Community Health Network

Differences and Similarities in Inpatient and Outpatient Endoscopy; Quality Indicators in Endoscopy

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By: Tammy Richardson, RN, BSN, MHA
Director, Community Endoscopy Center

Objectives

- Discuss the similarities in Inpatient and Outpatient Endoscopy including the evolution of outpatient endoscopy, procedure types, quality outcomes, quality indicators, safety and infection control guidelines, documentation requirements and changes, patient satisfaction, and practice guidelines
- Discuss the differences in Inpatient and Outpatient Endoscopy including cost-effectiveness, procedure types, acuity/patient complexity, indications for procedures, anesthesia type and efficiency
- Discuss Quality Indicators in Endoscopy including the impact of health care reform, what indicators to track, and the importance of quality indicators in your QA program

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Evolution of Outpatient Endoscopy

- How has outpatient endoscopy evolved?
- Up until about 40 years ago, virtually all endoscopy procedures were performed in hospitals
- First ASC built in 1970 in Phoenix, AZ by two physicians who wanted to establish a high-quality, cost-effective alternative; in the 1990's, GI specific surgery centers came into play
- Frustrations driving this change included scheduling delays (poor access to care), limited procedure rooms, slow turn-over times, challenges in obtaining equipment due to hospital budgetary restraints and policies

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Evolution continued:

- Endoscopy units have evolved from small rooms usually placed at the end of general medical floors to multipurpose units as part of the OR department or to large stand-alone suites either inside or outside the hospital with multiple rooms to accommodate many diagnostic and advanced therapeutic procedures
- Scheduling pressures for endoscopy time crowded many hospitals which also drove the formation of outpatient endoscopy
- Insurance reimbursement also incentivized endoscopy performance outside of the hospital

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Benefits Outpatient Endoscopy in ASC's

- Physicians have better control with time management; maximizes efficiency; scheduling procedures more conveniently; more of a business model
- Procedures can be performed in sequence that conforms to individual physician style and patient load
- In the hospital setting, the endoscopist often times has limited flexibility as multiple physicians are being accommodated and time must be reserved for urgent cases

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Benefits continued:

- In GI specific ASC's, it allows for high productivity due to specialization and patient selection (patients are ASA ratings 1-3); lower acuity levels
- Newer facilities equipped with the latest technology
- Better staffing models
- Professional autonomy
- In 90% of all ASC's, physicians are owners which allows them to have a say in quality, safety, capital equipment purchases, patient/staff satisfaction, and budgets
- Frees up block time in the hospitals for acute patients

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Similarities in Inpatient and Outpatient Endoscopy – Procedures

- Both provide outpatient endoscopy services including but not limited to screening and diagnostic colonoscopies, flexible sigmoidoscopies, EGD's with and without dilation, and placement of Bravo capsules
- All operative under the same practice guidelines: SGNA, ASGE, AORN, CDC, APIC, ASPAN et al
- All strive to provide excellence in GI services for our patients
- Highly trained and skill staff

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Similarities continued:

- Both inpatient and outpatient endoscopy units have a QA program which should be tracking endoscopy specific quality indicators and quality outcomes
- Safety & Infection Control requirements; may vary slightly based on accrediting body
- All regulated by State Board of Health, CMS, and accrediting body (JCAHO, AAAHC et al)
- Patient satisfaction

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Documentation

- We all have documentation requirements as outlined by regulatory bodies – ISDH, JCAHO, AAAHC, and CMS
- SGNA has a great position paper on this: *Guidelines for Documentation in the Gastrointestinal Endoscopy Setting* – this applies to both in and outpatients
- CMS is separating moderate sedation as a procedure code in 2017 for endoscopy procedures under Medicare Part B

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Documentation continued:

