

# BUILDING YOUR NONPROCEDURAL BUSINESS LINES

## A PROGRAM OF THE AGA INSTITUTE

The AGA Roadmap to the Future of GI Practice is designed to provide practical information for gastroenterologists who are looking to meet the challenges of health-care reform in the next decade. This publication was created to help GIs understand the value of diversifying service offerings to boost revenue in an era of health-care reform.

## Change can be an opportunity.

It's time to embrace the future and adapt.

Every product or service has its own life cycle. Most businesses follow a typical cycle (see graph) — each cycle begins with a development period, eventually leading to the deployment of a product or service. This is then followed by a phase during which the business struggles to take hold. If it is a solid business, early adopters drive its success, which results in a rapid growth phase with expanding margins and solid profits. Competition eventually enters, which compresses margins and profits. The lack of profit results in the decline of the business leading to either senescence or replacement with less expensive innovative products.

Medical services have life cycles as well. Any of you who have been in practice as long as I have will clearly realize this. We've all seen the rise and demise of certain procedures as technological change shapes the market. Colonoscopy is no exception. It has gone through a rapid growth phase triggered by the "Katie Couric effect" of the last decade and augmented by changes in reimbursement designed to cover preventative care. We are now in a mature period of the cycle for colonoscopy. Margin compression has resulted in less profit and there are multiple potentially less expensive replacements on the horizon.

It is therefore time to look for other nonprocedural business lines that will lend themselves to the risk-based changes that are developing as a result of health-care reform. How do we identify those businesses? We need to focus on the high frequency services that bear the highest risk to the population.

The AGA Practice Management and Economics Committee has been focusing on nonprocedural business lines since 2011. We

identified several potential business lines that represent high frequency/high risk services and identified three experts in the field to provide their insight and advice.

### Nutrition services PAGE 2

Jay Kuemmerle, MD, AGAF, begins with a summary of the nutrition service that has been developed at the Medical College of Virginia. He focuses on obesity, as well as malnutrition.

### GI geriatric services PAGE 5

Karen Hall, MD, PhD, summarizes for us the work she has been doing with GI geriatric services at the University of Michigan Health System in conjunction with her primary care colleagues.

### Women's health services PAGE 8

Kimberly M. Persley, MD, will tell us about the challenges that exist in building a GI women's health program in a private practice setting at Texas Digestive Disease Associates in Dallas.



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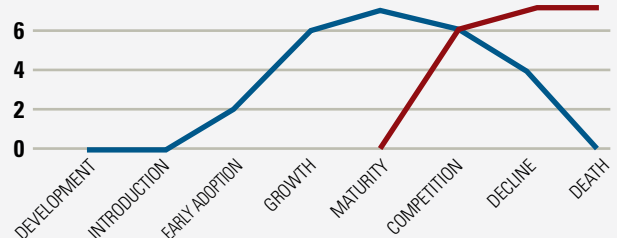
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Gastroenterologists have enjoyed a wonderful period of stability with respect to our endoscopic services; however, we are probably too dependent upon their revenue. They are now under market pressures and are threatened by technological advances that will, in the end, result in declines in reimbursement and utilization. Change can be an opportunity. It's time to embrace the future and adapt.

### BUSINESS LIFE CYCLE

— Product  
— Innovation



# Non-Procedural Nutrition Service Line

**T**raining in nutrition is part of the core curriculum of fellowship training in GI and part of our day-to-day practice of gastroenterology. Reimbursement for nutrition-related procedures and placement of enteral feeding devices, such as percutaneous endoscopic gastrostomy (PEG) tubes or percutaneous endoscopic gastrostomy/jejunostomy (PEG/J) tubes, unquestionably adds to our bottom line. Yet few gastroenterologists or GI practices have evaluated the profitability of a non-procedural nutrition service line or approached this segment of their business in a systematic fashion. Sweeping changes in health-care delivery set in motion by the Patient Protection and Affordable Care Act of March 2010,<sup>1</sup> the advent of accountable care organizations (ACO) and integrated delivery networks (IDN), and recent changes in CMS rulings on reimbursement<sup>2</sup> have all increased the opportunities for gastroenterologists and GI practices to develop profitable non-procedural nutrition service lines.

