FERRING PHARMACEUTICALS INC. GASTROENTEROLOGY PRACTICE MANAGEMENT BENCHMARK REPORT

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Sonnenreich, P, Zoeller, J, eds.
The Ferring Pharmaceuticals Inc. Gastroenterology Practice Management Benchmark Report,
Parsippany, NJ: Ferring Pharmaceuticals Inc.; 2015.

PK/1991/2014/US

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Executive Summary

The Ferring Pharmaceuticals Inc. Gastroenterology Practice Management Benchmark Report is an informational resource for gastroenterologists and their practice managers. The report is based on the findings of two statistical surveys. The survey research was conducted by Kikaku America International, an independent market research firm, with assistance from an Editorial Advisory Panel of nine experts, and with funding provided by Ferring Pharmaceuticals Inc. The survey findings were analyzed by the Editorial Advisory Panel, whose members include gastroenterologists, gastroenterology practice managers, and a practice management consultant, and who also provided commentary for the report.

The report is divided into two main parts: Part I: The Gastroenterologist Perspective and Part II: The Practice Management Perspective. Letters were sent by fax to 5000 randomly selected gastroenterologists in 2014 inviting gastroenterologists and gastroenterology practice managers to go online to complete the relevant survey. The first 64 surveys completed by gastroenterologists and the first 40 surveys completed by gastroenterology practice managers were selected for analysis. All survey respondents received a small honorarium. Survey responses are presented as percentages in the text and charts. The designation of "n" in the charts indicates the number of respondents who answered each question. Response percentages do not always total 100% because of multiple responses and rounding to whole numbers. In addition to the two surveys, the report also includes three related articles.

Top-line findings from Part I: The Gastroenterologist Perspective

- Payer formularies and obtaining preauthorizations for medications and treatments are by far the greatest challenges facing gastroenterologists, cited as significant challenges by two-thirds of survey respondents.

- Other notable challenges for gastroenterologists: patients not keeping appointments and patients not following physician directions, selected by 92% and 89% of survey respondents, respectively, when significant and minor challenges were combined.

- Commercial insurance is the biggest payer for gastroenterology practices on average, according to survey respondents, covering 44% of patient visits, followed by Medicare, with 39%, and Medicaid, 10%.

- Survey respondents report that reimbursement rates have decreased for Medicare, commercial insurance, and Medicaid over the last 2 years.

- The average percentage of treatments subject to prior authorization by survey respondents' largest payer is 28%, increasing to 35% for procedures, and 38% for medications.

- The greatest proportion of patient visits, 29%, are for routine colonoscopy, followed by irritable bowel syndrome (IBS), 20%, gastroesophageal reflux disease (GERD), 14%, and inflammatory bowel disease (IBD)/Crohn's disease/ulcerative colitis, 10%.

- More than half (56%) of survey respondents expect to see an increase in patient volume for liver disease/hepatitis, with 37% expecting to see an increase of more than 5%.

- Of survey respondents, 44% expect to see an increase in patient volume for routine screening colonoscopies, with 34% expecting to see an increase of more than 5%. Aging of the population is fueling that growth, as is coverage under the Affordable Care Act (ACA), according to our Editorial Advisory Panelists.

- Gastroenterologists rate patient comfort as the most important reason for offering anesthesia during a colonoscopy, deemed a high priority

by 78%, followed by patient safety, 64%, and ease of procedure, 50%.

- The average age of patients receiving their first colonoscopy is 53 years, say survey respondents; 84% of patients receiving their first colonoscopy are between the ages of 50 and 55 years.

- Although survey respondents perform an average of 147 colonoscopies a month, the largest percentage, 39%, report they perform 50 to 99 colonoscopies a month.

- According to survey findings, an average of 4% of colonoscopies can't be completed as scheduled, either because of poor bowel preparation, 58%, or because of anatomic issues, 42%.

- Factors found to be most important when prescribing a bowel preparation are product efficacy, 86%, followed by product safety, 64%, product tolerability,* 57%, and patient's renal health, 50%.

- Leading factors that would cause survey respondents to recommend a different bowel preparation for certain patients are product tolerability, 71%, a patient's renal health, 66%, and patient expense, 61%.

- Just 36% of survey respondents say they currently track their adenoma detection rate. More (43%) say they plan to in the near future. Average adenoma detection rates reported by survey respondents are 34% for men and 29% for women.

- Of survey respondents, 60% agree that adenoma detection rates should be a leading quality benchmark.

- Seventy percent of survey respondents are currently using electronic health records (EHRs). Another 13% plan to implement EHRs in the near future.

- Forty-four percent of survey respondents are currently reporting quality measures to the CMS Physician Quality Reporting System (PQRS); another 24% intend to participate in the future.

- As a result of data reporting through PQRS, survey respondents report that the following aspects of their practices have either greatly decreased or somewhat decreased: provider morale, 64%, staff morale, 56%, practice efficiency, 51%, and quality of provider-patient interactions, 36%.

- Just 22% of survey respondents are currently participating in quality care initiatives; 16% intend to participate in the future. Most of these practitioners, 54%, are participating or planning to participate in the Gastrointestinal Quality Improvement Consortium (GIQuIC), administered by the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy.

- While 35% of survey respondents agree that registries will lead to improved care within 5 years, in the future, or at some point, 38% say registries are either not likely or unlikely to lead to improved patient care; 27% are unsure or don't know.

- Although more than half of survey respondents, 53%, do not intend to participate in Accountable Care Organizations (ACOs), 23% are currently participating and 25% plan to participate in the future.

- Just over half of survey respondents, 53%, indicated that the practice has a Web site. Features of sites include: patient education, 68%, downloadable forms, 65%, and a patient portal, 50%.

- Gastroenterologists have not embraced social media as a way to market their practices. Just 26% of responding gastroenterology practices have a Facebook page.

- Only 13% of survey respondents regularly manage the practice's online reputation. Most, 62%, say they don't use social media at all.

- Forty-one percent say their practice is rated on physician rating sites but 55% say they have not checked.

- To attract new patients, gastroenterologists rely on print advertising, 47%, free lectures, 47%, brochures, 39%, and participation in health fairs, 28%. Just 17% use the Internet for patient outreach.

- Asked what technologic and clinical advances have had the greatest impact on practice, survey respondents name: EHRs/e-prescribing, better endoscopes, and better drugs for hepatitis C and IBD.

- Survey respondents were also asked to name three developments on the horizon having a significant impact in the next 5 years. Responses include: new drugs for hepatitis C and IBD, early retirement of physicians/physician shortage, improved endoscopies/procedures, decreased reimbursement, quality measures, the ACA, Web access/social media, ACOs, and DNA stool testing.

*Tolerability reflects patient experience and ability to complete the preparation as instructed and is not related to safety.

Top-line findings from Part II: The Practice Management Perspective

- According to practice manager survey respondents, each gastroenterologist sees, on average, 84 patients per week.
- Each gastroenterologist spends on average 44 hours per week with patients, and in patient-related work.
- Time spent on administrative/business functions averages 16 hours per week per physician.
- The number of clinical staff members, including physician assistants (PAs), nurse practitioners (NPs), nurses, and medical assistants average 1.85 per gastroenterologist.
- For non-clinical staff members including: front-desk, schedulers, billing/collections, and practice managers, the average ratio is 2.28 per physician.
- Slightly more than half of responding practices (53%) are affiliated with an ambulatory surgery center (ASC) compared with 48% that have no such relationship. One in five are the sole owners of an ASC; one in four of the practices are part owners of the ASC.
- The most common service provided at the gastroenterology practice or ASC is anesthesia services, 60% of practices, of which 38% of services are provided by an anesthesiologist and 23% are provided by a certified registered nurse anesthetist.
- Annual revenues for 2013 from ancillary services, per gastroenterologist, averaged $158,331.
- Annual gross charges per physician for gastroenterology practices in 2013 averaged $1,490,268.50, according to survey respondents.
- Annual gross collections per physician in 2013 averaged $585,084 or 39% of gross charges.
- Annual overhead costs per physician in 2013 averaged $202,604.75 or 14% of gross charges.
- Annual net collections per physician in 2013 averaged $435,831.81 or 29% of gross charges.
- Annual net revenue per physician in 2013 averaged $396,086.05 or 27% of gross charges.
- The accounts receivable (A/R) average percentages reported by survey respondents are: 0 to 30 days, 44%; 31 to 60 days, 26%; 61 to 90, 16%; 91 to 120 days, 14%; and over 120 days, 18%.
- The days of gross charges in A/R at gastroenterology practices average 39.2 days. An A/R amount in the range of 35-to-50 days is considered an average result.
- The largest volume of patients is covered by commercial health plans, with 47%, closely followed by Medicare, with 43%. Medicaid accounts for 10% of patients. Self-pay is 5%.
- Practice managers surveyed expect to see more patients covered by Medicare and Medicaid in the next 2 years. Patient volume for commercial health plans is expected to remain the same or even decrease.
- Colon health screenings and routine colonoscopies are the leading reason for patient visits, accounting for 29%, according to survey respondents.
- More than half (56%) of patients are referred to gastroenterology practices by primary care physicians, which exceeds those referred by other specialists, 17%, and other patients, 13%.
- For the past 2 years, 58% report decreased reimbursement from Medicare; 50% report decreased reimbursement from commercial health plans; and 44% report decreased reimbursement from Medicaid.
- Gastroenterology practice managers report that their largest payer had prior authorization requirements as follows: 43% of their prescribed medications; 34% of their prescribed procedures; and 32% of prescribed treatments.
- Half of practice managers found copay assistance cards to be very useful in their practice. Another 23% found them useful.
- Two-thirds of the gastroenterology practice managers (67%) do not foresee the possible sale or merger of their practice within the next 5 years. Another one in seven practices (15%) are considering such a sale or merger, with an almost equal percentage (18%) stating that they were unsure.

PART I

The Gastroenterologist Perspective

Gastroenterology practices face many challenges, including more government mandates, transition to electronic health records (EHRs), quality care initiatives and participation in registries, consolidation of private practices, and declining reimbursements. There is also much good news, such as new drug therapies for hepatitis C, inflammatory bowel disease (IBD), and irritable bowel syndrome (IBS), introduction of multi-imaging high-definition endoscopes and capsule endoscopy, and recognition of how routine colonoscopy screening saves lives by reducing the incidence and mortality associated with colorectal cancer. Other topics impacting gastroenterologists include: the importance of adequate bowel preparation in performing a quality colonoscopy examination, trends in conditions most commonly treated, and adapting to a new practice environment.

These are among the major topics discussed in The Gastroenterologist Perspective, Part I of *The Ferring Pharmaceuticals Gastroenterology Practice Management Benchmark Report*. A total of 64 practicing gastroenterologists were surveyed. Survey findings are presented along with expert commentary of five gastroenterologists and a practice management consultant:

- Sam Moskowitz, MD, FACP, FACG, Gastroenterologist, Sam Moskowitz PC, Brooklyn, NY.
- Daniel J. Pambianco, MD, FACG, FASGE, Partner, Charlottesville Gastrointestinal Associates, Charlottesville, VA.
- Harry E. Sarles Jr., MD, FACG, Founding Partner, Digestive Health Associates of Texas, Richardson and Rockwall, TX.
- Irving M. Pike, MD, FACG, Chief Medical Officer, John Muir Health, Walnut Creek, CA.
- Steven Fochios, MD, Attending Physician, Section of Gastroenterology, Lenox Hill Hospital, New York, NY
- George S. Conomikes, President, Conomikes Associates, Inc., Practice Management Consultants, San Diego, CA.

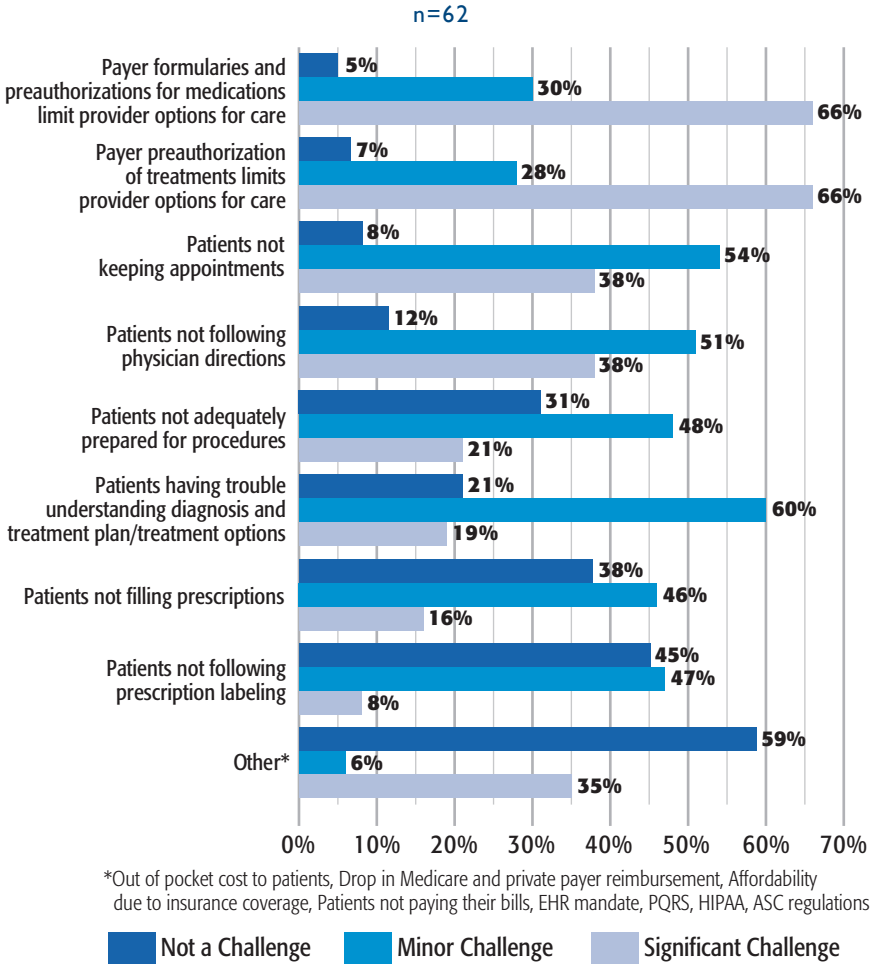
Challenges Facing Gastroenterologists

Payer formularies and obtaining preauthorizations for medications and treatments are by far the greatest challenges facing gastroenterologists, cited as significant challenges by two-thirds of survey respondents **(Figure 1)**. Many comments by survey respondents reflect frustration with payer policies. The biggest complaint is that seeking preauthorizations is time-consuming, mentioned by eight respondents. Some practitioners find themselves squeezed between declining reimbursements and rising costs.

"Formularies and preauthorizations are very time-consuming for doctors in their offices trying to provide the best care for their patients. Doctors may not be able to prescribe their preferred therapy. Instead, doctors may be required to prescribe an alternative medication dictated

FIGURE 1

Which aspects of caring for patients present the greatest challenges?



by the patient's insurance company. Only after the patient fails to improve on the alternative therapy will the insurance company permit the patient to try the original choice of the physician. It is a very frustrating situation because it is insurance company economics that often dictate medication choice that may not be in the patient's best interest," says Steven Fochios, MD, of Lenox Hill Hospital. "The physician should be the one deciding the therapeutic regimen for patients, not the insurance companies."

Harry E. Sarles Jr., MD, of Digestive Health Associates of Texas, notes that it can take an hour of back and forth with the pharmacy and health plan to prescribe a single, nonformulary drug.

Other notable challenges: patients not keeping appointments and patients not following physician directions, selected by 92% and 89% of survey respondents, respectively, when significant and minor challenge responses are combined. "Patients not keeping appointments means lost revenue for the practice," says George Conomikes, a practice management consultant. "Similarly, not following directions in a gastroenterology practice can mean that patients are not properly preparing for their colonoscopy, resulting in an unsuccessful procedure," he adds.

Early Screening Recommended—but Underutilized — in High-Risk Groups

"Serrated polyps have only recently been recognized as an important precursor to colon cancer," said Dennis J. Ahnen, MD, FACG, in his presentation "Controversies in Surveillance Guidelines," on October 21 at ACG 2014, the annual meeting of the American College of Gastroenterology, held in Philadelphia. Dr. Ahnen, who is staff physician, Department of Veterans Affairs, Eastern Colorado Healthcare System, discussed serrated polyps and heightened risks associated with gender, race/ethnicity, and family history.

"Until a few years ago, we didn't have specific surveillance guidelines for people with sessile serrated polyps," said Dr. Ahnen. He described sessile serrated polyps as the "evil twin" of conventional polyps. "Sessile serrated polyps tend to be flat, covered by a mucous cap, and it can be hard to define the edges. Therefore, serrated polyps are more likely to be missed and incompletely removed. It is important that these polyps be completely removed because once they develop foci of cytologic dysplasia, they can rapidly progress to colon cancer," he explained. "People with serrated polyps also have a high risk of synchronous advanced conventional polyps."

