

Sample business plan presentation to Admin

7/13/22

AFib is a growing national health concern



<10%

Drug-resistant paroxysmal AFib remains significantly undertreated with less than 10% undergoing ablation^{1,2}



50%

Over 50% of AFib patients do not respond to or cannot tolerate drug therapy³



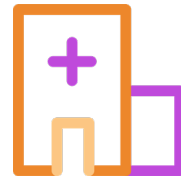
5X x2

Risk of heart failure and risk of stroke are both five-fold in patients with AFib⁴



5.5 MM

Estimated number of individuals with AFib in the U.S.¹



750,000

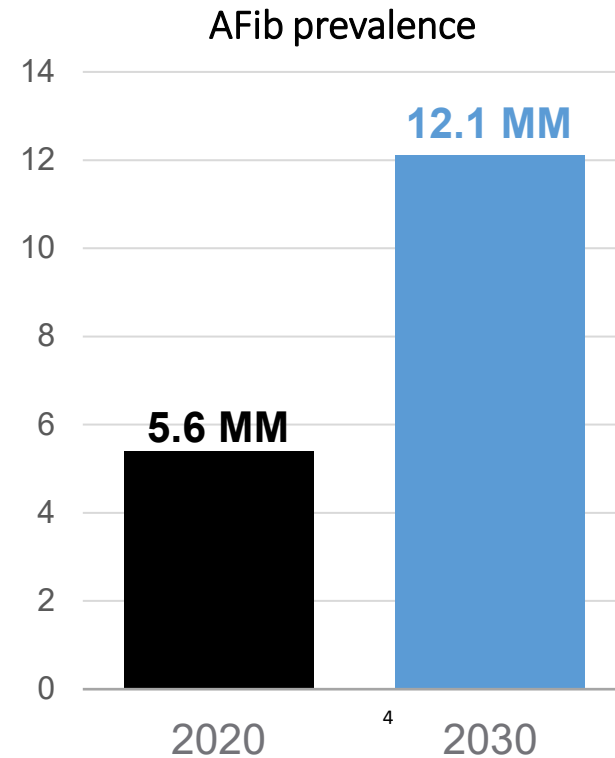
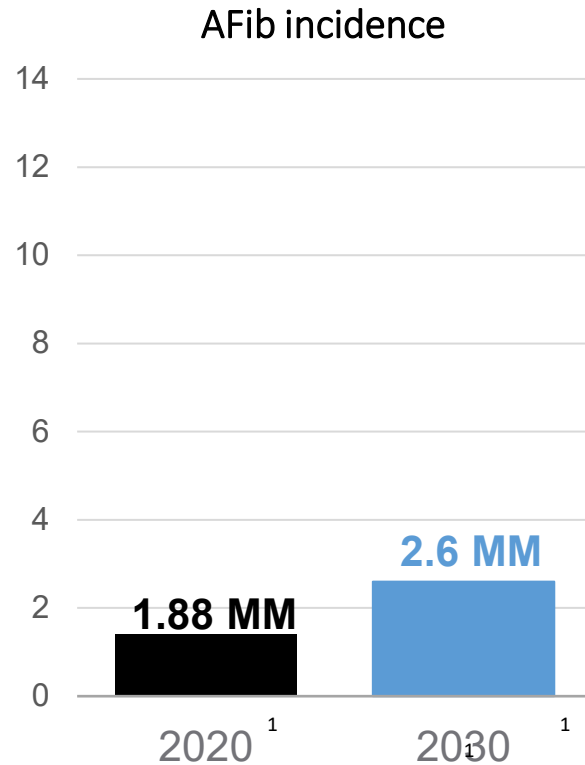
People in the U.S. are hospitalized and ~ 150,000 deaths from AFib each year⁴



\$35.7 B

In the U.S. alone, AFib puts an estimated \$35.7 billion burden on the health care system each year¹