Over the last 25 years, we have maintained a robust footprint in outpatient and inpatient non-procedural nutritional support in the GI division at the Medical College of Virginia of Virginia Commonwealth University. Several important events recently led us to review and redesign our non-procedural nutrition service line. The first was the ongoing changes in health care and CMS policy on a national level. The second was the understanding of the linkage between obesity and non-alcoholic fatty liver disease (NAFLD). We are now better positioned to address the epidemic of obesity and NAFLD in our patient population. Our changes also address a need within our expanded clinical inflammatory bowel disease operation, which is to deliver care to IBD patients with malnutrition or intestinal failure.

Our patients needing nutritional education and support lie at both ends of the spectrum: underweight patients or patients at risk of malnutrition due to a variety of medical and/or surgical conditions and obese patients at risk for obesity-related health complications, including NAFLD. Delivery of nutritional care for both groups of patients represents an

excellent opportunity for multidisciplinary care, development of partnerships with ACOs and growth in GI practices. Caring for these patients has allowed our practice to increase revenue from this non-procedural business line. The partnership has benefited the health system financially as well.

In this review, I will provide an overview and roadmap for why and how we redesigned our non-procedural nutrition service line, outline the resources we needed to garner to be successful, and then the gains this made for our practice.

## Personalized Medicine: Lipid Disorders, NAFLD and Weight Loss Clinic

### CASE 1:

A 43-year-old executive was referred for evaluation of persistently mildly elevated alanine aminotransferase (ALT) levels. His past medical history was unremarkable. Physical examination identified abdominal obesity (BMI = 42). No viral cause for the elevated ALT was identified. Lipid analysis showed elevated numbers of HDL particles. Liver biopsy demonstrated nonalcoholic steatohepatitis (NASH) with an elevated fibrosis score.

Medications for the lipid disorder were initiated. In consultation with the registered dietician, a weight loss diet and a graded program of exercise was begun. Over the next year, the patient participated in regular behavioral therapy sessions and successfully decreased his BMI to 35 and normalized his ALT.

We targeted our services for patients with obesity and NAFLD in order to address the epidemic of obesity in the U.S. and leverage the increasing numbers of referrals to our practice of patients with abnormal liver function tests thought to be due to NAFLD.

To maximize our opportunities for success in caring for this patient population, we identified several crucial needs:

- A physician with interest and knowledge of liver disease and nutrition.
- A mid-level provider to help extend this segment of the practice.



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- A registered dietician with the necessary nutritional assessment tools.
- A psychologist.
- Dedicated clinic space to house this multidisciplinary team.

## Reimbursement

Physician and mid-level provider services are reimbursed by Medicare, Medicaid and third-party payors. In addition to the billable services for evaluation of abnormal liver function tests and suspected NALFD, the recent expansion of service coverage by CMS and Blue Cross for obese patients allows us to obtain payment specifically for a medical weight loss program in these patients. The CMS-related change request CR7641 informed Medicare providers on coverage of intensive behavioral therapy for obesity.<sup>2</sup> Healthcare Common Procedure Coding System (HCPCS) code G0447 can be used to bill for face-to-face behavioral counseling for obesity (15 minutes) in a primary care setting for patients with an ICD-9 code for BMI > 30: V85.30-V85.39, V8541-C85.45 (ICD-10 codes: Z68.30-Z68.39, Z68.41-Z68.45). This service can be billed a maximum of 22 times in a 12-month period, but only for months seven to 12, if the patient obtains a documented weight loss of 3kg.

## Marketing and Referrals

The dramatic increase in national attention of the epidemic of obesity synergizes with our marketing of this service to patients as personalized medicine. Our team can identify a lipid disorder and the presence of NAFLD, and then develop an individualized medical approach to correcting these problems and achieving weight loss. Our referring physicians find this service very attractive to assist in evaluating and developing a treatment plan in their patients with obesity, abnormal lipid profiles and elevated LFTs thought secondary to NAFLD.

Delineation of this service line is a useful partnership within an ACO, an IDN or an

academic medical center (AMC). It allows for a robust cohort of patients identified and referred from primary care to subspecialty care and for seamless cost-effective care of these patients. The infrastructure and the costs needed to provide expanded service in GI nutrition are shared with the academic medical center or an IDN; this service line facilitates this partnership.

In our institution, we also partner closely with bariatric surgeons in the care of the morbidly obese patient and with the department of surgery, further reducing costs and maximizing reimbursements for all three entities.