Most guidelines recommend that patients with sessile serrated polyps be followed in a manner similar to those with conventional adenomas with surveillance intervals of 3 to 5 years depending on the number, size, and histologic features of the polyp. Sessile serrated polyps with cytologic dysplasia should be considered to be like an advanced conventional adenoma.

Incidence and mortality of colorectal cancer are higher in men than in women. Colorectal cancer develops in men at younger ages than in women.

African American men and women are at higher risk for colorectal cancer than their white counterparts. White men and black women have approximately the same age distribution for colorectal cancer.[1] White women are at lowest risk while black men are at highest risk. The ACG and the American Society for Gastrointestinal Endoscopy recommend starting screening in African Americans at age 45.

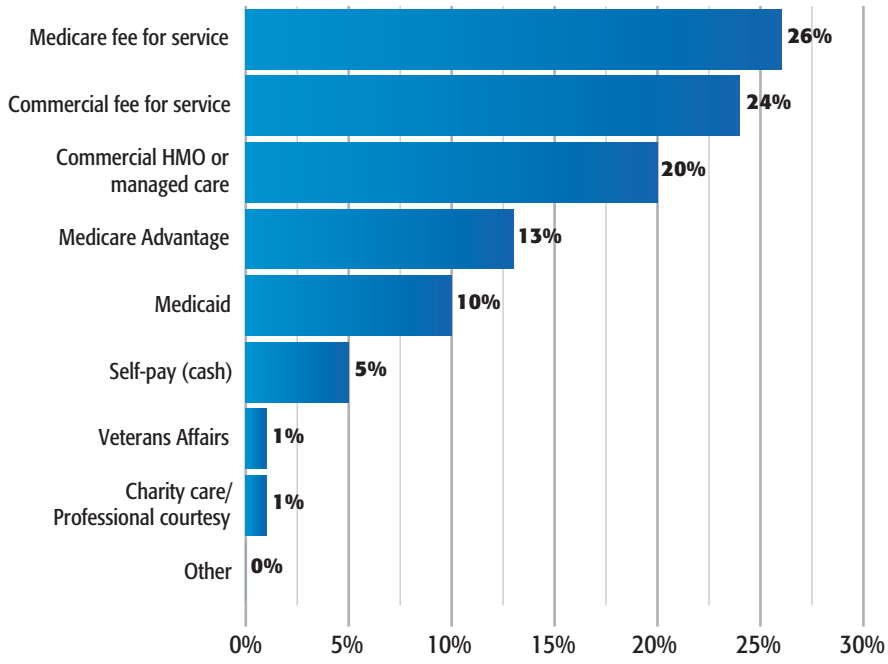
Having a first-degree relative with colorectal cancer raises a person's risk of the disease. The incidence of colorectal cancer for a person age 50 is the same as for a person age 40 with a family history of the disease.[2] Earlier screening is recommended, starting at age 40 for those with a first degree relative with colorectal cancer under the age of 60. However, screening rates remain low for those age 40 to 50 years.[3]

"We have a ways to go to make the dangers associated with serrated polyps more widely known and in starting screening at an earlier age for those in high-risk groups, especially families of those with colorectal cancer," said Dr. Ahnen. "Rates of colorectal cancer have gone down for all demographic groups except in those under age 50 for whom incidence and mortality have increased."[4]

FIGURE 2

What percentage of patient visits is reimbursed by each of these payers?

n=58



"Patients not keeping appointments is an increasing problem in all medical practices," says Mr. Conomikes. "Some practices have reduced no-show rates by e-mailing reminders two days before the appointment. Many patients prefer the confidentiality of e-mail compared with receiving reminder phone calls.

"Patients not following physician directions suggests some revamping is needed." Mr. Conomikes says patient education handouts should be available in all examination rooms. "Many physicians delegate most patient instruction and education following the physician encounter to their clinical staff," he adds.

Four survey respondents cite high patient copays, deductibles, and cost-shifting to patients as barriers to care. Lack of patient adherence in some cases is because patients can't afford their medication copays, says Daniel Pambianco, MD, of Charlottesville Gastrointestinal Associates.

Three survey respondents cite language barriers and/or cultural issues. Doctors may have to hire translators and there may not be any provision for reimbursement, says Dr. Fochios.

> "Patients do not understand the importance of bowel prep as it relates to getting an adequate exam."
>
> – Survey Respondent

"Reimbursement and practice management challenges can be met successfully by embracing technology solutions, including use of EHRs and an automated patient recall system, and having an experienced office support staff," says gastroenterologist Sam Moskowitz, MD.

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3. Ait Ouakrim D, Lockett T, Boussioutas A, et al. Screening participation for people at increased risk of colorectal cancer due to family history: a systematic review and meta-analysis. *Fam Cancer.* 2013 Sep;12(3):459-472.
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FIGURE 3

How have reimbursement rates for the same services changed over the past 2 years?

n=56

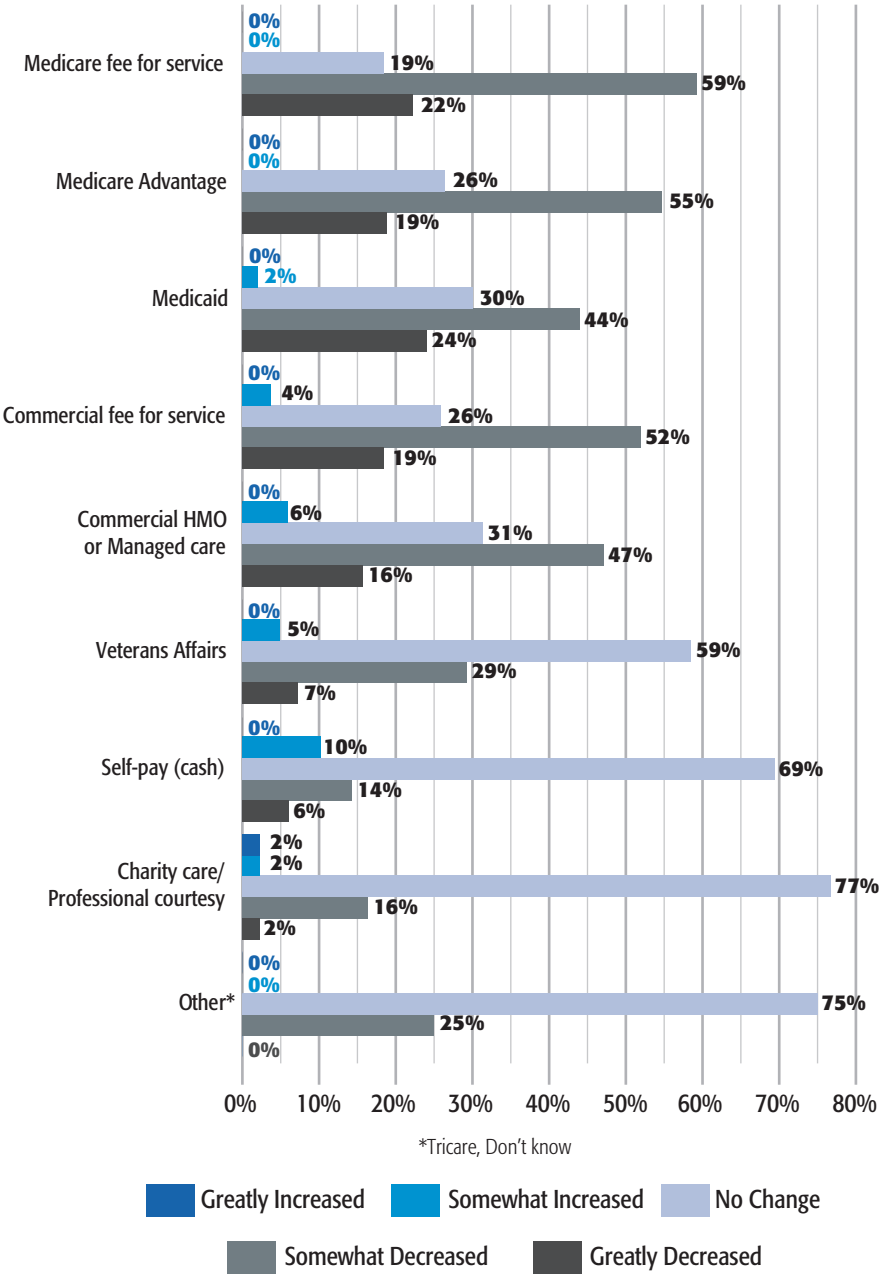
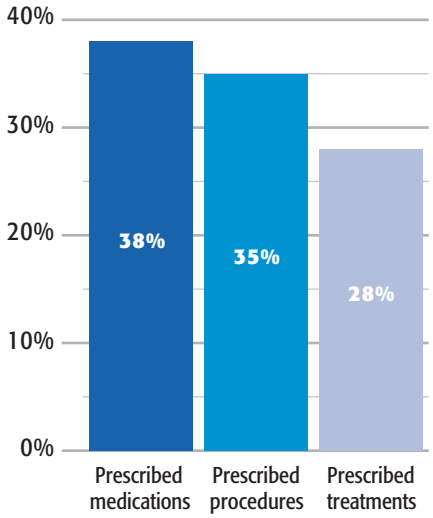


FIGURE 4

What percentage of the following is subject to prior authorization by your largest payer?

n=54



Commercial insurance is the biggest payer for gastroenterology practices on average, according to survey respondents, covering 44% of patient visits, followed by Medicare, with 39%. Medicaid, at 10%, is a distant third **(Figure 2)**.

"Many gastroenterology practices do not take Medicaid unless the state requires that they do so," says Dr. Sarles. "We don't accept Medicaid. It pays low and slow."

Survey respondents report that reimbursement rates have decreased for Medicare, commercial insurance, and Medicaid over the last 2 years **(Figure 3)**. For example, 81% of survey respondents say reimbursement rates for Medicare fee for service have greatly decreased or somewhat decreased.

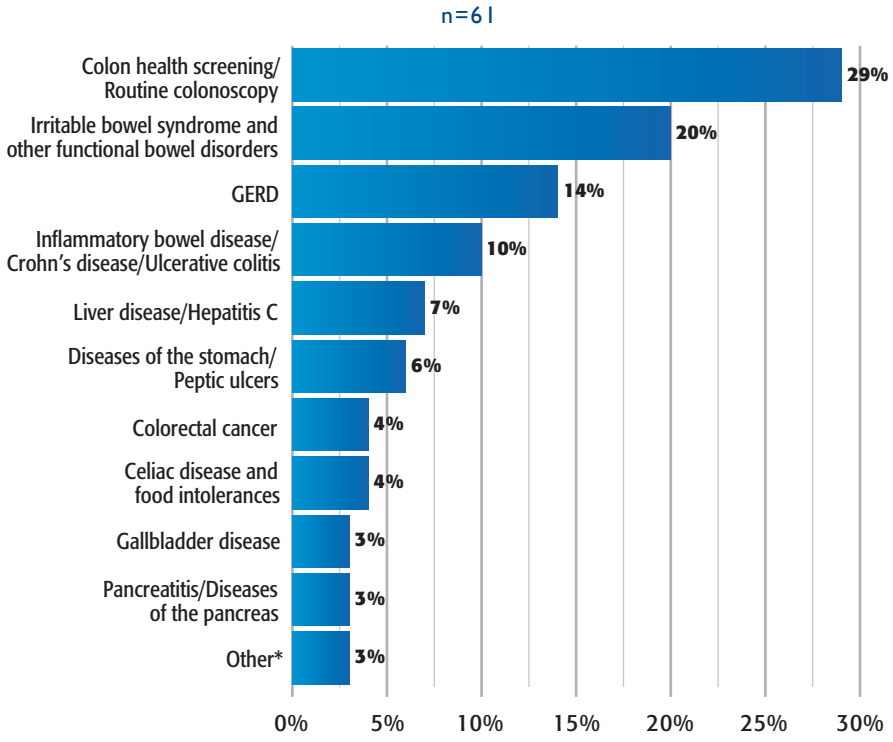
All reimbursement rates have decreased, note Drs. Sarles and Pambianco. Dr. Pambianco estimates that over the last 5 years, Medicare reimbursement has decreased by 20% and is heading to Medicaid rates, while commercial insurance reimbursement has remained relatively stable.

The average percentage of treatments subject to prior authorization by survey respondents' largest payer is 28%, increasing to 35% for procedures and 38% for medications **(Figure 4)**.

"We are up to 30% of payers now requiring prior authorization for CT scans and MRIs," says Dr. Pambianco.

FIGURE 5

What percentage of patient visits is related to treatment for the following diseases/conditions?



*Thyroid nodules, GI cancers, Obesity, Bariatric surgery related problems, Nutrition, metabolic and endocrine disorders, Eating disorders, Constipation, Lactose intolerance, Stress, Gut dysbiosis, Common duct stones

"We are seeing the same trend for medications used to treat hepatitis C and IBD."

"The survey findings are reflective of what we are seeing and it's getting worse," observes Dr. Sarles. "The prior authorization process is so complicated. We would like to be able to go online to find out if a drug or procedure is covered."

Conditions Most Commonly Treated

The greatest proportion of patient visits, 29%, are for routine colonoscopy, followed by IBS, 20%, gastroesophageal reflux disease (GERD), 14%, and IBD/Crohn's disease/ulcerative colitis, 10% **(Figure 5)**.

Increases in patient volume over the next 2 years are projected for liver disease/hepatitis C and routine colonoscopies **(Figure 6)**. More than half (56%) of survey respondents expect

Guidelines Tie Good Bowel Preparation to Colonoscopy Success

The success of a colonoscopy is closely linked to good bowel preparation, with poor bowel preparation often resulting in missed precancerous lesions, according to consensus guidelines released September 22, 2014, by the U.S. Multi-Society Task-force on Colorectal Cancer.[1,2] Up to 20% to 25% of all colonoscopies are reported to have an inadequate bowel preparation.[3,4]

"When prescribing bowel preparation for their patients, healthcare professionals need to be aware of medical factors that increase the risk of inadequate preparation, as well as nonmedical factors that may predict poor compliance with instructions," according to David A. Johnson, MD, lead author of the guidelines, professor of Internal Medicine and chief of the Division of Gastroenterology, Eastern Virginia Medical School, Norfolk. "Gastroenterologists should use this information when determining whether to use a more effective or aggressive bowel preparation regimen, as well as the level of patient education needed about the prep."

The U.S. Multi-Society Task Force on Colorectal Cancer is composed of gastroenterology specialists representing the American Gastroenterological Association (AGA), the American College of Gastroenterology (ACG), and the American Society for Gastrointestinal Endoscopy (ASGE) consensus statement, "Optimizing Adequacy of Bowel Cleansing for Colonoscopy: Recommendations from the US Multi-Society Task Force on Colorectal Cancer," is published in *Gastroenterology*, the official journal of the AGA Institute; *The American Journal of Gastroenterology*, the official journal of ACG; and *GIE: Gastrointestinal Endoscopy*, the official journal of ASGE.