US incidence of AFib projected to more than double¹



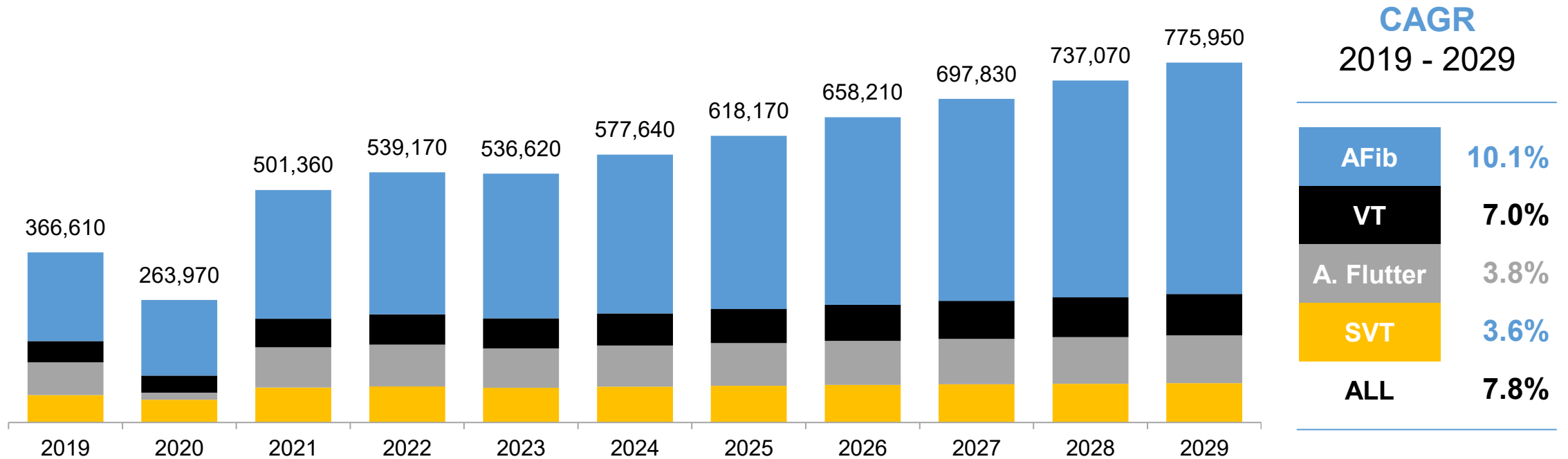
Growth attributed to:

- Growing elderly population¹
- Improved AFib diagnostic procedures¹
- Improved survival rates in those with coronary artery disease, heart failure and hypertension²
- Lifestyle factors³

An increase in the prevalence of AFib is likely to be exponential and sustained in the foreseeable future.²

1. Colilla, A, Crow, A et. Al. Estimates of Current and Future Incidence and Prevalence of Atrial Fibrillation in the U.S. Adult Population. American Journal of Cardiology, 15 October, 2013. Vol. 112, Issue 8, pp. 1142-1147. 2. Bajpai A. Epidemiology and Economic Burden of Atrial Fibrillation; 2007 US Cardiovascular Disease p14-17. 3. Hugh Calkins, Gerhard Hendricks, Ricardo Cappato, et al. 2017 HRS/EHRA/ECAS/APHS/SOLACE expert consensus statement on catheter ablation and surgical ablation of atrial fibrillation 2017. 4. Nelson, Sue, et al. "Projections of cardiovascular disease prevalence and costs." RTI Int., Res. Triangle Park, NC, USA, Tech. Rep 214680.001.001 (2016).