## Nutrition Support

### Case 2:

A 27-year-old patient was referred for evaluation of malnutrition. The past medical history was notable for extensive small bowel Crohn's disease. The patient was being evaluated by neurology for possible multiple sclerosis (MS) with symptoms of extremity weakness, inability to walk without losing her balance, diplopia and dysarthria. The patient's Crohn's disease was difficult to manage due to intolerance to azathioprine and 6-mercaptopurine (AZA/6-MP) and reluctance to initiate anti-TNF therapy with a presumptive diagnosis of MS. PE was notable for cachexia with a BMI of 14.

After evaluation by a dietician and metabolic cart analysis, the patient was found to have severe malnutrition and was markedly catabolic. Home total parenteral nutrition was initiated. After eight weeks, the patient's BMI increased to 18 and there was a noted resolution of many of the symptoms leading to evaluation for MS. Initiation of anti-TNF therapy for extensive Crohn's disease resulted in significant improvement in her symptoms and quality of life.

Patients with nutritional deficits represent the opposite end of the spectrum from obese patients. This group of patients also presents a fruitful opportunity for our

division to head a nutritional support team that evaluates and manages inpatient and outpatient nutrition consults and delivery of both enteral and parenteral nutrition (TPN). This service is complemented by the concurrent expansion of our IBD program to attract and care for patients with ulcerative colitis and Crohn's disease, including patients with short bowel and nutritional failure from intestinal Crohn's disease.

## Impact on Patient Care

In partnership with our AMC, development of a nutrition service line to address the needs of patients with malnutrition or at risk of malnutrition also provided benefit to the AMC and to the practice. Providing adequate nutrition is a component of quality care for all patients that shortens hospital stays and decreases the cost of care delivered. Delivery of pre-operative nutrition and TPN, for example, can decrease post-operative complications by approximately 10 percent.<sup>3,4</sup> The nutrition support team, under the supervision of a gastroenterologist, assesses patients and manages their inpatient and outpatient nutrition needs and TPN. Development of a business plan for this service line by GI nutrition, in partnership with our AMC, made it an attractive opportunity for both groups, significantly improved quality of care of these patients, increased reimbursements for our GI practice, and ensured cost-effective care for the AMC.

## Marketing and Referrals

We market this service in conjunction with our expanded IBD operation as one component of our unified digestive health service. This is attractive to our patients who can obtain seamless inpatient and outpatient multidisciplinary care in one place within the AMC. It is also an excellent source of referrals for the patients with nutritional compromise from complicated IBD or other GI disorders.

While our practice does not actively

seek out patients with celiac disease, this could be an attractive opportunity to market this aspect of a GI/nutrition practice with the recent focus of this disease in the GI and lay press alike.

### Staffing

The AMC provides the dedicated contiguous inpatient and outpatient clinic space that houses our nutrition and IBD practice. The personnel needs of the nutrition support team are largely met by the AMC and include registered dietitians, pharmacists, social workers and nurses. One benefit to our practice that was specifically negotiated is the provision of funding for a GI nutrition fellowship position and a mid-level provider funded by the AMC to support this operation in both the inpatient and outpatient venues. These positions, while paid for by the AMC, have the expected positive impact of extending nutrition physician capacity and increasing billing and reimbursement.

### Non-Personnel Nutrition Support Needs

In addition to personnel, other resources required to support the nutrition service line include nutrition, support assessment

## SNAPSHOT OF OUR CLINIC

### NUTRITION CLINIC

**HOURS:** Two half days per week with a physician, mid-level provider, nutrition fellow and clinic support staff.

**SCHEDULE:** Five new patient and 12 established patient visits per half day.

**MULTIDISCIPLINARY CLINIC:** Registered dietitian available for nutrition consultations with patients, office staff, registered nurses for telephone calls, and physical therapy.

**PHYSICAL RESOURCES:** Medical procedure unit run by GI division located in an adjoining building with dedicated radiology and laboratory facilities on site.

### KEY RECOMMENDATIONS

For practices affiliated with larger systems, I would recommend exploring goals, shared resources and responsibilities before embarking on this venture. The infrastructure and costs required to launch a new service line should not be taken lightly; robust planning among all stakeholders is necessary to lay a foundation for success.

tools and guidelines for the evaluation and management of these patients.

There are also hardware needs to support this service line. Measurement of resting or basal metabolic rate can be an important component in the care of the nutrition patient, but requires a metabolic cart or indirect calorimetry. An indirect calorimetry device can be purchased for between \$5,000 and \$10,000. Interpretation of metabolic rate determined by this method can be billed for under code 94690 and ICD-9 794.7 abnormal basal metabolic rate resting.