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2. Good bowel cleansing is key for high quality colonoscopy [press release]. Bethesda, MD. American College of Gastroenterology; September 22, 2014.
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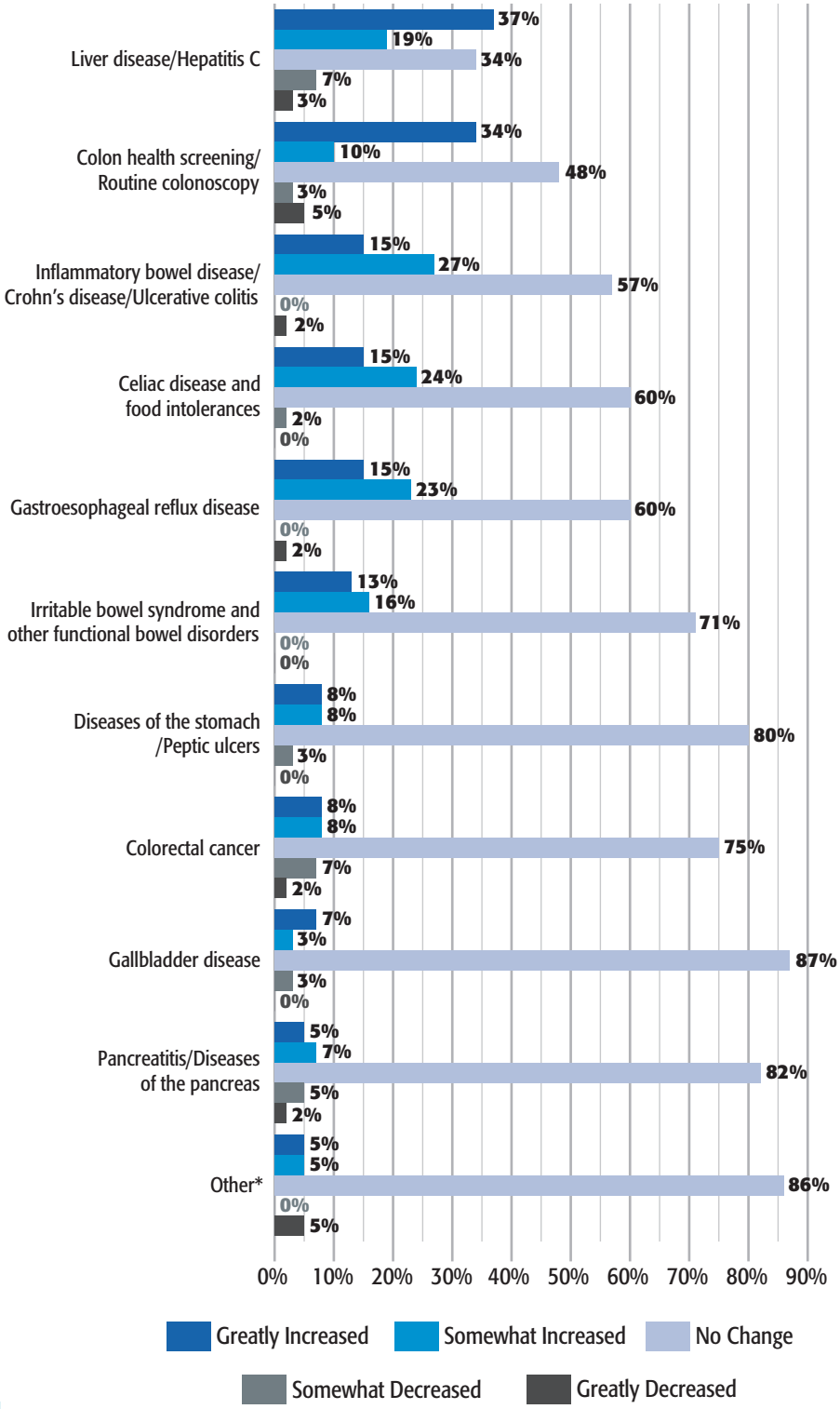
4. Harewood GC, Sharma VK, de Garmo P. Impact of colonoscopy preparation quality on detection of suspected colonic neoplasia. *Gastrointest Endosc.* 2003;58:76-79.

FIGURE 6

Do you anticipate any significant increases/decreases in patient volume for the following conditions over the next 2 years?

n=62



to see an increase in patient volume for liver disease/hepatitis, with 37% expecting to see an increase of more than 5%. Growth in patient volume for hepatitis C is being driven by the availability of new treatments.

There were 44% of survey respondents who expect to see an increase in patient volume for routine screening colonoscopies, with 34% expecting to see an increase of more than 5%. "Aging of the population is fueling that growth," notes Dr. Sarles. "There is more emphasis on screening for colorectal cancer in the Affordable Care Act (ACA) and Medicare, thus increasing demand," observes Dr. Pambianco. Consequently, according to Dr. Fochios, as gastroenterologists perform more screening colonoscopies, the incidence and mortality associated with colorectal cancer is expected to decrease.

Practice Ownership

More than half (60%) of survey respondents are in private practice (chart not shown). Another 14% are part of a multispecialty group practice, 13% are hospital owned or partnered, and 11% are part of a single-specialty group practice.

"The proportion of gastroenterologists in private practice is expected to decline, however. More physicians, including gastroenterologists, are selling their practices to hospitals or joining group practices," says Dr. Moscowitz. In the current practice environment, "doctors don't want to be by themselves," he explains.

"More physicians, including gastroenterologists, are becoming employees of large healthcare organizations. The economics of private practice have become quite a burden. The situation is reaching a point where physicians are not able to maintain independent

FIGURE 7

Is your practice affiliated with an ambulatory surgery center?

n=58

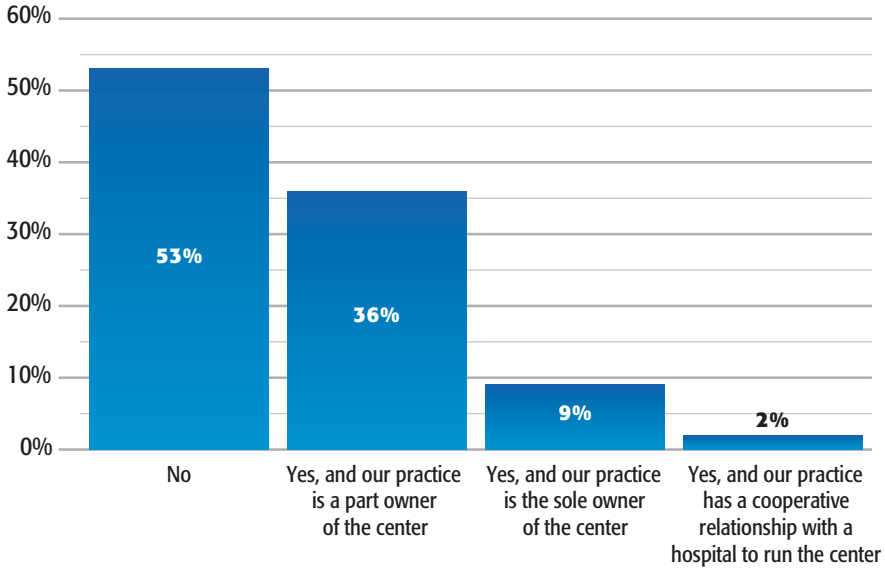
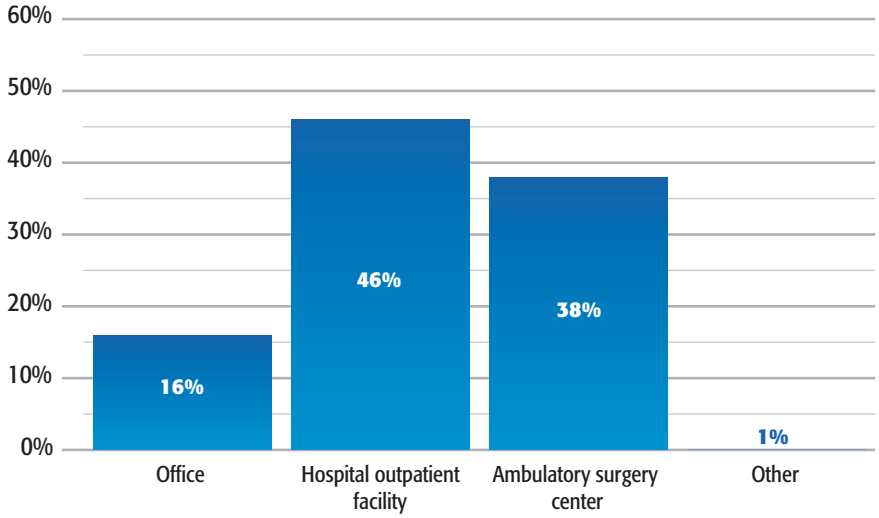


FIGURE 8

What is the location of care for your colonoscopies, including virtual colonoscopies?

n=60



"We are up to 30% of payers now requiring prior authorization for CT scans and MRIs."

— Daniel Pambianco, MD

practices. Large healthcare organizations have the economic power and resources to pay physician salaries and all the expense of operating office practices, including participation in risk-sharing arrangements," says Dr. Fochios.

Most practices of survey respondents, 55%, operate one location, with 16% operating two locations, 10% operating three locations, and 20% operating four or more locations (chart not shown).

More than one-third (36%) of survey respondents are part owners of an ambulatory surgery center; another 9% are sole owners **(Figure 7)**. Most survey respondents, 53%, are not affiliated with an ambulatory surgery center, however.

Most survey respondents perform colonoscopies at either a hospital outpatient facility (46%) or ambulatory surgery center (38%), with 16% opting for office-based procedures **(Figure 8)**. "Colonoscopy volume is shifting to ambulatory surgery centers, which are generally safer and more efficient," says Dr. Moskowitz. "More gastroenterologists are performing procedures in ambulatory surgery centers because the economic climate is more favorable there than in the practitioner's office," adds Dr. Fochios.

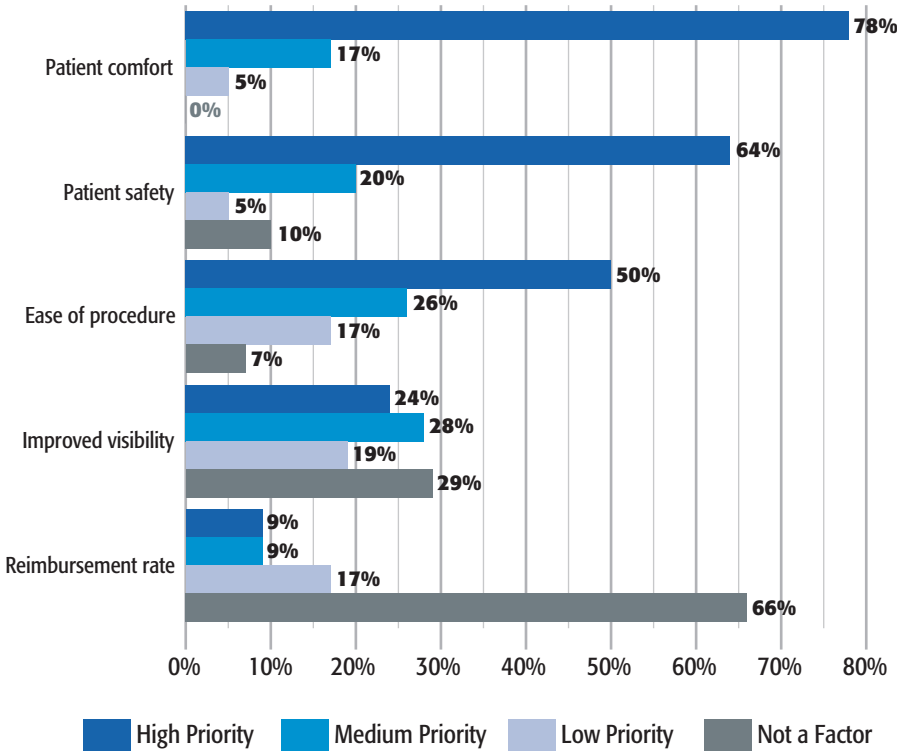
Administering Anesthesia

Survey respondents report that on average, 72% of colonoscopy patients receive anesthesia (chart not shown). Two-thirds of survey respondents report that 90% or more of their patients received anesthesia for colonoscopies. Anesthesia was administered to 51% to 100% of patients either by an anesthesiologist, 53%, or a certified registered nurse anesthetist, 42% (chart not shown).

FIGURE 9

Please give your reasons for offering anesthesia during the procedure:

n=59



Gastroenterologists rate patient comfort as the most important reason for offering anesthesia during a colonoscopy, deemed a high priority by 78%, followed by patient safety, 64%, and ease of procedure, 50% **(Figure 9)**. Reimbursement rate was not a factor, according to 66%.

Colonoscopy Procedure

The average age of patients receiving their first colonoscopy is 53 years, say survey respondents (chart not shown); 84% of patients receiving their first colonoscopy are between the ages of 50 and 55 years.

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and American Society of Gastrointestinal Endoscopy (ASGE) advise undergoing a colonoscopy every ten years, starting at age 50.[1,2] Screening at earlier ages and at more frequent intervals are recommended for persons at higher risk for colorectal cancer (See "Early Screening Recommended—but Underutilized—in High-Risk Groups").

Although survey respondents perform an average of 147 colonoscopies a month (chart not shown), the largest percentage, 39%, report they perform 50 to 99 colonoscopies a month.

The Importance of Bowel Prep

The U.S. Multi-Society Taskforce on Colorectal Cancer, made up of representatives of ACG, AGA, and ASGE, emphasizes the importance of adequate bowel preparation in its recently updated guidelines (See "Guidelines Tie Good Bowel Preparation to Colonoscopy Success").

According to survey findings, an average of 4% of colonoscopies can't be completed as scheduled (chart not shown), either because of poor bowel preparation, 58%, or because of anatomic issues, 42% (chart not shown). "The prep is very important," says Dr. Moskowitz. "With a cleaner colon, you can find the polyps."

Both Dr. Moskowitz and Dr. Pambianco favor the use of low volume preps and take the time to explain the benefits to patients.

> "Our practice favors use of a low volume prep. The quality of the exam is much better."
>
> – Sam Moskowitz, MD

Bowel preparation before a colonoscopy can be a big issue, with some bowel preparation products requiring patients to drink such a high volume that some patients may not finish it. "Our practice favors the use of a low volume prep," says Dr. Moskowitz. "The quality of the exam is much better."

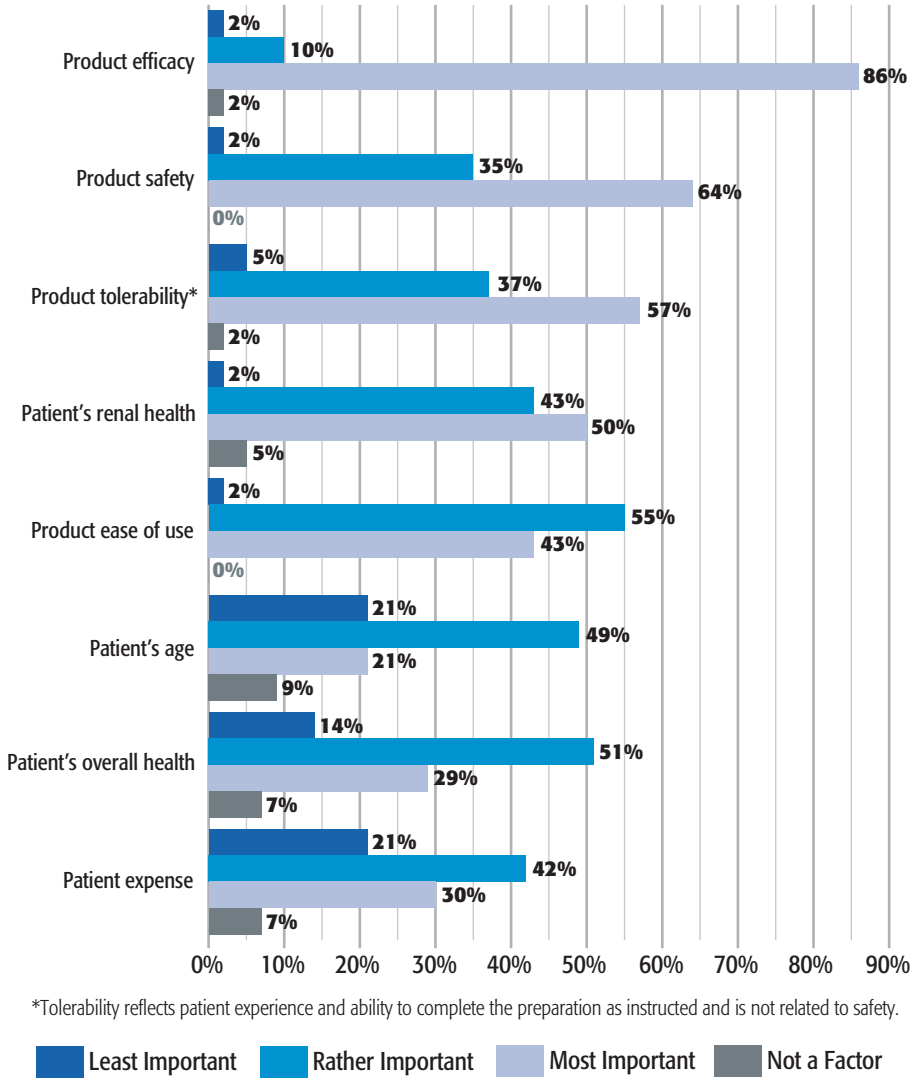
"I only recommend the low volume preps. Patient adherence is much higher," says Dr. Pambianco. "My nurses explain what we recommend and why, that it is most effective and worth spending a bit more to have a good outcome of their exam."

According to Dr. Fochios, "Use of better tolerated colonoscopy preparations results in better patient adherence and improved detection rates of adenomas

FIGURE 10

Please rate which factors are most important when prescribing a bowel preparation:

n=60

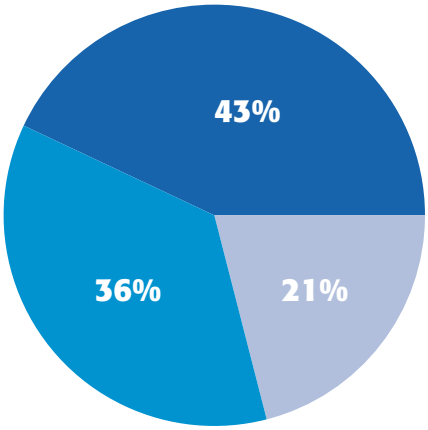


*Tolerability reflects patient experience and ability to complete the preparation as instructed and is not related to safety.

