability in the physician's schedule arises within the next three weeks.
- Patients who are evaluated by phone are also both scheduled normally and asked about priority list placement.
- If a patient slot opens up in any physician block at the ASC within four business days, patients on the priority list are contacted until one fills the gap.

Adding just one incremental case to each room daily works out to more than 750 annually for the typical three-room ASC — about $375,000 in revenue annually. This is a way the schedulers can contribute to one of the biggest contributors to profitability — utilization — and much can be done on the ASC side as well.

3. Assess room utilization. This is a very important decision the board needs to make regarding what it will and won't require of utilizing physicians and physician-owners alike.

"[To keep up with the Medicare cuts], we are planning to enhance business as usual," says Dr. Overholt. "That means being sure that our volumes

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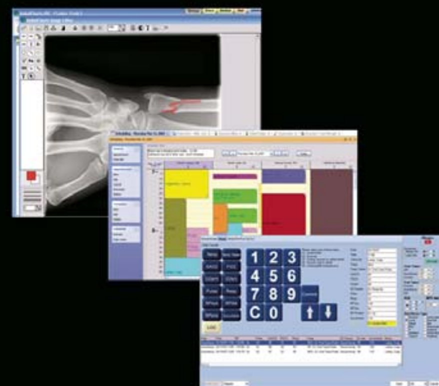

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are high, scheduling properly to fill block times and being sure people start on time. We don't tolerate tardiness and we want people on task."

The difficulty is that, in GI, physicians by and large want morning blocks — but you're paying for the room, whether it's full or sits empty, all day.

"We tend to see very high utilization rates in rooms in the morning, typically greater than 95 percent," says Mr. Poisson. "But in the afternoon it often plummets to the mid-70s. Yes, it's hard to ask a patient on NPO to come in at 3:30; however, it's very important to examine whether you're running rooms at lower utilization for physicians' convenience or because you don't have the cases."

When approaching utilization issues in your center, honestly determine whether you are already high-utilization or have room for improvement, based on these criteria:

- performing 3,000 to 3,500 procedures a year per room;
- performing 12 to 16 procedures per room per day between 7:30 a.m. and 3 p.m.;
- meeting a utilization rate of 95 percent in the morning; and
- meeting a utilization rate of 80 percent in the afternoon.

For those centers in which all rooms are being utilized to a large degree each day — in other words, the minority of centers — you're not a victim of your own success.

"If you happen to be well-utilized, you have the ability to make the decision to not bring certain payors into the mix," says Mr. Poisson. "Have physicians take the less-profitable cases to the hospital or another venue. For example, the Medicare codes for screening, which took the biggest hit, that's the first thing I pull out of our fully utilized centers. If you know a particular patient is just a simple screening, and you have the option of filling that slot with a payor that's more profitable, you should do that."

The second kind of center, those with potential for greater utilization, are those running under the 90 or 95 percent mark, and that's where most fall. The good news: You likely have opportunities for improvement.

"It's just a matter of coming up with what works for your center, or even physician by physician," says Mr. Poisson.

On the center level, one example of a fix is slightly overbooking the schedule.

"You can usually count on one or two patients either canceling or not showing, so knowing that, you can double-book and add one or two patients beyond the slots available," he says. By doing so, "nine times out of 10, if you've got 15 patient slots for a given room that day, you end up with 15 actually showing up. When all 17 do show up, in my experience, it doesn't cause a bump; staff and physicians step up to that challenge and meet it."

Don't be afraid to customize physicians' blocks if they work at different speeds — especially if it means enhancing utilization.

"Most centers book each physician a 30-minute patient block, but there are just some physicians who are faster at the same level of quality," says Mr. Poisson. "There's nothing to say that, for certain faster physicians, you couldn't book 20-minute blocks. The ability to add one procedure per room per day adds up to tremendous additional profits by the end of the year."

You must ensure that relative staffing levels in admitting and recovery permit these moves, of course; "the No. 1 objective always has to be patient safety," he says. "I'm a big believer that patient safety and quality medicine can be mutually inclusive with profitability."

4. Undertake quality initiatives. "High quality just improves the product of endoscopy," says Dr. Overholt. "Not just how you perform it, but it also improves patient satisfaction scores and physician satisfaction scores."

Further, when you track quality indicators, you can put the performance data to use as a bargaining chip with insurers.

"Some centers, with certain payors, have arrangements where, for example, on a quarterly basis, they will provide quality reporting to the insurer and get a reimbursement increase for meeting specific

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targets," says Mr. Poisson. "An extra 5 percent in reimbursement, that translates to a lot of dollars."

Within your center, you can use quality tracking to detect inefficiencies and devise methods for improvement that will produce savings that go directly to the bottom line, says Sean Benson, the vice president of consulting and co-founder of Provation Medical, which makes procedure documentation software. As an example, he cites Central Bucks Specialists in Doylestown, Pa., was suffering from inconsistent room turnover that caused scheduling problems and resultant frustration on all sides.

"When we tried to get to the bottom of the problem we got myriad answers," says Zvi Weinman, MBA, the administrator of Central Bucks, which performs 8,000 GI procedures annually. "The staff thought it was caused by the physicians, the physicians thought it was caused by the staff, and occasionally, everyone thought it was caused by the anesthesiologists."

Mr. Weinman was able to have hard data in hand that allowed him to analyze the problem objectively by tracking quality indicators: arrival to patient in room; patient in room to time-out; time-out to scope-in; scope-in to scope-out; scope-out to recovery start; recovery start to discharge; and polypectomy rate. Two areas stood out.

• **Time-out to scope-in time.** Five of six practicing physicians, were averaging within minutes of one another; the sixth was averaging close to 20 minutes longer than the others per procedure. The discrepancy was due to his conscious sedation practice: "Rather than giving a big bolus up front, he was doing a little at a time, and onset of the anesthetic took markedly longer as a result," says Mr. Benson. "When he was able to see the difference his conscious sedation practices were having on his procedure times, and that what his peers were doing wasn't affecting outcomes adversely, he changed practice."

• **Scope-in time to scope-out time.** Four of six doctors averaged within minutes of one another for scope time. One took markedly longer, and another was significantly shorter. It was not a matter of quality, but rather a matter of practice preference. For the physician who took longer, "they just scheduled his procedures for an extra 15 minutes each, and built it into the schedule," says Mr. Benson. "That way, the staff could anticipate, and backups for his patients were eliminated."

The faster physician opted to slow his scope withdrawal to ensure greater consistency and better adhere to identified GI best practices.

Some good news is that "GI is clearly out in front of every other specialty with regards to quality improvement," says Mr. Benson. "There are a lot of things going on in the world of GI QI, thanks to the ASGE and ACG getting together to create a QI pilot study that captures 80 data points for each colonoscopy (download it: http://www.asge.org/WorkArea/downloadasset.aspx?id=3386). For day-to-day practice, this needs to be distilled down to a handful, but it's helpful that efforts in this area are so thorough."

(For more on GI and QI, see "Are You Ahead of the GI QI Curve?" on page 10.)

Stick to basics

"The best ways to enhance profitability are by looking at fundamentals; there's nothing really new here," says Mr. Poisson. "It's just a reminder that, to run a GI ASC, you really need to be an efficiency expert."

Further, the four-year phase-in will help offset declining Medicare reimbursements, especially in GI.

"Reimbursement is clearly going down," says Mr. Poisson. "But you can't look at it in a vacuum; if you do, the situation is horrible. The average center's cases are two-thirds non-governmental payors. If you integrate Medicare payments with the rest of your payer mix, the situation is not nearly as Draconian as has been broadcasted." ■

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