While CMS will allow reimbursement under these codes only for evaluation of pulmonary disease, other insurance plans allow reimbursement, but require a diagnosis in addition of that of asymptomatic weight loss.

### Financial Impact

The two half days of patient care and related non-procedural billing has generated approximately 3500 work relative value units (RVUs) for our nutrition provider faculty member during the previous 12-month period.

## REFERENCES

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).
2. "Medicare Physician Fee Schedule," Fact Sheet, ICN 006814, Related Change request CR#7641. Effective Date November 29, 2011.
3. Noblett SE, Watson DS, Huong H, Davison B, Hainsworth PJ, Horgan AF. Pre-operative oral carbohydrate loading in colorectal surgery: a randomized controlled trial. *Colorectal Dis.* 2006 Sep;8(7):563-9.
4. Kratzing C. Pre-operative nutrition and carbohydrate loading. *Proc Nutr Soc.* 2011 Aug;70(3):311-5.



# Non-Procedural Geriatric Gastroenterology Service Line

**W**ith the rapid aging of the population, all gastroenterologists who treat adults will see an increasing number of patients in the geriatric age range (65 years and older). These patients represent a majority of the cohort requiring screening and surveillance colonoscopy. However, visits by geriatric-aged patients for other GI complaints such as constipation, diarrhea, weight loss, dysphagia, fecal incontinence and reflux, comprise a significant percentage of the total medical visits to primary care physicians. It is estimated that 30 percent of all adult medical visits are for GI disorders of some kind. Because of this, training in geriatric gastroenterology is part of the core curriculum of fellowship training in GI and trainees should graduate with knowledge of the effect of normal aging on GI function and how to manage elderly patients in their practice.

Recent changes in legislation affecting medical reimbursement, such as the Patient Protection and Affordable Care Act, the formation of accountable care organizations (ACO) and integrated delivery networks (IDN) that stress coordination of care and bundling of services, have created an opportunity for gastroenterologists to better position themselves within an ACO to add non-procedural geriatric gastroenterology care. The barriers to providing care for this population, which might have precluded some centers from considering this option, can be addressed by an alliance with a medical group that provides these services. We think that now is an excellent time for centers that have a large number of elderly patients in their catchment area to evaluate the profitability of a non-procedural geriatric gastroenterology service line.

## Our Approach

We have developed a model within a multi-specialty geriatric clinic at the University of Michigan Healthcare System (UMHS) that allows gastroenterologists to provide non-procedural care while triaging patients for endoscopy and other procedures. Buy-

in by the leadership in internal medicine, gastroenterology and geriatric medicine was necessary to negotiate the use of the geriatric medicine space, while allowing the gastroenterology division to keep the revenues from visits. Two providers with interest and expertise in geriatric gastroenterology formed the initial provider pool and patient demand for “one-stop” specialty and primary care provided the motivation for the development of the clinics.

## Marketing and Referrals

Referrals were initially from within the geriatric medicine division, but quickly expanded through word-of-mouth and internal advertising in the UMHS system. The number of outpatient clinics, involved providers and patients has expanded steadily, with consults and limited follow-up visits comprising the majority of the schedule. Approximately 30 percent of the referrals ultimately require a procedure for diagnosis. The geriatric GI clinic is listed in the specialty clinics on the internal medicine Web page and patients self-refer from a large area surrounding Ann Arbor. We also have developed a large referral pool of primary care physicians both within the UMHS system and in private practice. At this point, we are limited by space from further expansion and have a wait time of two to three weeks to get an appointment.

An important step in developing this service line is to identify a primary care partnership within an ACO, an IDN or an AMC that has geriatric resources. Many primary care physician offices have some, and this type of partnership could leverage the resources of both primary care and gastroenterology to optimize the staffing and space.

## Growing Patient Population

Our most recent expansion has been the addition of a half day geriatric hepatology clinic to address the issues of elevated liver function tests and increasing burden of chronic viral



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hepatitis in our geriatric population. There are a large number of older adults from countries where hepatitis B is endemic who have moved to Ann Arbor to be near their adult children. There is also a growing cohort of people with chronic hepatitis C who were infected in the 1960s-1980s. While some are diagnosed in mid-life and followed in regular hepatology clinics, we anticipate that with the new recommendations for hepatitis C screening in all people born between 1945-1965, a large number of new geriatric (or near-geriatric) patients will be diagnosed with chronic viral hepatitis and require long-term follow-up.