FIGURE 11

Do you track your adenoma detection rate?

n=61



and colon cancers and patients will be more willing to undergo follow-up examinations."

Some Medicare Part D plans may not cover low volume preps but most are covered under commercial insurance with a copay, says Dr. Sarles. "The key to a good exam is involvement with patients, getting them to modify their diet a week ahead of time. You can't just hand patients a script the day before."

Factors found to be most important when prescribing a bowel preparation are product efficacy, 86%, followed by product safety, 64%, product tolerability, 57%, and patient's renal health, 50% **(Figure 10)**. Leading factors that would cause survey respondents to recommend a different bowel preparation for certain patients are product tolerability, 71%, a patient's renal health, 66%, and patient expense, 61% (chart not shown).

"I find tolerability or how much you have to drink to be most important," says Dr. Moscowitz. "A bowel prep of a gallon is effective if you drink it all but most patients don't."

Adenoma Detection Rate

Just 36% of survey respondents say they currently track their adenoma detection rate **(Figure 11)**. More (43%) say they plan to in the near future. Average adenoma detection rates reported by survey respondents are 34% for men and 29% for women (chart not shown).

"I would have expected that more than 50% of gastroenterologists would be tracking their adenoma detection rate," says Irving Pike, MD, of John Muir Health. "With 43% saying they expect to track adenoma detection rates, this shows they recognize its importance."

FIGURE 12

Do you agree that adenoma detection rates should be a leading quality benchmark?

n=60

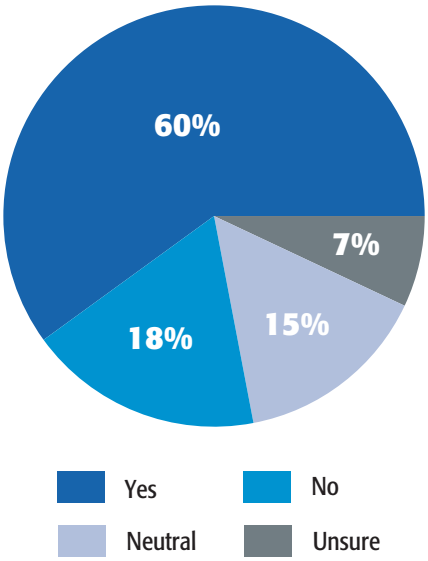


FIGURE 13

Do you use certified electronic health records (EHRs), as defined by the Centers for Medicare and Medicaid Services (CMS)?

n=60

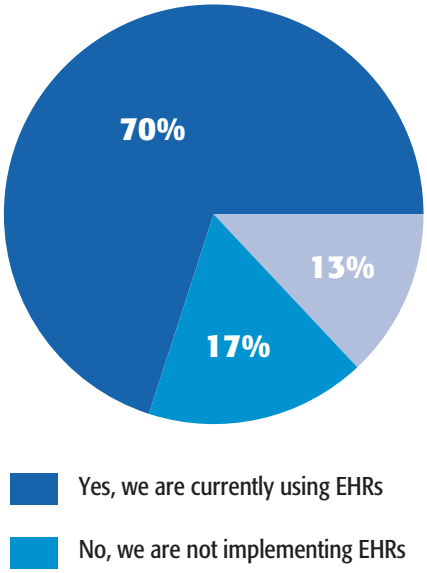
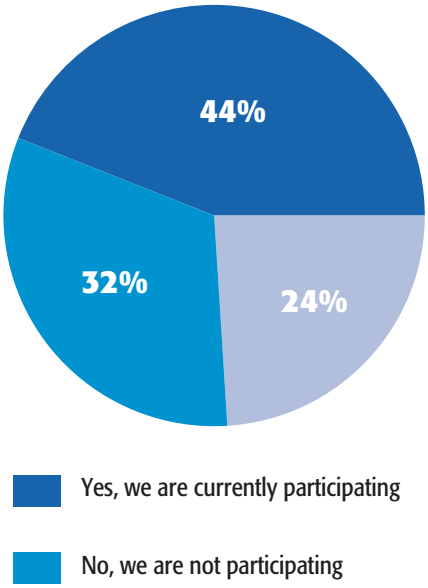


FIGURE 14

Are you currently participating in the CMS Physician Quality Reporting System (PQRS)?

n=59



> "Everybody should be tracking their adenoma detection rate. It is the wave of the future."
>
> – Harry Sarles Jr, MD

Drs. Moskowitz and Sarles both track their adenoma detection rate. "Everyone will have to do it," says Dr. Moskowitz. "Everybody should be tracking their rate. It is the wave of the future," says Dr. Sarles.

Of survey respondents, 60% agree that adenoma detection rates should be a leading quality benchmark **(Figure 12)**. One survey respondent comments: "It is the reason we do colonoscopies, so the detection rate is the best way to evaluate the quality of colonoscopies." Two other respondents disagree, however. One argues: "Too many factors, such as bowel prep quality, are outside the doctor's control." Another respondent notes: "I am doing this to screen for colon cancer. If patients screened do not have adenomas, is this an indication of the quality of my procedure?"

"I would have expected 80% to agree," says Dr. Pike. "The adenoma detection rate is a proven predictor of that physician's ability to prevent colon cancer. I think that a practitioner's adenoma rate should be made publically available."

"Physicians will be required to enroll in registries that will track their adenoma detection rate and reimbursement will be tied to these quality measures," says Dr. Fochios.

Electronic Health Records

Of survey respondents, 70% are currently using EHRs **(Figure 13)**. Another 13% plan to implement EHRs in the near future.

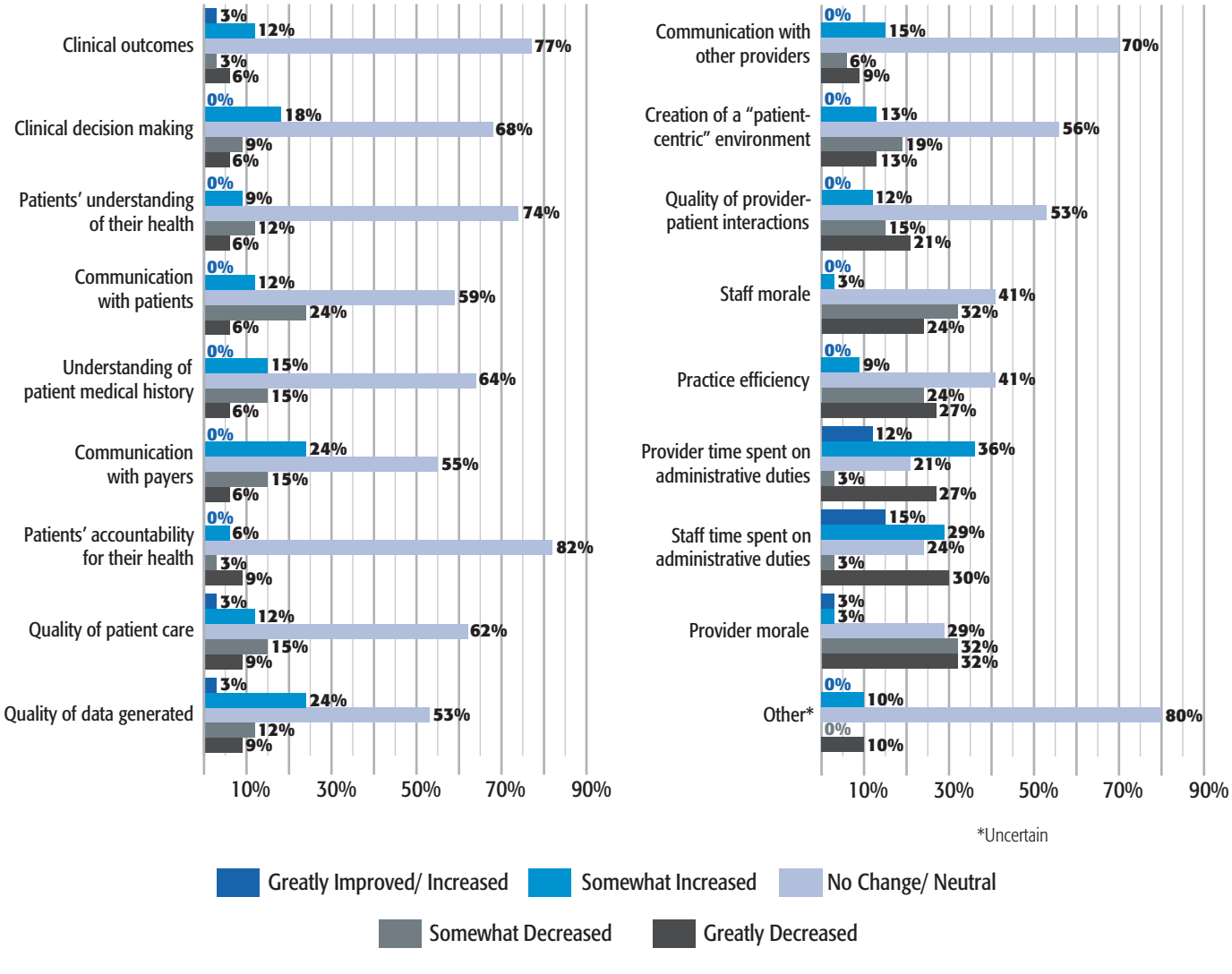
"We use EHRs, but the benefit we get from doing so is not worth the effort we put into it," says Dr. Pambianco. "We use EHRs, but it's a nightmare," says Dr. Sarles. "There is no increase in patient safety, and everything takes twice as long."

"We use EHRs and e-prescribing," says Dr. Moskowitz. "Doctors would be better off embracing EHRs," he maintains. "It is much easier to find laboratory test results, etc., and everything is dated rather than sifting through pages in a chart."

FIGURE 15

If you are participating in PQRS, how have CMS reporting requirements impacted these facets of your practice?

n=38



Reporting Quality Measures

The reporting of quality measures and tying such measures to reimbursement is here to stay, maintained Aasma Shaukat, MD, MPH, in her presentation at ACG 2014 (See "Colonoscopy Quality Measures Linked to Reimbursement).

Of survey respondents, 44% are currently reporting quality measures to the CMS Physician Quality Reporting System (PQRS); another 24% intend to participate **(Figure 14)**. Drs. Moskowitz, Sarles, and Pambianco are among those doctors currently participating. "More practices will do so," says Dr. Moskowitz. "Practices will have to participate to avoid financial disincentives," says Dr. Sarles. "These data will be very helpful."

More than half (56%) report quality measures as individual practitioners (chart not shown). More than a third (35%) report quality measures as part of a group practice through the Group Practice Reporting Option.

Individual quality measures are mainly reported through Medicare Part B claims, 36%, qualified PQRS registry, 36%, and direct electronic health records using certified EHR technology (CEHRT), 33% (chart not shown). Group practice quality measures are mainly reported through a qualified PQRS registry, 54%, and direct EHRs using CEHRT, 35% (chart not shown).

According to Dr. Fochios, registries are increasing capturing meaningful use data from the EHR, reducing practitioner workload.

> "Physicians will be required to enroll in registries that will track their adenoma detection rate and reimbursement will be tied to these quality measures."
>
> – Steven Fochios, MD

Data reporting through PQRS has apparently had an overall negative impact on gastroenterology practices. Survey respondents report that the following aspects of their practices have either greatly decreased or somewhat decreased: provider morale, 64%, staff morale, 56%, practice efficiency, 51%, and quality of provider-patient interactions, 36% **(Figure 15)**.

Of 22 comments received from survey respondents on this topic, 15 are negative, including "tedious and cumbersome," and "It is a chore to collect the data; the data are mostly clinically meaningless." One survey respondent observes: "Metrics are mostly clinically meaningless and wastes time that could have been spent on patient care." Some respondents, however, did see improvements in staff and provider time spent on administrative duties.

"I agree that the PQRS measures currently are meaningless, time consuming, and there is no benefit for patients," says Dr. Pambianco. "There is a potential that these measures will yield benefits in the future, but that day is at least 5 years away."

"I don't know if any of this helps patients," says Dr. Moskowitz.

"It's all negative: EHRs, meaningful use, PQRS, and it is what our entire

FIGURE 16

Does your organization participate in quality care initiatives?

n=58

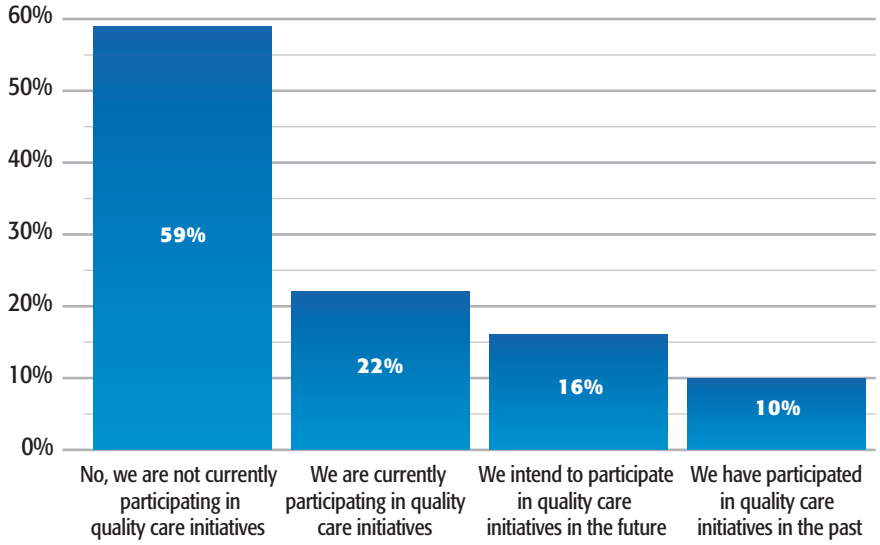
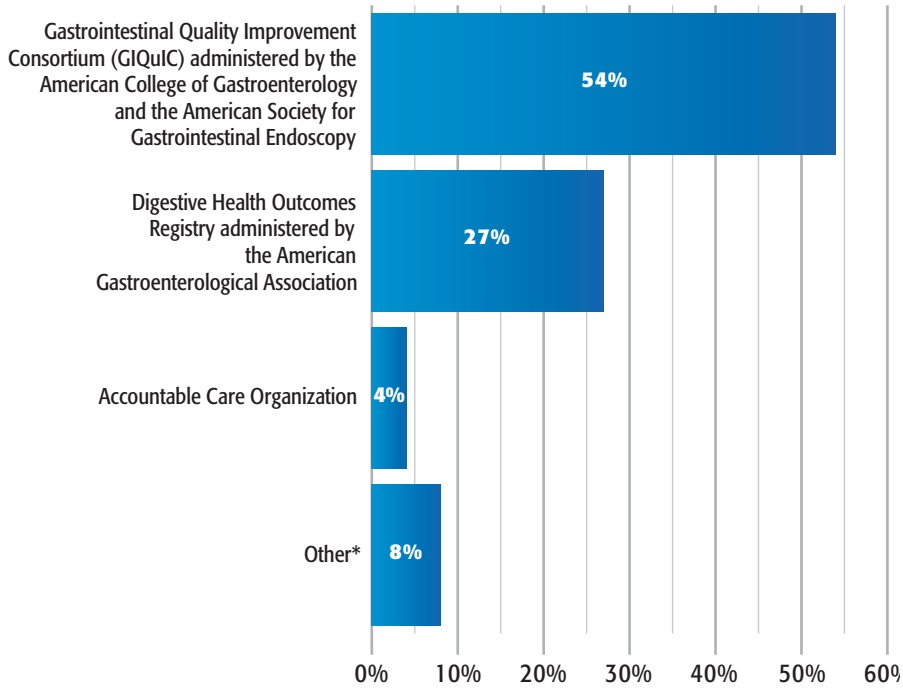


FIGURE 17

In which quality care initiatives are you participating, or planning to participate?

n=24



*Whichever is decided on by the entity for which I work, NH Colonoscopy Registry

healthcare system is to be built around. If you don't have data, reimbursement will be cut," says Dr. Sarles.

Dr. Fochios disagrees that such reporting is meaningless: "The collection of data and its subsequent analysis will ultimately have a beneficial impact on the delivery of quality care."

Just 22% of survey respondents are currently participating in quality care initiatives; 16% intend to participate in the future **(Figure 16)**. Most of these practitioners, 54%, are participating or planning to participate in the Gastrointestinal Quality Improvement Consortium (GIQuIC) **(Figure 17)**. Another 27% participate in Digestive Health Outcomes Registry.