- What does this change mean?
- It means that physicians performing moderate sedation with have to document the "sedation time" and they will now get credit in the form of work RVU's
- Your billing departments are probably already aware of this and making these changes
- This will involve additional CPT codes as well specific language like: "Moderate (conscious) sedation was administered by the endoscopy nurse and supervised by the endoscopist. The following parameters were monitored: oxygen saturation, heart rate, blood pressure, and response to care. Total physician intraservice time was 18 minutes. "

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Cost-effectiveness of ASC's

- Not only are the ASC's focused on ensuring patients have the best surgical experience possible, they also provide cost-effective care that saves the government, third party payers and patients money
- On average, the Medicare program and its beneficiaries share in more than $2.6 billion in savings each year
- This is because the program pays significantly less for procedures performed in ASC's when compared to hospital or HOPD rates; patient co-pays are also typically lower in ASC's

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Cost-effectiveness continued:

- Currently, Medicare pays ASC's 55% of the amount paid to hospital outpatient departments for performing the same services
- For example, for an EGD with biopsy, HOPD would get paid $745 and ASC's would get paid $417 at Medicare rates
- A colonoscopy in the HOPD would get paid $753 and an ASC $421

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Procedure types

- In the hospital setting, a variety of diagnostic and advanced therapeutic procedures can be performed that cannot be performed in the ASC's like: EUS, ERCP, endoscopic mucosal resection, endoscopic submucosal dissection, endoscopic fistula closure, cholangioscopy, manometry, and radiofrequency ablation
- These procedures require different equipment and specially trained staff

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Acuity/Patient Complexity

- Sicker and more complex patients are referred to hospital endoscopy units because additional resources are available that may be needed to care for these patients
- HOPD's have access to emergency care, intensive care, advanced anesthesia care, and subspecialty care when needed
- HOPD's may be also be affiliated with teaching hospitals which also have additional resources available

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Acuity continued:

- Performing an inpatient colonoscopy can be fraught with frustration as these patients can have multi-organ failure, be on multiple medications, undergoing multiple investigations simultaneously – high risk
- These patients often have cardiac and/or respiratory issues with electrolyte and delicate fluid balance issues for which sedation and full colonic preparation could lead to further compromise
- As a general rule, inpatients tend to have poor preparation and mobility status as well

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Indications

- Determination of appropriateness of endoscopic procedures is a dynamic process right now
- Studies report that 11-39% of endoscopy procedures are performed with inappropriate indications
- ASC 9 – Appropriate follow-up interval for normal colonoscopy in average risk patients
- ASC 10 – Colonoscopy interval for patients with a history of adenomatous polyps
- CMS mandated these reporting guidelines in 2014

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Anesthesia Type

- The use of Propofol for endoscopy cases is on the rise; many though still use moderate sedation
- From the provider perspective, Propofol has a quicker onset and recovery which yields a faster discharge; efficiency in the endoscopy unit
- From the patient perspective, there's greater satisfaction because there's less pain and awareness during the procedure, yet increased awareness in recovery to receive results and instructions
- MAC sedation is the preferred method for the more acute cases in hospital settings

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Propofol

- Intravenous sedative/hypnotic/anxiolytic
- Onset 30 seconds in a 20 year old
- Onset 4 minutes in a 90 year old
- Half life 2-4 minutes
- Average sedative dose varies
- Some antiemetic properties
- Cost is higher than benzodiazepines

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Benzodiazepines

- Sedation, anxiolysis and amnesia
- Rapid onset of action
- Clinical experience
- Low acquisition cost
- Reversal agent available
- Longer time to recovery
- Respiratory depression
- Hypotension with CV instability
- Paradoxical agitation

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Efficiency

- At least 70% of procedures in an ASC start within 7 minutes of their scheduled time
- Additionally, 77% of ASC procedures are finished within the scheduled time, compared to 38% at a hospital facility
- As mentioned before, there are many reasons for this: outpatients are healthier; coordination of critical patients being moved to an endoscopy unit can be quite an orchestrated event which takes more time, not to mention coordinating anesthesia, etc.