**Potential Expansions**

One issue gastroenterologists face is the potential decrease in revenue with longer, slower visits and decreased reimbursement by Medicare compared to some private insurance. We believe our model can be expanded to include mid-level providers for follow-up visits and initial triage of patient questions. Our clinic has developed models of care for other geriatric problems that use nurse practitioners to provide specialized care for urinary incontinence, foot care and diabetes management. They can also practice independently for routine problems. We believe that a GI nurse practitioner, under the supervision of a gastroenterologist, could improve both the profitability of the clinic and patient satisfaction with telephone follow up and rapid visits.

This model also lends itself to inclusion of other product lines, such as diet counseling for both obesity and weight loss and psychology/biofeedback for motility disorders, such as IBS and fecal incontinence. While we do not perform sigmoidoscopy or anoscopy in our current clinic space, the addition of these non-sedated procedures during patient workup is a straightforward step in a clinic that would provide additional service and revenue. Limitations include the need for dedicated nursing

**SNAPSHOT OF OUR CLINIC**

**GERIATRIC GASTROENTEROLOGY CLINIC**

**HOURS:** Luminal — Monday and Thursday afternoon, two providers each half day; Hepatology — Friday afternoon, one provider.

**SCHEDULE:** Seven patients per half day; 35-40 patients per week.

**MULTIDISCIPLINARY CLINIC:** Geriatric attending available for immediate consultation, geriatric medicine social worker in clinic to provide consultation, if required, and other specialists (neurology, geriatric psychiatry, endocrinology, rheumatology) practice in same clinic space.

**USE OF GERIATRIC MEDICINE CLINIC STAFF FOR SUPPORT:** Medical assistants, office staff, registered nurses for telephone calls and basic procedures (enemas, wound care), social work, physical therapy.

**PHYSICAL RESOURCES:** Medical procedure unit run by GI division located in an adjoining building, dedicated radiology and laboratory facilities on site, shuttle bus to main hospital.

**KEY RECOMMENDATIONS**

- Do a pre-needs assessment of the demographic distribution of patients in your catchment area to define the geriatric population. Compare this with your existing clinic population.
- Contact patient advocate groups to get their perspective on whether they would preferentially come to a “Geriatric GI Clinic” — you may find more patients than you expected.
- Investigate whether there is an existing geriatric medicine group that you can collaborate with. If your organization is negotiating joining an ACO, a geriatric GI clinic may provide perceived added value by the ACO that would result in increased shared reimbursement.
- Does your facility have appropriate support for older patients? Examples include the tests and procedures (including swallowing disorders and endoscopy) that older patients need, but also consider social work and pharmacy. Can the latter be shared by other specialties in a group practice? Do you have valet parking, which is very popular with older patients, and can be advertised?
- Is your facility elder-friendly with no stairs, wheelchair-accessible sliding doors, and wide corridors for walkers and wheelchairs? Older patients who ambulate on their own at home often come in the clinic in a wheelchair due to long distances from parking to facility. Factor the costs of renovations into the decision. Is your staff elder-friendly and interested in this population?
- Do the math — does Medicare reimbursement pay your costs? Does being in an ACO or academic facility share the risk in a more cost-effective way?

assistance during procedures and equipment cleaning and maintenance.

**Reimbursement**

Physician and mid-level provider services are reimbursed by Medicare and Medicaid and by third-party payors. The baby boom cohort, in particular, often have third-party insurance that pays more than Medicare. This cohort is also very interested in rapid access to services. The very elderly patients often require multiple people with them during the visit and families appreciate the efficiency of a “one-stop” clinic.

The addition of a “Welcome to Medicare” new patient visit has enriched our clinic population with “young-old” patients in the 63 to 68 age range; it turns out many of these patients have chronic motility disorders, such as IBS and chronic

GERD. This clinic can also provide a center for weight loss in the older patient. We have an increasing obesity problem in this age group in Michigan, and have discussed expansion of our diet counseling services to allow us to take advantage of the new billing codes for weight loss counseling by mid-level providers.