"About 2600 physicians participate in GIQuIC," says Dr. Pike. "GIQuIC is a live, Internet-based registry collecting information on 13,000 to 15,000 colonoscopies each week, for a total of 1.03 million colonoscopies. The data are fairly robust. Practitioners can benchmark against all users or within their own facility. There are 11 standard measures related to colonoscopies, including adenoma detection rate, withdrawal rate, and appropriate surveillance intervals."

Dr. Sarles participates in GIQuIC. "It is the best way to report quality measures, and the fee is nominal."

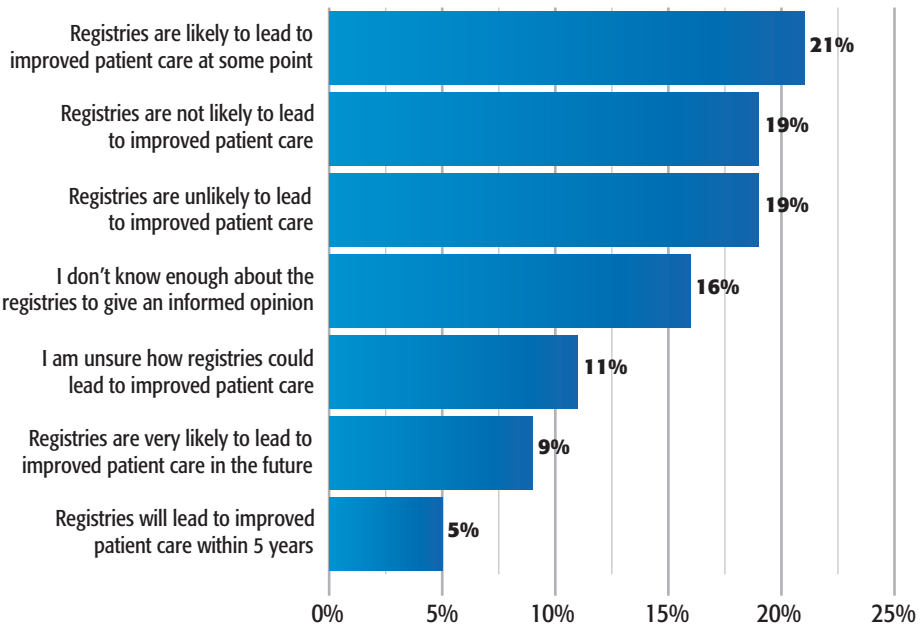
Most respondents (69%) are participating in quality care initiatives to comply with CMS reporting requirements (chart not shown). "We participate because we are forced to do so or we will be penalized by CMS," says Dr. Moskowitz. Another 25% say they participate to share data that may be helpful.

There is no consensus on whether such registries will lead to improved patient care **(Figure 18)**. While 35% agree that registries will lead to improved care within 5 years, in the future, or at some point, 38% say registries are either not likely or unlikely to lead to improved patient care; 27% are unsure or don't know.

FIGURE 18

In your opinion, what is the probability that these registries will lead to improved patient care?

n=57



Dr. Moskowitz agrees that registries won't improve care significantly. "They may help a little, but nothing dramatic." "Registries will lead to some improvement by forcing doctors to be more careful doing the screening exam," adds Dr. Sarles. "We are a few years away from deriving useful patient care information from these registries," suggests Dr. Pambianco.

> "We are already beginning to see quality improvements that can be attributed to the use of registries."
>
> – Irving Pike, MD

"We are already beginning to see quality improvements that can be attributed to the use of registries," says Dr. Pike. "Physicians have seen increases in their own adenoma detection rates."

ICD-10 Coding

Most gastroenterology practices, 69%, expect to be ready for implementation of ICD-10 coding by the deadline, including 12% who are ready now (chart not shown).

Drs. Pambianco, Moskowitz, and Sarles are in the process of implementing ICD-10 coding and will be ready by the deadline.

Accountable Care Organizations

Although more than half of survey respondents, 53%, do not intend to participate in Accountable Care

Organizations (ACOs), 23% are currently participating and 25% plan to participate in the future **(Figure 19)**. Dr. Pambianco is among those participating.

"We are seeing more commercial ACOs in California," says Dr. Pike. "The goals of ACOs are better outcomes, improved patient experience, and affordable cost. Medical costs in the U.S. are very high but we are nowhere near the top in terms of outcomes. What the final care model will be remains to be seen."

Clinical Research

Just 14% of survey respondents currently participate in clinical research (chart not shown). Dr. Pambianco is among those participating in clinical research. Dr. Moskowitz has conducted clinical research in the past and may do so again in the future.

New Patients

New patients account for 32% of all patients (chart not shown). "That is reflective of our practice," agree Drs. Pambianco and Moskowitz.

Gastroenterologists depend primarily on primary care physicians for patient referrals, accounting for 68% **(Figure 20)**.

Web Site Features

A total of 53% of survey respondents indicated that the practice had a Web site **(Figure 21)**. Features offered include: patient education, 68%, downloadable forms, 65%, and a patient portal, 50%.

Dr. Sarles's practice has a Web site with a patient portal. The practices of Drs. Pambianco and Moskowitz both have Web sites but no patient portal.

FIGURE 19

Do you participate in an Accountable Care Organization?

n=57

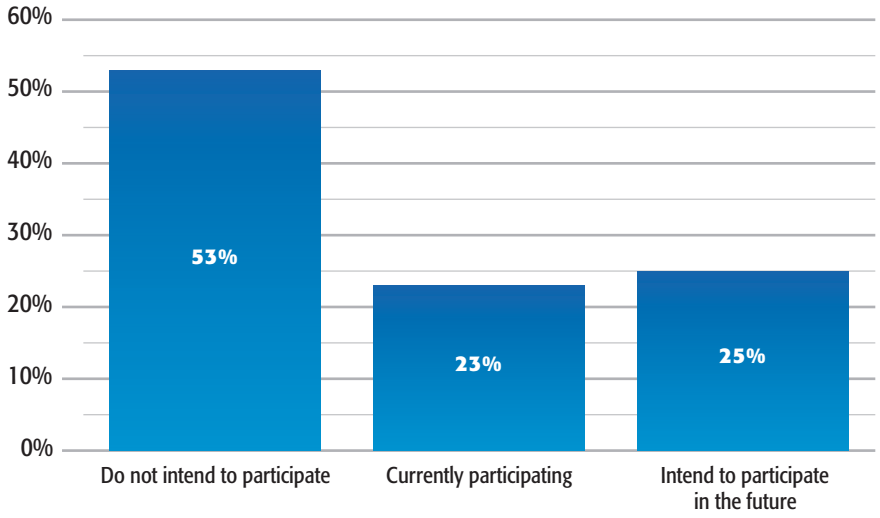


FIGURE 20

Of your patients who are referred, what is the source of the referral?

n=58

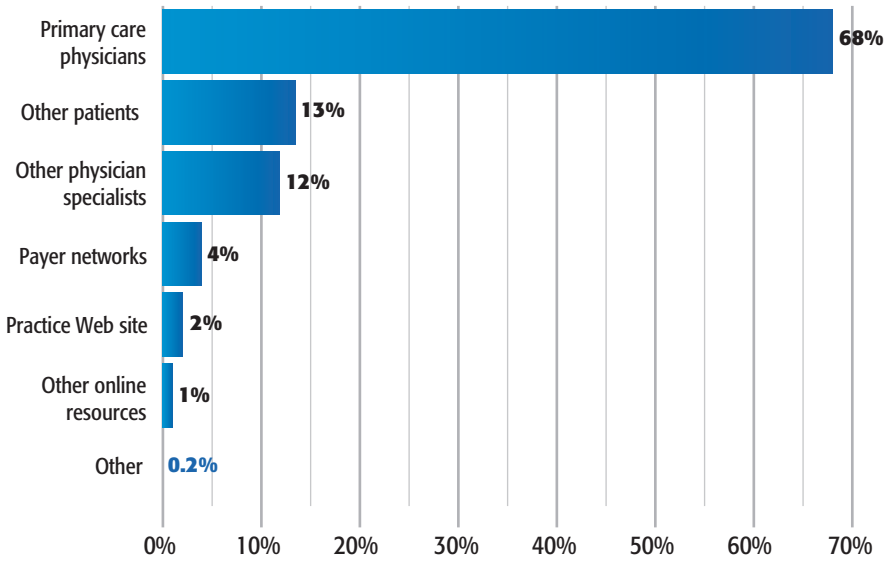


FIGURE 21

If your practice has a Web site, do you have the following available?

n=34

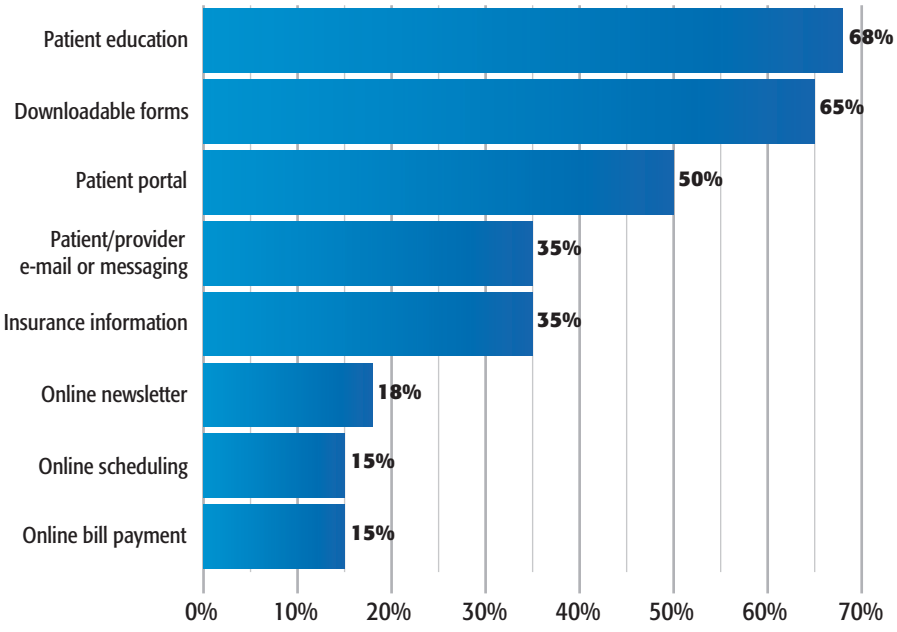
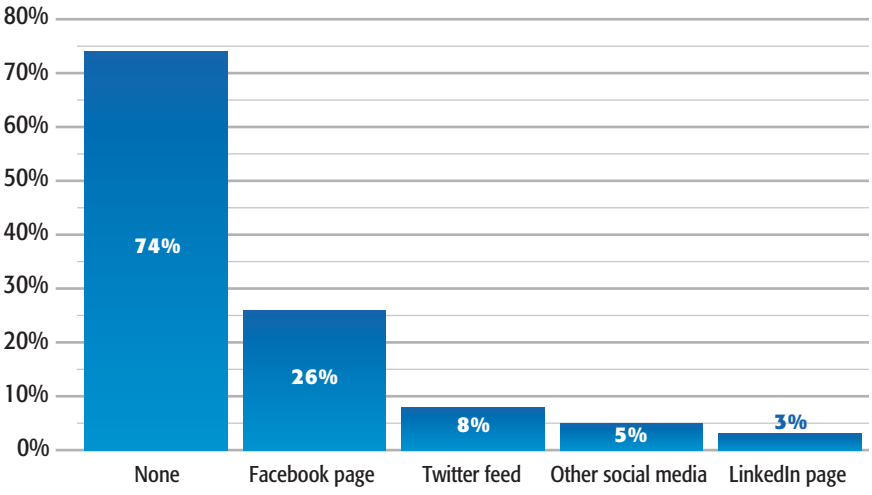


FIGURE 22

Does your practice have a social media outreach using any of the following platforms?

n=39



As use of the Internet by the public increases, practices will offer online appointment scheduling, online bill paying, and patient-provider e-mail communication, predicts Mr. Conomikes.

Social Media Outreach

Gastroenterologists have not embraced social media as a way to market their practices. Just 26% of responding gastroenterology practices have a Facebook page (**Figure 22**). Our panelists attribute the low level of participation by gastroenterology practices in social media to the fact that most gastroenterology patients are age 50 and older. They add that younger physicians and those who perform cosmetic procedures are more likely to engage in social media.

Just 13% regularly manage the practice's online reputation (chart not shown). Most, 62%, say they don't use social media at all. "We check our online reputation on a regular basis," says Dr. Pambianco.

Of respondents, 41% say their practice is rated on physician rating sites, such as Healthgrades.com and RateMD.com (chart not shown), but 55% say they have not checked. Findings of a study published in *JAMA* suggest that many consumers rely on such sites.[3] While awareness of online physician ratings was 65% (compared with 87% for car rating sites), of those who accessed such sites in the past year, 35% report seeing a physician based on good ratings. Just as important, 37% report avoiding a physician because of bad ratings.

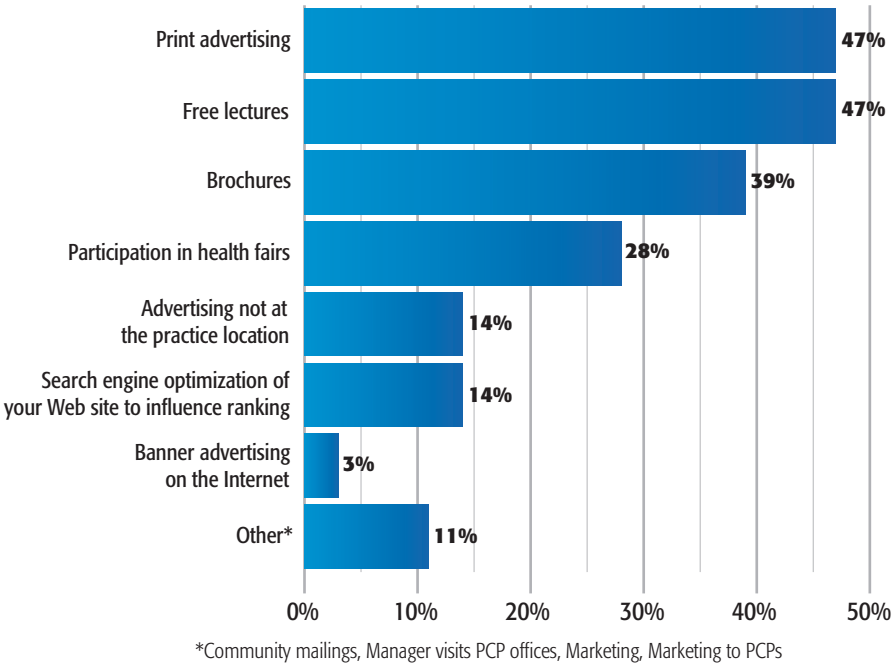
Marketing the Practice

To attract new patients, gastroenterologists rely on print advertising, 47%, free lectures, 47%, brochures, 39%, and participation in health fairs, 28%

FIGURE 23

Does your practice use any of the following outreach/advertising to attract patients?

n=36

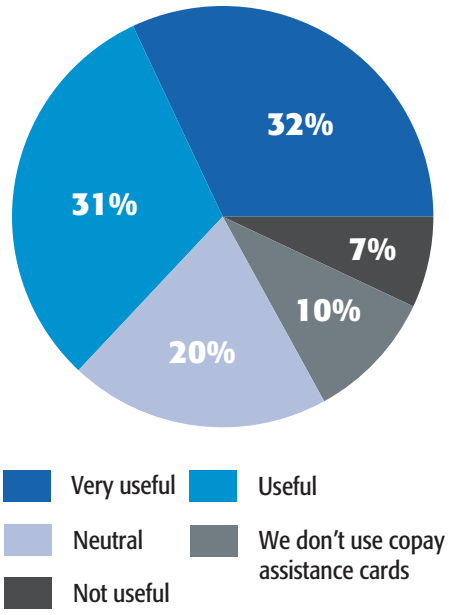


*Community mailings, Manager visits PCP offices, Marketing, Marketing to PCPs

FIGURE 24

How useful are copay assistance cards in helping patients obtain medications?

n=59



(Figure 23). Just 17% use the Internet for patient outreach.

"Our practice does not use the Internet for patient outreach," says Dr. Pambianco. "Physicians in general are not in the mindset of marketing. We give free lectures and participate in health fairs, but most new patients are because of reputation and word of mouth." Dr. Moskowitz says he sees value in search engine optimization.

Copay Cards Offer Assistance

Nearly two-thirds (63%) of survey respondents have found copay assistance cards to be either very useful or useful in helping patients obtain medications **(Figure 24)**. "We find copay assistance cards to be very useful," agree Drs. Moskowitz and Pambianco.