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Quality Indicators in Endoscopy

- Commitment to quality is not only important to patients, but it can impact the bottom line too
- ASC's have an excellent track record of providing safe care
- Studies show 1 post-op infection out of 1,000 in outpatients vs. 20 per 2,000 in hospital facilities
- One study indicates 128 deaths reported from 371,099 outpatient colonoscopies for a death rate of 0.03%, almost always related to a comorbid disease
- CMS mandates the tracking of: patients burns, falls, wrong site, side, procedure, transfers, and prophylactic antibiotic timing since 2012

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Quality continued:

- ASC success is due to a keen focus on continuous quality improvement
- Strict guidelines exist for establishing a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities
- How robust in your QA program?
- A good place to start is right here – review SGNA Standards and Practice Guidelines, as well as Position Statements; also lots of great resources for Infection Prevention and Safety programs

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Quality continued:

- ASGE also has multiple practice guidelines related to quality indicators common to GI endoscopic procedures
- As leaders in endoscopy, we should always be asking: how can we improve?
- There are multiple indicators that we can track; some are true quality measures and some are performance indicators
- Your quality will only be as good as your QA program; tracking quality indicators is always a great source for QI projects

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Performance Measures

- Procedure volume/OR utilization – how can we grow?
- No shows/cancellations – what can we prevent?
- Procedure duration – does scheduling need to be adjusted?
- Room turnover time – how can we be more efficient?
- Percent of first case on time starts – what adjustments can be made here?

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Quality Measures

- G codes – CMS mandated measures discussed earlier (burns, falls, wrongs, transfers, antibiotics)
- Post-op infection rates
- Medication errors
- Specimen errors
- Reversals

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Endoscopy Specific Quality Measures

- Post-polypectomy bleeds/30 day re-admissions
- Cecal intubation rate
- Withdrawal time
- Bowel preparation
- Adenoma detection rate
- Perforation rate

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Quality Dashboard

COMMUNITY ENDOSCOPY CENTER QUALITY INDICATORS DASHBOARD		
2017 - 1st Qtr	TOTAL	TARGET
Total Cases		N/A
Total Colon Cases		N/A
Post Polypectomy Bleeds		≤ 1% of total cases
Cecal Intubation Rate		≥ 95%
Average Withdrawal Time		≥ 6 minutes
Adenoma Detection Rate		≥ 25%
Perforation Rate		≤ 1 in 1000
Post Op Infection Rate		0
Sedation Reversals		0
Bowel Prep Quality		≥ 85%

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Pay for performance impact

- Reduced reimbursements; do more with less philosophy
- Despite cuts in Medicare payments, most providers continue to accept Medicare patients
- More insured patients; growth in volumes in some locations
- High deductibles for patients
- Payment discrepancy continues to exist between HOPD's and ASC's for same procedures
- Shift from fee-for-service to value-based payments

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Pay for performance impact continued:

- Improving quality requires substantial capital investments in areas such as information technology and staffing; this can be more challenging for hospital providers with budgetary restrictions
- Despite limited evidence of effectiveness, pay for performance remains popular with policy makers as a tool for improving care and containing costs
- Skeptics are concerned that the underlying goal is cost containment at the expense of patient care as well as the impact on vulnerable populations

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Pay for performance continued:

- As we all know, healthcare is in a constant state of flux
- As leaders, we will always have to try to cut costs while preserving quality endoscopy care
- As endoscopy providers, whether inpatient or outpatient, we just all need to be mindful of being in a state of continuous improvement and keeping our patients first

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Conclusion

- Moving appropriate patients to ASC's really benefits all parties involved; patients receive care in appropriate locations based on their needs and it frees up the HOPD's for the more complex and expensive procedures, providing efficiencies on both sides. This provides a symbiotic relationship between hospitals and ASC's
- Let's all continue the good work together to provide the highest quality endoscopy services in all locations

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Questions & Discussion

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