**A Teaching Resource**

The product line has also become a valuable teaching resource for the internal medicine residency program and the medical school. Because the clinic can guarantee a high volume of elderly patients with GI problems per half day, rotations in the geriatric GI clinic satisfy requirements for geriatric patient exposure for our third-year medical students, internal medicine

residents, and fellows in geriatric medicine and gastroenterology. With this model, GI fellows also have the opportunity to provide continuity of care for procedures and follow-up visits.

### Financial Impact

- The clinic space costs are covered by the ambulatory care unit group at the University of Michigan, but the gastroenterology division covers the costs of the medical procedures unit and staff.
- A substantial percentage of patients

referred to the geriatric GI clinic end up requiring endoscopy (~75 percent) and most patients are seen as a new consultation with one to two follow-up visits. There is a strong referral base within the geriatric medicine division, internal medicine and family practice. The four GI clinics handle at least 25 patients per week.

- Medicare is considering two new reimbursement codes to encourage rapid follow up after hospitalization (within seven to

14 days) by the patient's primary care physician.

- We have leveraged funds from the federal government for pilot studies using the geriatrics primary care and specialty clinics to assess quality care and Medicare savings provided by an interdisciplinary practice. This is an opportunity that is going to be available for several years, as the government is clearly more open to innovation and change to preserve Medicare for future generations.

# Non-Procedural Women's Health Service Line

**“W**hy can't a woman be more like a man?” I can recall hearing this famous quote from the musical, *My Fair Lady*, several times during my fellowship training. This quote was usually uttered during a difficult colonoscopy in a female patient, as we were trying to advance the colonoscope through a tortuous sigmoid colon, which involved changing to a pediatric colonoscope and applying abdominal pressure to the abdomen in order to advance the scope to the cecum. I became aware early on in my GI training that there were many differences in male and female patients. Although gastrointestinal disorders were quite common in both men and women, digestive disease symptoms and outcomes could be quite different if the patient was male versus female. I soon realized that there were some diseases that disproportionately affected women. I also realized communication was different between doctors and patients, based on gender.

I was the first woman to join a four-person GI practice and I was quite surprised to see how quickly my office filled with female patients. It was not initially my intention to have women's clinic for digestive diseases, but I began seeing patients who had been waiting a long time to see a female gastroenterologist to address issues from colon cancer screening to pelvic floor dysfunction.

After completing a three-year GI fellowship program, I decided to do an additional year with a focus on inflammatory bowel disease. I saw many patients (male and female) with Crohn's disease and ulcerative colitis when I started my practice. However, I quickly noticed how many female patients filled my office schedule. It soon became clear that there were specific and unique medical issues affecting my female patients that required an integrative, multidisciplinary approach to treat not only my patients with inflammatory bowel disease, but also many of the female patients whom I was seeing in the practice.

Why focus on digestive health in women?

Digestive disorders are common in men and women, but the gastrointestinal health of women can be quite unique. Digestive health in women can be influenced by hormonal fluctuations, pregnancy and childbirth. Many women have a gender preference for a female endoscopist, and these women may be willing to wait longer for an office visit or a procedure performed by a female endoscopist. The gender preference is greater among women compared to men. Also, gender preference can be seen in patients of a lower income bracket or who have had a history of physical or emotional abuse.

It is important to realize that these differences and preferences exist. Once recognized, we can create a practice to meet those specific needs for our female patients.

## Establishing the Need for a Women's Health Clinic

The first step in creating a women's health clinic is to ask: “Is there a need for a specific women's health clinic?” It is currently estimated that about 50 percent of women age 50 or older actually undergo colon cancer screening with colonoscopy. There are probably several reasons why only half of female patients are having adequate colon cancer screening; these may include cost, fear, non-referral by primary care physicians and gender preferences for female endoscopists. Patients may specifically request a female gastroenterologist. Moreover, referring physicians may look for a practice that has female providers to see patients who have gender preferences. If the need is identified within the community or practice, then efforts should be made to accommodate that patient preference.

## Develop a Vision

Once the need has been identified, the next step is to set a vision for the clinic. The clinic may take on a “spa” like feel or it could be a traditional clinic with a particular physician expertise/interest in women's health issues. Some practices incorporate



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massage therapists, along with dietitians, mental health providers and acupuncturists, to attract patients. The type of women’s digestive health clinic depends upon the vision of the provider. Mental health, another area that I wanted to incorporate, required the addition of a clinical psychologist to address the psychosocial issues that may contribute to gastrointestinal symptoms.