Technologic and Clinical Advances

Asked what technologic and clinical advances have had the greatest impact on practice, survey respondents name: EHRs/e-prescribing (20 responses: positive and negative), better endoscopes (seven responses), and better drugs for hepatitis C (six responses) and IBD (two responses).

Four of the gastroenterologist panelists cite better drugs, especially for hepatitis C and IBD. Drs. Moskowitz and Pambianco also mention high-definition endoscopes. Dr. Moskowitz says implementation of EHRs has helped him see more patients, but Drs. Sarles describes the impact of EHRs as "mostly negative and a burden." In Dr. Fochios's experience with EHRs, office volume productivity decreased significantly for him and his colleagues for the first few months because inputing data in electronic records is more time consuming. "This reduces the number of patients who can be seen in the physician's practice." Also having an impact on practice, according to Dr. Fochios: the ACA, quality measures, and ICD-10 coding.

A Look Ahead

Survey respondents were also asked to name three developments on the horizon having a significant impact in the next 5 years. Responses include: new drugs for hepatitis C and IBD (16 responses), early retirement of physicians/physician shortage (12 responses), improved endoscopies/procedures (nine responses), decreased reimbursement (eight responses), quality measures (eight responses), the ACA (seven responses), Web access/social media (six responses), ACOs (five responses),

Colonoscopy Quality Measures Linked to Reimbursement

"Every practice should be making a commitment to quality, have a method to measure and report quality indicators, and provide feedback to physicians," said Aasma Shaukat, MD, MPH, FACG, FASGE, FACP, in her October 21 presentation, "Quality Indicators in Colonoscopy and How to Improve Them in Practice," at ACG 2014, the annual meeting of the American College of Gastroenterology, held in Philadelphia.

"Physicians should care about the quality of colonoscopies to prevent colon cancer, detect and remove precancerous lesions, and improve patient satisfaction," noted Dr. Shaukat. "There is also another reason, however. Physicians' reimbursement is increasingly being tied to quality through the Physician Quality Reporting System (PQRS), developed by the Centers for Medicare and Medicaid (CMS), and used by Medicare and commercial insurers to set reimbursement rates," said Dr. Shaukat, who is GI Section Head, Minneapolis VAMC, and associate professor, Division of Gastroenterology, Department of Medicine, at the University of Minnesota.

"Quality indicators for colonoscopies include: completion rate, adenoma detection rate (ADR), withdrawal time (number of minutes the physician spends inspecting the colon on the way out), and follow-up intervals. These quality indicators are also being used as reporting requirements for PQRS," explained Dr. Shaukat.

"Practices need to develop a program to track quality metrics, measure them, and then report them to Medicare to be reimbursed," said Dr. Shaukat. Under the Accountable Care Act (ACA), such reporting has become mandatory. Until 2014, physicians who reported these quality measures received bonus payments of an additional 0.5%. Beginning in 2015, however, there are financial penalties for not reporting of 1.5% in 2015, increasing to 2% in 2016, she explained.

CMS is also developing a Web site called Medicare Physicians Compare (http://www.medicare.gov/find-a-doctor/provider-search.aspx) that will detail physician quality measures on various services, including colonoscopies, eventually including measures for all practicing physicians.

In a survey of ACG members, just 38% of physicians reported receiving any feedback from their practices on the quality of their colonoscopy exams.[1] Dr. Shaukat described this finding as "concerning." She explained: "All physicians need to know their quality indicators because these will be reported."

The ADR is one of the most important quality indicators, said Dr. Shaukat, "A high ADR is evidence of a high-quality exam. In 25% of exams in men and 15% of exams in women, one should find at least one precancerous lesion.

"Interventions by practices to improve ADR include improving the quality of the bowel preparation for patients undergoing colonoscopy. For patients instructed to drink a 4-liter solution the night before the procedure, a meta-analysis showed that splitting the preparation so that half is taken the night before and half taken the morning of the procedure resulted in a cleaner colon and higher detection rate by making it easier to see and remove any adenomas.[2]

"A longer withdrawal time allows for more careful inspection of the colon and results in a higher detection rate of precancerous lesions," said Dr. Shaukat.

Dr. Shaukat led a study in Minneapolis, MN, that evaluated the impact of four interventions on colonoscopy quality: physicians were provided feedback on their ADR; physicians were observed as they did the procedure; leadership met with poor performers; and financial penalties were tried.[3] "Initially, there were no big changes, but over time, the ADR average for the practice increased from 22% to 33%," she noted.

A study of seven physicians in Indianapolis, IN, found that videorecording improved the quality of the colonoscopy exam.[4]

The take home message, said Dr. Shaukat: "Good technique is essential; technology can help; ADR is an important quality measure; ADR can be improved; splitting bowel preparations improves quality and tolerability; and practices can and should provide feedback. Poor performers may benefit from eye exams and being matched with high performers. Quality improvement is an ongoing process."

Gastroenterologists can develop their own methods to track quality indicators or participate in registries such as the Gastrointestinal Quality Improvement Consortium (GIQuIC), developed by the ACG and the American Society for Gastrointestinal Endoscopy. Physicians should concentrate on those quality indicators most relevant to their practice, said Dr. Shaukat. "Collecting and reporting such measures does pose a burden on physicians and their practices," she acknowledged, "but it must be done. Whatever happens with the ACA, tying reimbursement to quality indicators is here to stay."

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DNA stool testing (three responses), online immediate prior authorization notification (one response), and better understanding of the use of probiotics (one response).

Some of our panelists expressed concern about the current direction of gastroenterology practice.

"If reimbursements continue to decline, practices will not be able to continue to be in practice. More practices will be owned by ACOs or hospitals, which will change the quality of treatment in terms of patient access and where they receive care," says Dr. Pambianco.

There will be a shortage of physicians with baby boomers reaching Medicare age and baby boomer physicians retiring, predicts Dr. Pambianco. "The inability of physicians to practice the way they were used to may accelerate retirements. Many gastroenterology practices operate as small businesses and are being hit with declining reimbursements and rising premiums for providing health care coverage of their own employees while also needing to keep up with the latest advances in equipment," he notes.

"We are seeing increased pressure on practice revenues and will need to become more efficient in the delivery of service," says Dr. Pike. "However, over time, we should expect to see more transparency with respect to quality and cost of health care."

Dr. Sarles reflected on the profession's life-saving accomplishments while also sounding a note of caution. "My hope is that screening for colon cancer will be paid for at increased levels because it is the greatest success story in medicine in the past decade," says Dr. Sarles. "There has been a 30% reduction in diagnosis of colon cancer in the past 10 years because if we find polyps, we remove them.[4] And we've only screened 30% to 40% of the population. If screening could be increased to 80%, mortality would further decrease. My fear is that because of declining reimbursements and government policies, that 30% reduction could melt away."

Dr. Fochios adds that recent study findings suggest that risk reductions in colorectal cancer incidence and mortality in excess of 80% are achievable in routine practice and that vigilance in colorectal cancer screening will continue to reduce the incidence and mortality of this dreaded and preventable illness.[5]

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PART II

The Practice Management Perspective

When it comes to managing your gastroenterology practice, how do you compare with your peers? Find out with this *Benchmark Report*, examining such measures as average number of patients seen per physician per week, average number of days of practice revenue in accounts receivable, and patient volume by payer. *The Report* includes suggestions for improving gastroenterology practice performance.

Forty gastroenterology practice managers, representing a range of practice sizes and locations, completed the survey research. Survey findings are presented along with expert commentary provided by an Editorial Advisory Panel of three gastroenterology practice managers, one gastroenterologist, and one medical practice management consultant:

- Shelley L. Colon, Operations Director, Digestive Health Associates of Texas, Dallas, TX.
- Anne M. Koleson, Practice Manager, Metro East Gastroenterology Ltd., Belleville, IL.
- Karen Frieder, Office Manager, Practice of Ira R. Lefkof, MD, FACG, Hollywood, FL.
- Daniel J. Pambianco, MD, FACG, FASGE, Partner, Charlottesville Gastrointestinal Associates, Charlottesville, VA.
- George S. Conomikes, President, Conomikes Associates, Inc., Practice Management Consultants, San Diego, CA.

Gastroenterology Practice Characteristics

Three of four (75%) of the gastroenterology practice managers' practices responding to the survey are privately owned (chart not shown). One in five (20%) are single-specialty gastroenterology practices; 8% are part of a multispecialty group; while 8% are part of a gastroenterology "supergroup." (A supergroup is an entity where practices band together under a single tax identification number to better negotiate with payers while retaining their separate businesses.)

Metro East Gastroenterology Ltd. is a solo private practice operated by Aaron Greenspan, MD. "We are the reverse of the trend with Dr. Greenspan having separated from a large hospital system-owned gastroenterology practice in April 2013," says Anne Koleson, practice manager. Many other specialists are employed by large hospital systems, she notes.

Karen Frieder is the office manager for Ira Lefkof, MD, who is in solo private practice. Some local physicians belong to hospital systems, but to date, no local gastroenterologists have joined such systems, she says.

Digestive Health Associates of Texas (DHAT) is a large, privately owned single specialty practice with 74 physicians and more than 20 locations. "In the Dallas/Fort Worth metroplex, I'd estimate that fewer than 20% of gastroenterologists are employed by a hospital system," says Shelley Colon, DHAT operations director.

"The predictions are that more practices will be purchased by hospital systems," says Daniel J. Pambianco, MD,

of Charlottesville Gastrointestinal Associates, a single specialty practice of five gastroenterologists. However, George Conomikes, practice management consultant, notes that the boom in hospital acquisitions of medical practices has slowed.

Most practices are small (chart not shown). Nearly two-thirds (65%) of practice managers surveyed are in solo practices. Another 26% of practices are in small groups as follows: two physicians, 8%; three physicians, 5%; four physicians, 5%; and five physicians, 8%. The remaining 9% practiced in larger groups ranging from 7 to 74 physicians (chart not shown).

The majority of responding gastroenterology practices are at one practice location (63%) or at two locations (25%). Another 10% practice at three locations (chart not shown).

According to survey respondents, each gastroenterologist sees, on average, 84 patients per week **(Figure 25)**. The range of responses varies widely, from as few as 20 to as many as 200 patients per week.

Each gastroenterologist spends on average 44 hours per week with patients and in patient-related work. Again, the range of responses varies widely, from as low as 13 hours to a high response of 84 hours. The most frequently reported number of hours worked is 40 hours per week.

Administrative/business functions average 16 hours per week per physician. Responses range from 0 hours to 50 hours per week. The most frequently reported time involvement is 10 hours per week.

"Many of our doctors enjoy serving on committees and have leadership roles at the group, local, state, and national levels," says Ms. Colon. "Others just want to take care of patients."

"Dr. Greenspan is very active serving on various committees, which also helps to market the practice and build referrals," says Ms. Koleson.

"All of the gastroenterologists in our practice are active in professional societies, serve on various committees, and are involved in community patient education efforts," says Dr. Pambianco.

According to survey responses, gastroenterologists work an average of 60 hours a week: spending 44 hours on patient care and 16 hours on administrative/business functions.

The number of clinical staff members, including physician assistants (PAs), nurse practitioners (NPs), nurses, and medical assistants averaged 1.85 per gastroenterologist **(Figure 26)**. The range of responses varied from 0 to 8 clinical staff per physician. The most frequent responses were 1 and 2 clinical staff per physician.

FIGURE 25
Physician/Practice Performance Data
n=38

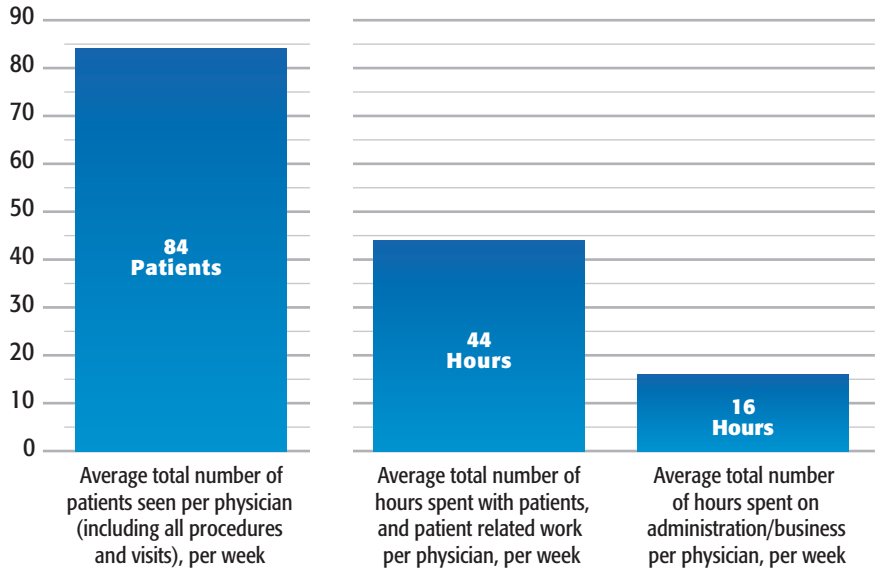
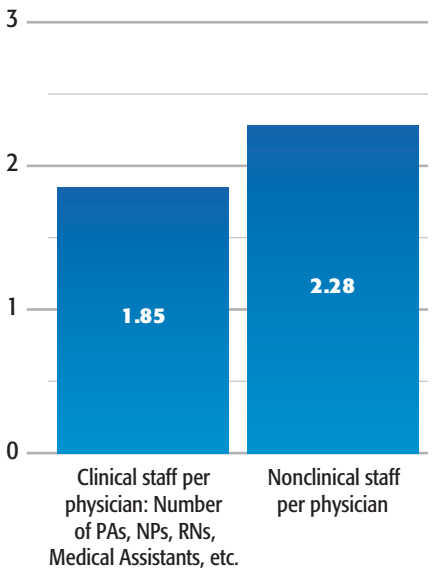


FIGURE 26
Nonphysician Staffing Data, Per Physician
n=39



Many physicians have expanded the use of PAs and NPs, primarily to provide care to established patients with chronic conditions, says Mr. Conomikes. According to Mr. Conomikes, the patient-management incentives to employing these midlevel healthcare professionals are:

- A "team" approach to patient care
- Delegating established-patient care for routine or chronic-care problems
- Allowing the physician to see more new patients and focus on more challenging cases
- Care provided by PAs and NPs is generally billable at 85% to 100% of the physician's fee.

"We've been working with midlevel practitioners in our practice for the past 18 years," says Dr. Pambianco. "They have been a tremendous help in getting patients seen, screening for comorbidities, and in working together as a team. They've been especially helpful in working with patients with hepatitis C and other chronic gastroenterology conditions in providing patient education and follow-up care that is cost-effective." The five-physician practice has five midlevel practitioners.

"Having a PA in the practice has worked out beautifully," says Ms. Koleson of Metro East Gastroenterology Ltd. "It has allowed the gastroenterologist to take time off and to do more procedures with the PA handling more office visits. Our PA works very closely with Dr. Greenspan, and patients are comfortable seeing the PA. Having a PA available also reduces the wait time for an appointment."

Metro East Gastroenterology Ltd. is now looking to add an NP. "The addition of an NP will allow the practice to see more Medicaid patients," says Ms. Koleson. Illinois Medicaid only pays NPs to see patients, not PAs, she notes.

DHAT with 74 physicians has 13 midlevel PAs and NPs. "In Texas under a delegation protocol, PAs and NPs can see patients in office visits, order lab tests, order imaging and procedures, refill prescriptions, refer patients, and take patient phone calls," says Ms. Colon. "They free up the doctors to do procedures. PAs and NPs also provide patient education regarding chronic conditions."

For nonclinical staff members including: front-desk, schedulers, billing/collections, and practice managers, the average ratio was 2.28 per physician. The range of responses was 0 to 7. The most frequent responses were 1 or 2 nonclinical staff per physician.

The average of 2.28 seems low, with the nonclinical staff to physician ratio increasing over the last few years, notes Dr. Pambianco. At Charlottesville Gastrointestinal Associates and DHAT, instruction on bowel preparation for a colonoscopy is typically provided by the medical assistant/patient scheduler.

Ancillary Services

Slightly more than half of responding practices (53%) are affiliated with an ambulatory surgery center (ASC) compared with 48% that have no such relationship (**Figure 27**). One in five (20%) are the sole owners of an ASC, and many are able to provide these services at the same location as their practices; one in four (25%) of the practices are part owners of the ASC; the remaining 8% have a cooperative relationship with a hospital to run the center.

The advantages of this affiliation for physicians include facility convenience and facility fees, in addition to professional fees. Patients benefit from greater convenience and more privacy than a hospital setting.

Metro East Gastroenterology Ltd. shares an endoscopy suite with another independent gastroenterologist, says Ms. Koleson. Colonoscopies are billed as an office procedure.