Women’s services are important to our hospital administration. My practice is located on campus and is connected, physically, to a 700-bed community hospital and professional offices. On our campus, there is a dedicated women’s and infants’ hospital. My first few months on campus, I was asked to give a grand rounds lecture to the OB/GYN staff on functional bowel disorders. As the first female gastroenterologist on campus, I became quite busy with new referrals.

We have a fitness center that offers nutritional counseling, massage therapy and an exercise facility; proper nutrition and exercise are extremely important for adequate gastrointestinal health. I have been encouraged by the number of patients who actually appreciate and participate in these alternative therapies to treat many gastrointestinal disorders.

**Ancillary Services**

Next, the clinic needs to decide if all providers will be encompassed in the same physical space. Bringing in a dietician may be a good starting point. Many patients will have questions regarding the role of diet in treating a particular digestive disease. Women may have detailed dietary questions that require more discussion than can be addressed in an office consultation/follow-up visit. Unfortunately, medical nutrition counseling may not be covered by insurance. If not covered, many patients will pay out-of-pocket at a discounted rate. Referrals for nutrition counseling have been helpful to many of my patients

**SNAPSHOT OF OUR CLINIC**

**WOMEN’S GASTROENTEROLOGY CLINIC**

**HOURS:** Two half days a month, a female gastroenterologist will see female patients with a clinical psychologist.

**SCHEDULE:** Three to five patients per half day, two times a month.

**MULTIDISCIPLINARY CLINIC:** A clinical psychologist will provide consultation for patients with functional bowel problems, depression and anxiety contributing to digestive problems.

**PHYSICAL RESOURCES:** Our gastroenterology practice is on the campus of a large, referral, private hospital, which includes a dedicated women’s hospital, and allows quick referrals to gynecologists, GI labs (anorectal manometry), nutritionists and exercise facilities.

**KEY RECOMMENDATIONS**

When deciding to develop a women’s clinic, it is important to:

- Identify a need in your individual practice.
- Make sure that physicians in the practice have an interest in women’s digestive health and wellness.
- Develop a practice model to suit your practice and financial goals.

At our practice, our goals were to:

- Provide women with a thorough evaluation of symptoms, including appropriate referrals.
- Provide a comfortable setting for women undergoing invasive endoscopic procedures.
- Increase the number of women undergoing routine screening for colon cancer.

We succeeded in all three.

with IBS, GERD and weight management.

Irritable bowel syndrome is found in 10 percent to 20 percent of the U.S. population, and most IBS patients are women. IBS visits account for a large percentage of visits to the GI practice. Treatment may require dietary and psychological intervention. The dietician and a mental health professional will help these patients clinically with their IBS symptoms.

Additional services could include mental health providers, which may include a life coach, and massage therapist.

**Schedule**

Decide how often the clinic will operate. A weekly, bimonthly or several times a month clinic devoted to women’s health may help schedule resources and ancillary services on the days when the largest numbers of women are in the clinic. Additional providers may be present on those days to address specific women’s digestive issues.

**Marketing and Referrals**

An increase in patient referrals and improved patient satisfaction are the

obvious benefits of a women’s health focus. I found the following tactics helpful to get the word out about our women’s health clinic:

1. Networking with physicians with similar experience will likely result in additional referrals.
2. Speaking to women’s civic organizations with presentations on hot GI topics from colon cancer screening to pelvic floor dysfunction.
3. Advertising the new service line on the practice website.
4. Reaching out to family practice, internal medicine and gynecology groups will also grow the new service line. Explaining the ancillary services offered, including the use of dietician and mental health providers, has been very attractive to referring physician.

In addition, I recommend identifying gynecologists, gyno-urologists, colorectal surgeons and internists with similar interests. Establishing relationships with these providers

allows easy referrals. A focus on pelvic floor dysfunction, a common problem in female patients, should be strongly considered; damage of the anal sphincter can occur in 30 percent of women at the time of vaginal delivery and fecal incontinence may be quite embarrassing for patients to talk about. A women's health focus may make it

easier for the patient to discuss this embarrassing issue with the health-care provider.

To conclude, a women's digestive focus has resulted in more patients coming to the practice, improved patient comfort and overall patient satisfaction.

## **Financial Impact**

From a financial standpoint, our practice has seen an increased number of referrals from primary care and OB/GYNs. Importantly, we have also increased the number of women undergoing routine screening for colon cancer. As a result, our practice has seen increased revenue and market share.