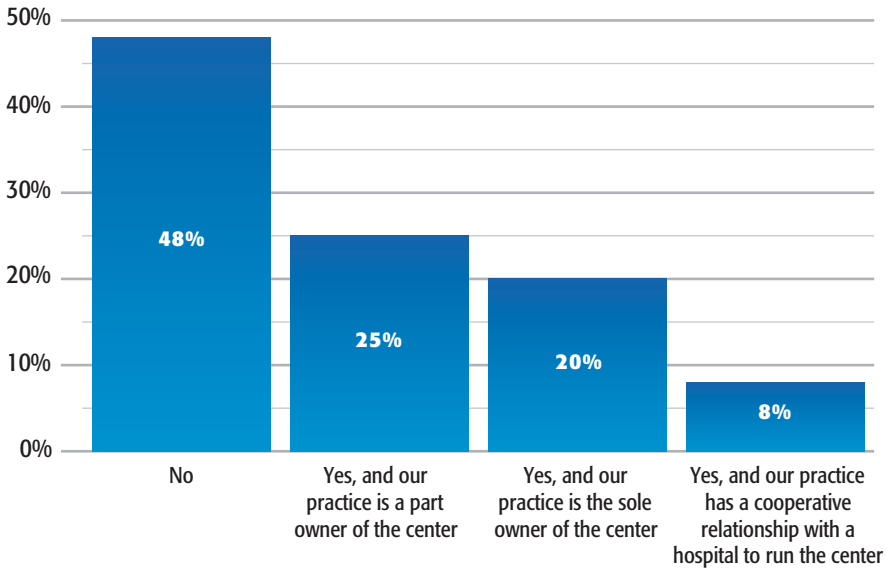
"Our practice has joint ownership of an ASC with a hospital that owns 51%," says Ms. Frieder.

"We have an office-based ambulatory endoscopy facility," says Dr. Pambian-

FIGURE 27

Is your practice affiliated with an ambulatory surgery center?

n=40



co. "We outsource anesthesia services to a company that employs our staff for the endoscopy facility."

"We have minority ownership of five endoscopy centers," explains Ms. Colon. "We provide staffing, but they are managed by our ASC partner." Other endoscopy centers in the market area are joint venture arrangements with hospitals and are reimbursed at a higher rate.

Anesthesia services are provided by 60% of gastroenterology practices/ASCs, of which 38% of services are provided by an anesthesiologist and 23% are provided by a certified registered nurse anesthetist **(Figure 28)**. Other services frequently provided are: hemorrhoid or rectal procedures, 48%; pathology lab, 43%; breath testing for bacterial growth, 30%; infusions, 25%; and bowel preparation kits for purchase, 18%.

Pathology and laboratory services for Dr. Lefkof's practice are outsourced by the ASC. Charlottesville Gastrointestinal Associates outsources pathology, breath testing, and infusion services. DHAT has a pathology lab where slides are prepared, but the professional services are outsourced to contracted pathologists, explains Ms. Colon.

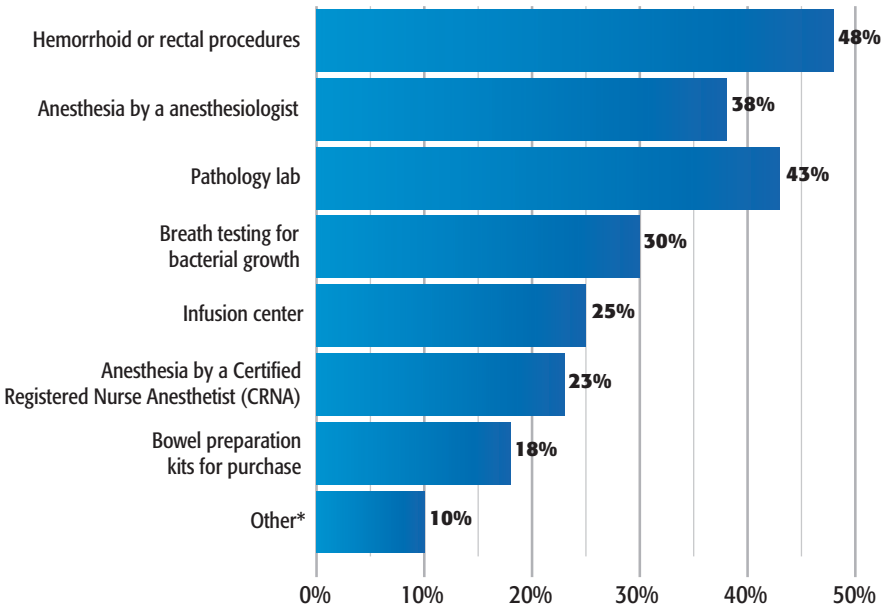
Ancillary services provide physicians with important revenues and incomes. Revenues from ancillary services, per gastroenterologist surveyed, averaged $158,331 (chart not shown). Ancillary revenues per physician surveyed varied widely from a low of $1,000 to a high of $716,666.

Nearly one-third (30%) of practices surveyed currently participate in clinical research **(Figure 29)**. Most, 63%, are not currently involved, although 25% have participated in the past. Just 8% plan on participating in clinical research in the future.

FIGURE 28

Please indicate the ancillary services that your practice/ambulatory surgery center offers:

n=40

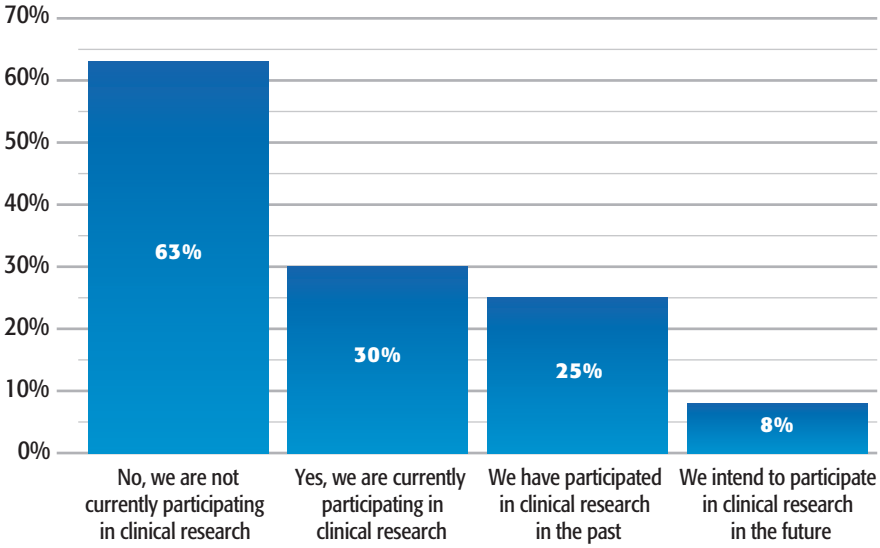


*Endoscopy services, Outpatient surgery

FIGURE 29

Is your practice performing clinical research?

n=40



Charlottesville Gastrointestinal Associates has been involved in clinical research for about 20 years, says Dr. Pambianco. "Patients can have access to cutting edge treatments, including new bowel preparations, acid-inhibiting medications, and motility medications."

In addition to private practice, several physicians at DHAT are involved in

clinical research, trialing new therapies for patients with gastrointestinal and liver diseases, says Ms. Colon.

Financial Data Per Physician

Gastroenterology practices surveyed average annual charges per physician of $1,490,268.50 **(Figure 30)**. Of that amount, an average of $585,084 was collected per physician or 39%. Annual charges per physician varied widely from a reported low of $125,000 to a high billing of $3,000,000.

Overhead costs (personnel, rent/facilities, utilities, medical and business equipment and supplies) per physician average $202,604.75 or 14% of gross charges.

Net collections per physician (roughly what remains after overhead costs are subtracted) average $435,831.81 or 29% of gross charges.

Net revenue per physician (net collections minus profit-sharing, legal and miscellaneous fees) average $396,086.05 or 27% of gross charges.

Billing and Collections

The accounts receivable (A/R) average percentages reported were: 0 to 30 days, 44%; 31 to 60 days, 26%; 61 to 90, 16%; 91 to 120 days, 14%; and more than 120 days, 18% **(Figure 31)**. These percentages could be improved, says Mr. Conomikes, and follow-up with outstanding accounts needs to be more aggressive. Little variation between A/R percentages of 61 to 90 days (16%) and 91 to 120 days (14%) suggests inadequate follow-up in the fourth month of nonpayment.

The gastroenterology practices profiled had better A/R results than the average survey respondents.

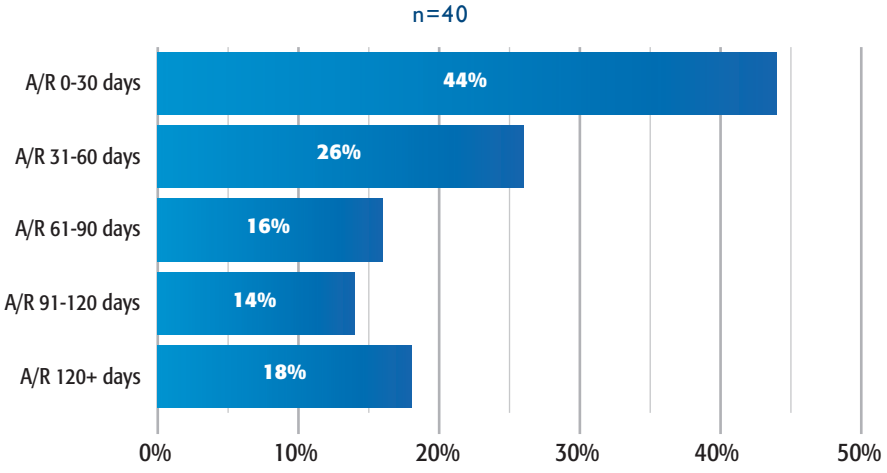
FIGURE 30

Annual 2013 Financial Data Per Physician

	Average Charges for 2013	% of Gross Charges
Gross charges, per physician	$1,490,268.50	
Gross collections, per physician	$585,084.00	39%
Overhead costs, per physician	$202,604.75	14%
Net collections, per physician	$435,831.81	29%
Net revenue, per physician	$396,086.05	27%

FIGURE 31

Average number of days of practice revenue in Accounts Receivable:



"Our billing director really rocks. She stays on top, looking for trends and addressing problems aggressively as soon as they come up," says Ms. Colon of DHAT. The practice's A/R percentages are: 0 to 30 days, 85%; 31 to 60 days, less than 8%; 61 to 90 days, 3%; and 91 to 120 days, 5%.

"Our business manager and her team are constantly monitoring this, staying on top, checking on coding issues, etc.," says Dr. Pambianco.

"Our A/R over 90 days is very low, and we have nothing over 120 days," says Ms. Frieder.

The days of gross charges in A/R at gastroenterology practices averaged 39.2 days (chart not shown). An A/R amount in the range of 35-to-50 days is considered an average result. The best performing practices have days of gross charges in A/R of less than 35 days, says Mr. Conomikes.

"Our total average days in A/R is 25.6, the lowest in our history," says Ms. Colon of DHAT. For Metro East Gastroenterology Ltd., total average days in A/R is 28, adds Ms. Koleson. "Our practice averages 30 days or less in A/R," says Dr. Pambianco.

"To reduce your accounts receivable, and the numbers of statements that need to be mailed, start with your appointment reminders," explains Mr. Conomikes. "Reminder calls or emails should be used to let patients know about their health plan's required co-

pays and/or deductibles. These reminders will prepare patients, at check-in, to pay their deductibles and/or copays."

One sign of follow-up weakness is exhibited when practices bill all outstanding accounts once a month.

The successful practice begins vigorous follow-up with plans and patients, and is sending statements on an almost-daily basis, says the practice management consultant. For example:

- First statement is sent to plans and patients 1 to 5 days after the visit/service.
- Second statement is sent to patients 16 to 20 days after the visit and marked "2nd Notice."
- A third statement is sent to patients 31 to 35 days after the visit and marked "Past Due" or "Final Notice."
- Follow-up with health plans by phone or email is 31 to 35 days after the visit. Fortunately, with the advent of electronic claims reimbursement, most health plans pay their claims within 30 days of submission. It is also important to address any claim denial or down-coding within 5 days, however.
- Follow-up with patients by phone or email is 46 to 50 days after the visit. Explain that if the outstanding balance is not paid within 5 days, the account will be turned over to a collections service.

"Better results will be achieved by this tighter sequence of dealing with outstanding receivables," says Mr. Conomikes, "with higher collection percentages, fewer accounts going to a collections service, and better cash flow."

Volume By Payer

The largest volume of patients is covered by commercial health plans, with 47%, closely followed by Medicare, with 43% **(Figure 32)**. Medicaid accounted for 10% of patients. As in most specialty practices, the percentage of self-pay is low. For these gastroenterology practices, it was only 5%.

"A lot of our patients are uninsured and don't qualify for Medicaid. We have a contract with the hospital to treat their uninsured clinic patients," explains Ms. Frieder. Dr. Lefkof performs colonoscopies on patients for whom the procedure is deemed medically necessary by the program's medical director. The hospital receives funding through real estate taxes and federal grants, she says. "The Affordable Care Act has made things worse. Access to physicians is limited. Premiums are going up. Patients say they can't afford care because of high deductibles."

"All practice managers should look at the collections percentages for all of their payers—and every effort should be made to give high priority in scheduling for new patients with the best payment plans," says Mr. Conomikes. "Patient schedulers should be made aware of these priorities, especially with new patients," he adds.

Ms. Colon and Ms. Koleson expect to see more patients covered by Medicare and Medicaid in the next 2 years **(Figure 33)**. Dr. Pambianco expects to see Medicare volume increase from 30% to 40%. "The prediction for the ACA is that it will fall apart," he says.

Ms. Frieder expects to see more Medicaid coverage, charity care, and more coverage under the ACA.

Ms. Colon and Ms. Koleson note that health plans are reducing the size of their provider networks. For example, United Healthcare recently cut 200,000 providers across the country

FIGURE 32

What percentage of your patient volume is covered by each of these payers?

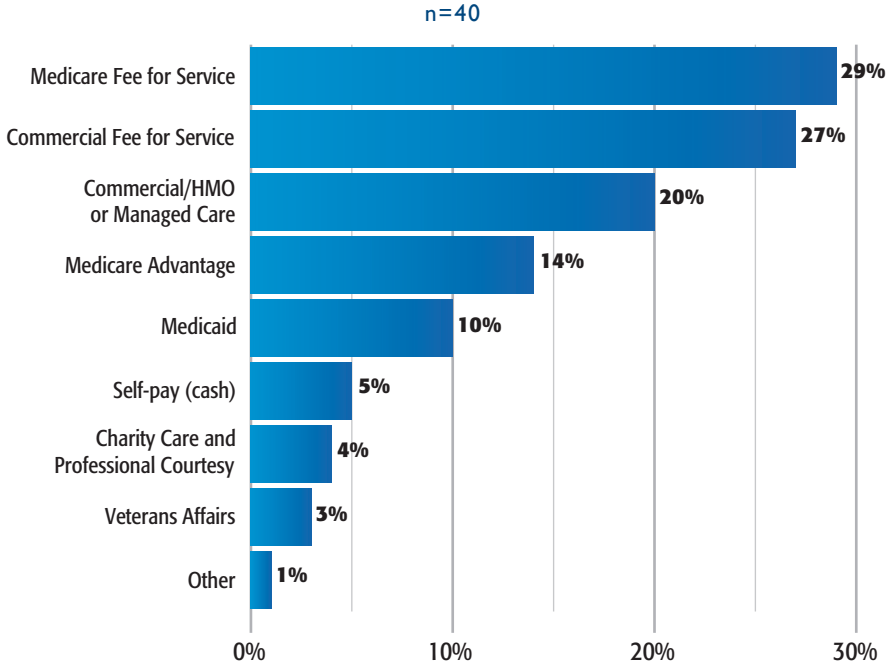
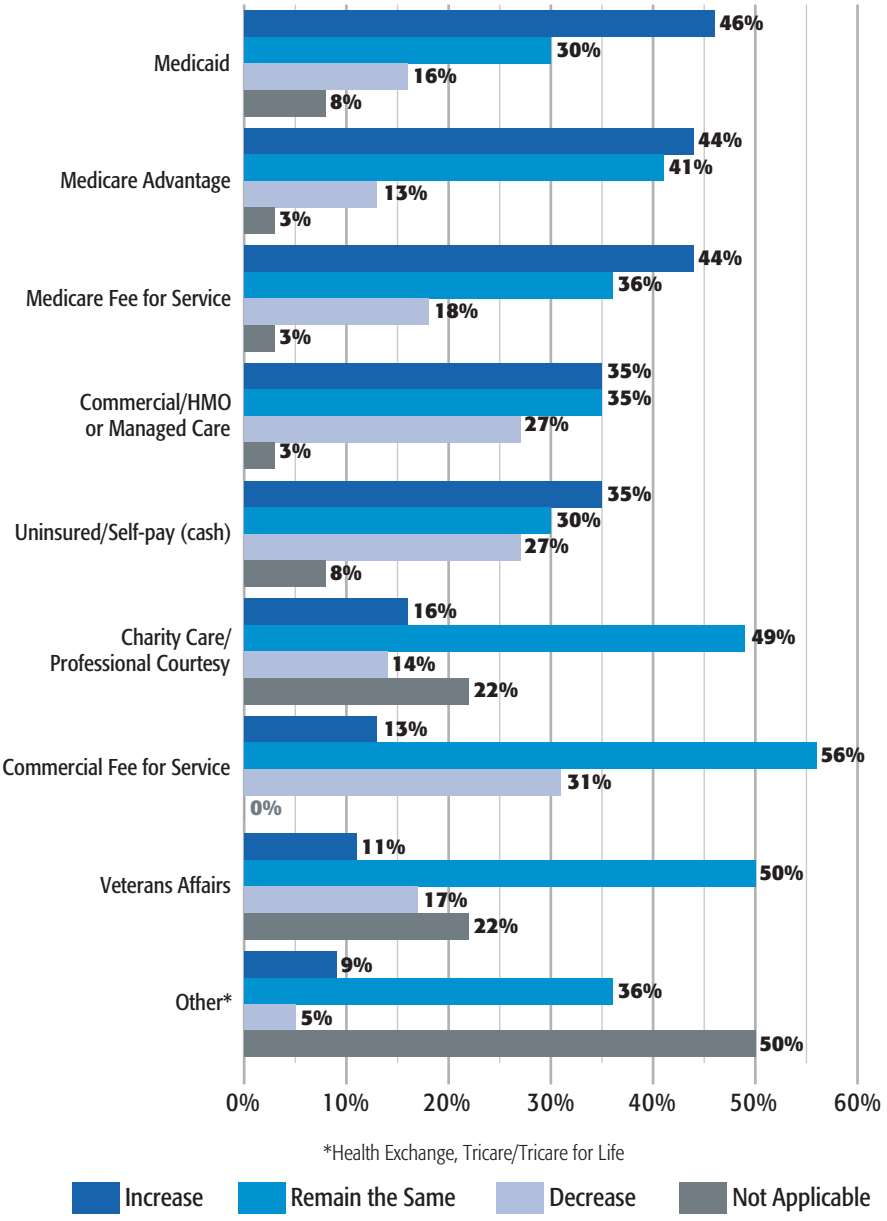


FIGURE 33

In your opinion, how will the patient volume of each payer change in the next 2 years?

n=39



from its Medicare Advantage plan network.

Visits to the Gastroenterologist

Colon health screenings and routine colonoscopies were the leading reason for patient visits, accounting for 29.2%, according to survey respondents **(Figure 34)**. Other common reasons were: irritable bowel syndrome and other functional bowel disorders, 13.2%; gastroesophageal reflux disease (GERD), 12.9%; and inflammatory bowel disease/Crohn's disease/ulcerative colitis, 10.7%. The remaining 34% of visits were shared by the other six conditions.

Ms. Colon says she expects the distribution of diseases and conditions to remain about the same going forward.

"Half of our patient visits are for colonoscopy screenings," says Ms. Frieder.

"More health plans are focusing on wellness and advertising that they cover 100% of colonoscopy costs under a wellness benefit," says Ms. Koleson. "If polyps are found and removed during the colonoscopy screening, however, some health plans will reclassify the screening as diagnostic. The diagnostic procedure is then covered under the medical benefit, which pays 80% with the patient responsible for the other 20% or may have a high deductible. Patients can become quite upset and blame the practice."

"This is becoming less of an issue, especially in Virginia, in part because of expanded coverage for colonoscopy screenings under the ACA," says Dr. Pambianco.

DHAT has developed a patient brochure that explains up front that colonoscopy screenings may not be covered 100% under a wellness policy if polyps are found and removed.

More than half (56%) of patients were referred to gastroenterology practices by primary care physicians (PCPs), which exceeded the proportion of those referred by specialists, 17%, and other patients, 13% **(Figure 35)**. The remaining four sources of referrals combined for a total of only 12%: payer networks; practice Web site; other online resources, and other.

"Most of our referrals are from primary care physicians," says Ms. Koleson.

"While most of our referrals are from PCPs, about 25% are self-referred, mostly through word-of-mouth," says

FIGURE 34

What percentage of patient visits is related to treatment for the following diseases/conditions:

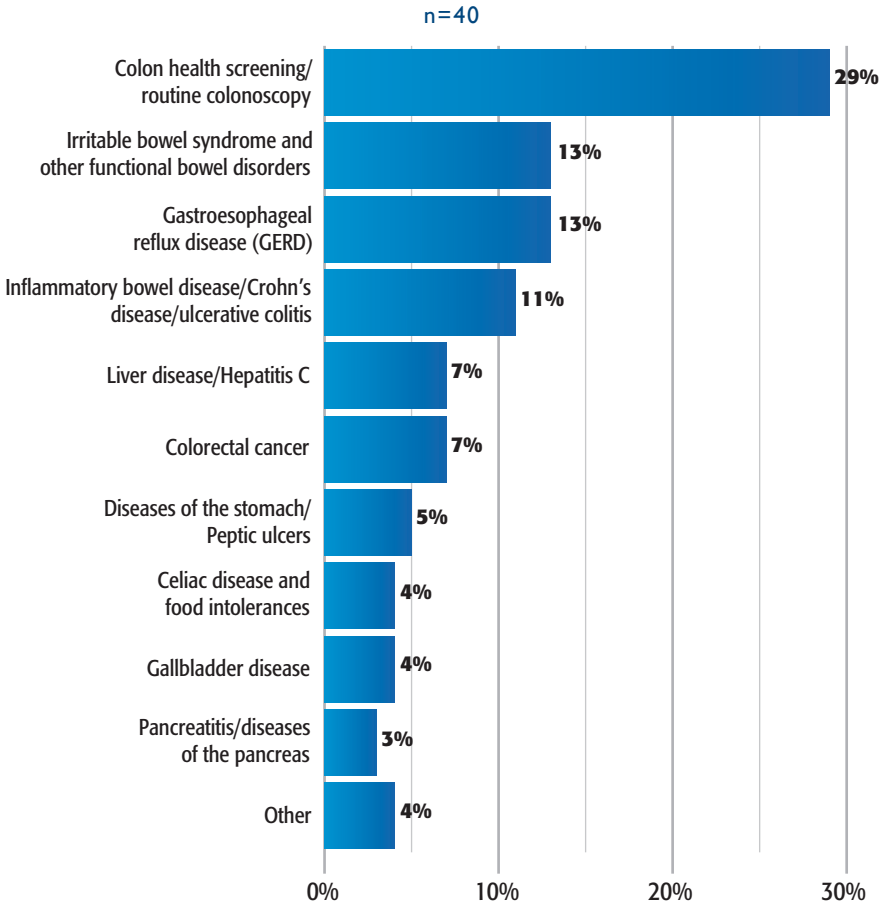
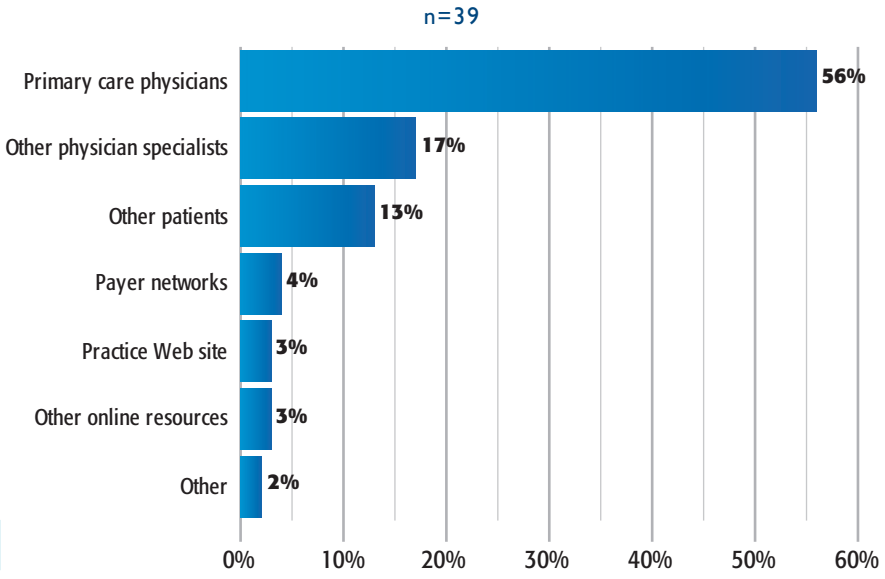


FIGURE 35

Of your patients who are referred, what is the source of the referral?



Dr. Pambianco. The practice encourages patients to return to their PCPs for follow-up treatment, he adds.

"We get referrals from PCPs and specialists and also from a referral Web site," says Ms. Frieder.

"We are seeing more steerage to specific providers by health plans," says Ms. Colon.

Reimbursement Rates

Gastroenterology practice managers painted a gloomy picture of reimbursement trends during the past 2 years **(Figure 36)**. Fifty-eight percent reported decreased reimbursement from Medicare; 50% reported decreased reimbursement from commercial health plans; and 44% reported decreased reimbursement from Medicaid. Little change was seen in self-pay rates.

Payer Policies

Gastroenterology practice managers reported that their largest payer had prior authorization requirements as follows: 42.7% of their prescribed medications; 33.6% of their prescribed procedures; and 32.3% of prescribed treatments (chart not shown). "Medications are the biggest issue for us, especially newer medications," says Ms. Frieder.

Copay Assistance Cards

Half of practice managers found copay assistance cards to be very useful in their practice. Another 22.5% found them useful **(Figure 37)**. "Patients love the copay cards," says Ms. Colon. "The cards are very helpful, especially with coverage gaps and the high cost of certain medications," adds Dr. Pambianco.

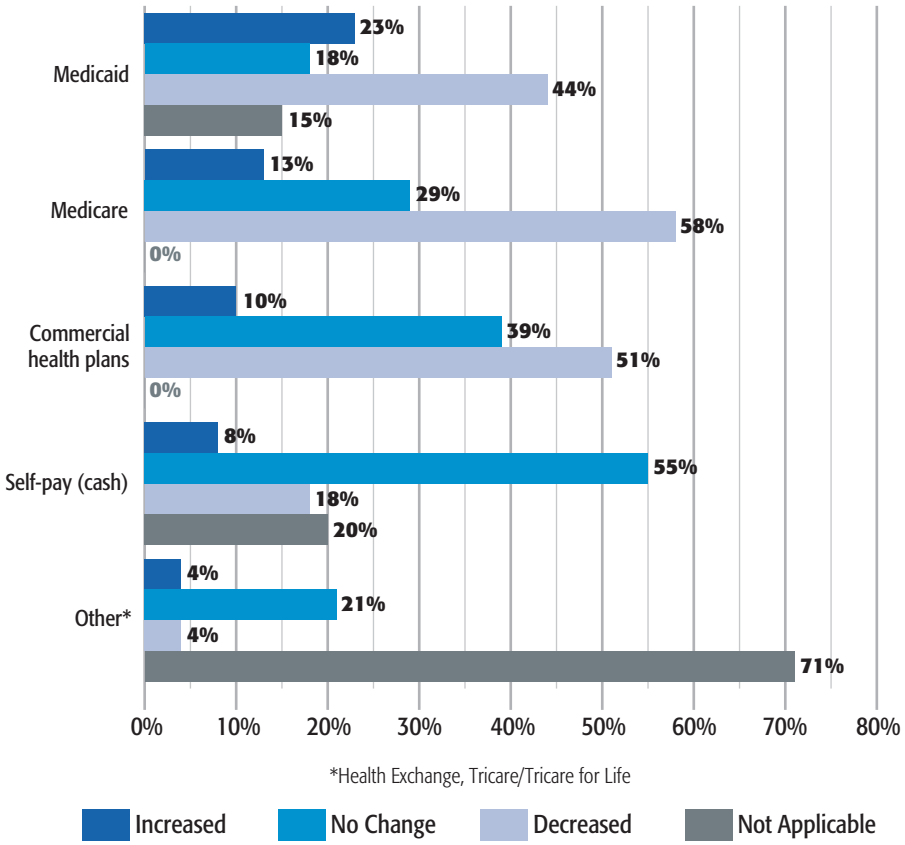
Future of the Practice

Two-thirds of the gastroenterology

FIGURE 36

On average, how have reimbursement rates for the same services changed over the past 2 years?

n=40



practice managers (67%) did not foresee the possible sale or merger of their practice (chart not shown). Another one in seven practices (15%) were considering such a sale or merger, with an almost equal percentage (18%) stating that they were unsure.

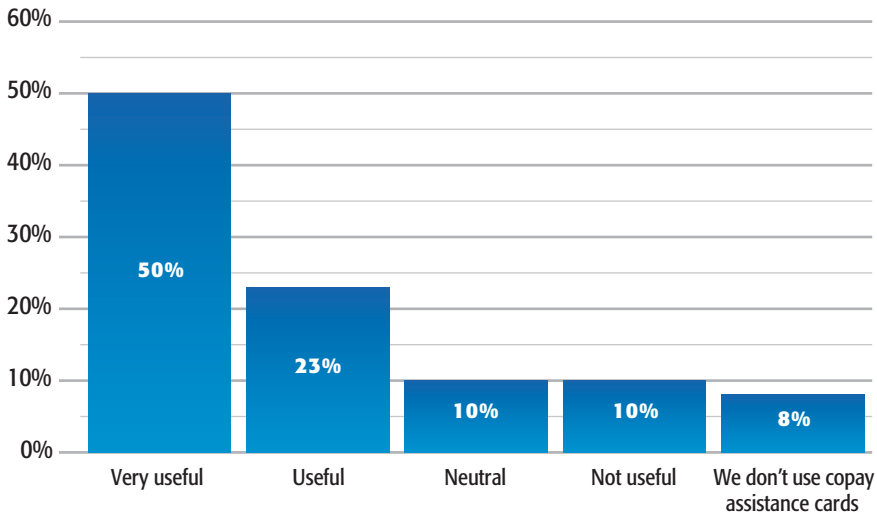
Half of the 15% of practices considering a sale would look to sell the practice to another gastroenterology practice; one-third would sell to a hospital (chart not shown).

Looking ahead, there is such fluidity and uncertainty in the marketplace in terms of reimbursements and networks, says Dr. Pambianco. "Most likely there will be bundling fees and more limited networks that are part of healthcare systems." But Dr. Pambianco also sees a future for independent private practice. "Quality measures will become more important but may not generate hoped for cost savings. Efforts to boost screening will reduce the incidence of colon cancer but at an increased cost."

FIGURE 37

How useful are copay assistance cards in helping patients obtain medications?

n=40



Conclusion

The value of screening colonoscopies is well established: colonoscopies save lives. Yet gastroenterologists as well as most other physician specialists face challenges as they continue to seek to deliver quality patient care. Survey findings and interviews with experts reveal the following trends:

- The greatest proportion of patient visits, 29%, are for routine colonoscopy; 44% of survey respondents expect to see an increase in patient volume for screening colonoscopies, spurred by the aging of the population and expanded coverage
- At the same time, gastroenterologists face declining reimbursement rates and more restrictions due to payer formularies and preauthorization requirements
- Product efficacy, product safety, and product tolerability are the most important factors when prescribing a bowel preparation. Those Editorial Advisory Panelists stating a preference favored the use of low-volume preps
- Sixty percent agree that adenoma detection rates should be a leading quality benchmark but most practices do not currently track their rates
- Most survey respondents are reporting quality measures through the CMS PQRS but such participation, tied to reimbursement and expected to increase, is viewed as cumbersome and has decreased provider morale
- Survey respondents are mixed on the value of patient care registries but proponents say that analyzing outcomes will provide a higher level of quality care
- Almost half of ambulatory surgery centers are either solely or in part physician-owned, according to survey respondents
- Gastroenterologists are expanding their use of physician assistants and nurse practitioners, gaining practice efficiencies and fostering a "team" approach
- Primary care physicians are a key referral source, responsible for more than half of patient referrals to gastroenterologists' offices
- Gastroenterologists see an average of 84 patients a week and spend on average 44 hours on patient care and 16 hours on administrative/business functions each week
- Despite challenges faced, some of our Editorial Advisory Panelists foresee a future of greater transparency with respect to quality and cost of health care and where quality care is supported and rewarded.

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Special Thanks to the American College of Gastroenterology for Assistance in Providing Input for Survey Questions and Reviewing the Final Report


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