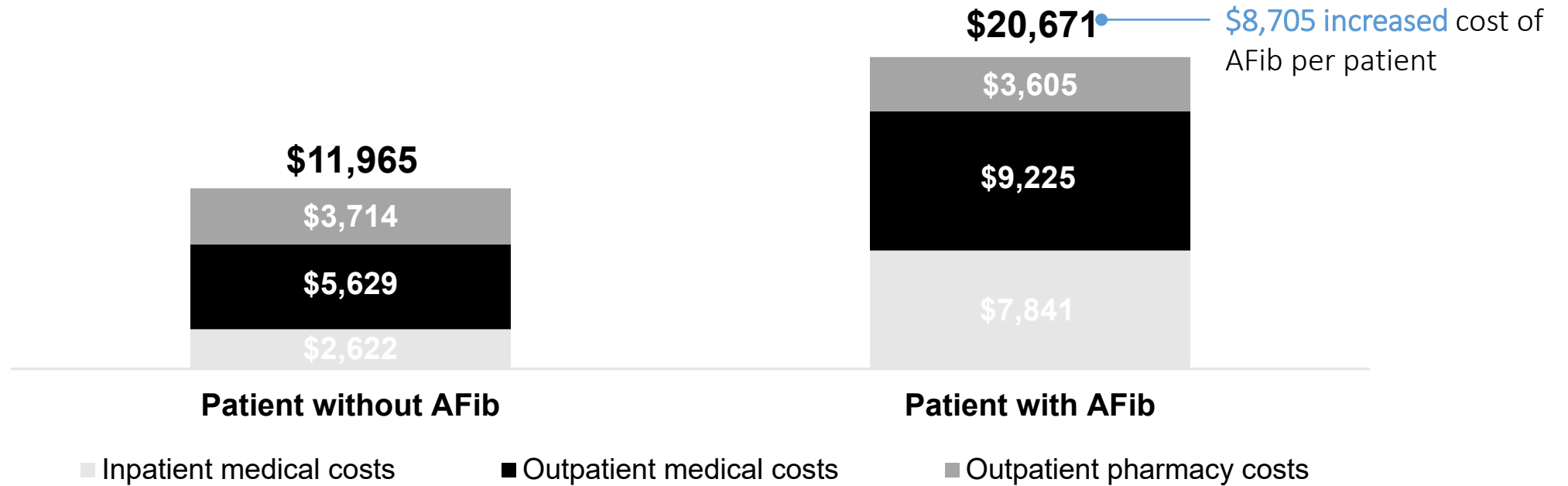
AFib ablations are forecast to grow 10.1% with over 750,000 procedures by 2029



All ablation procedure types in U.S. will continue to increase.

Economic burden of Atrial Fibrillation

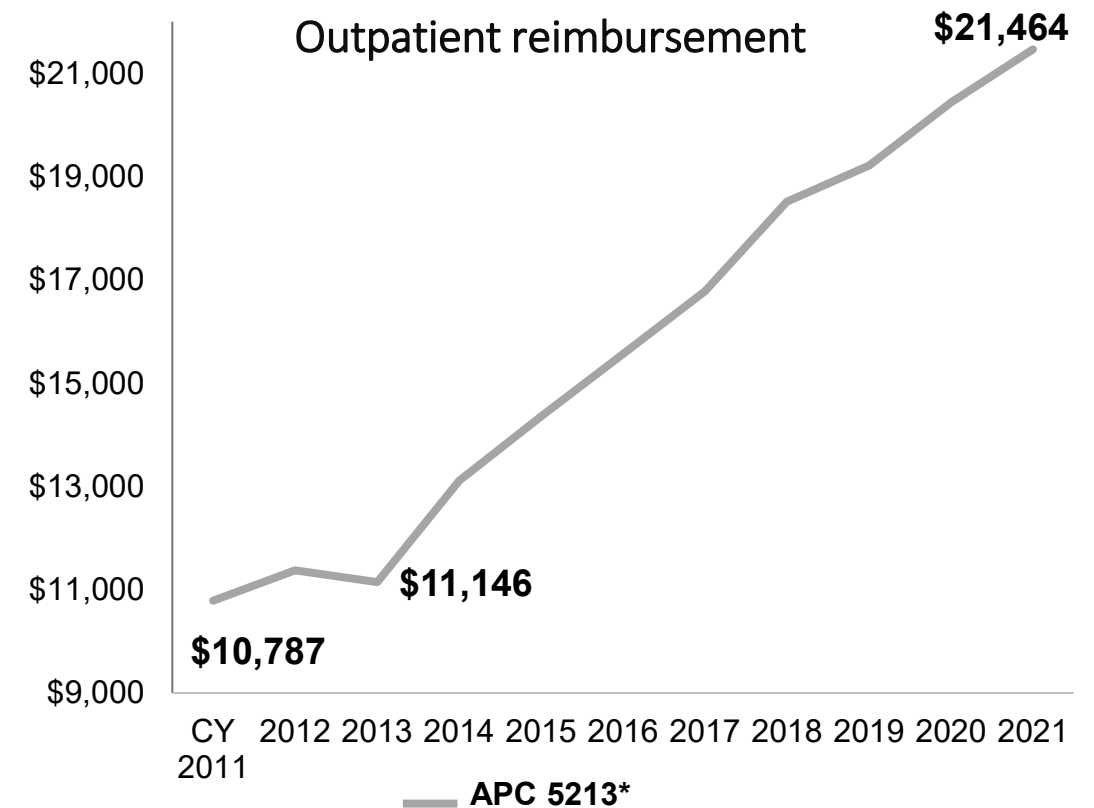
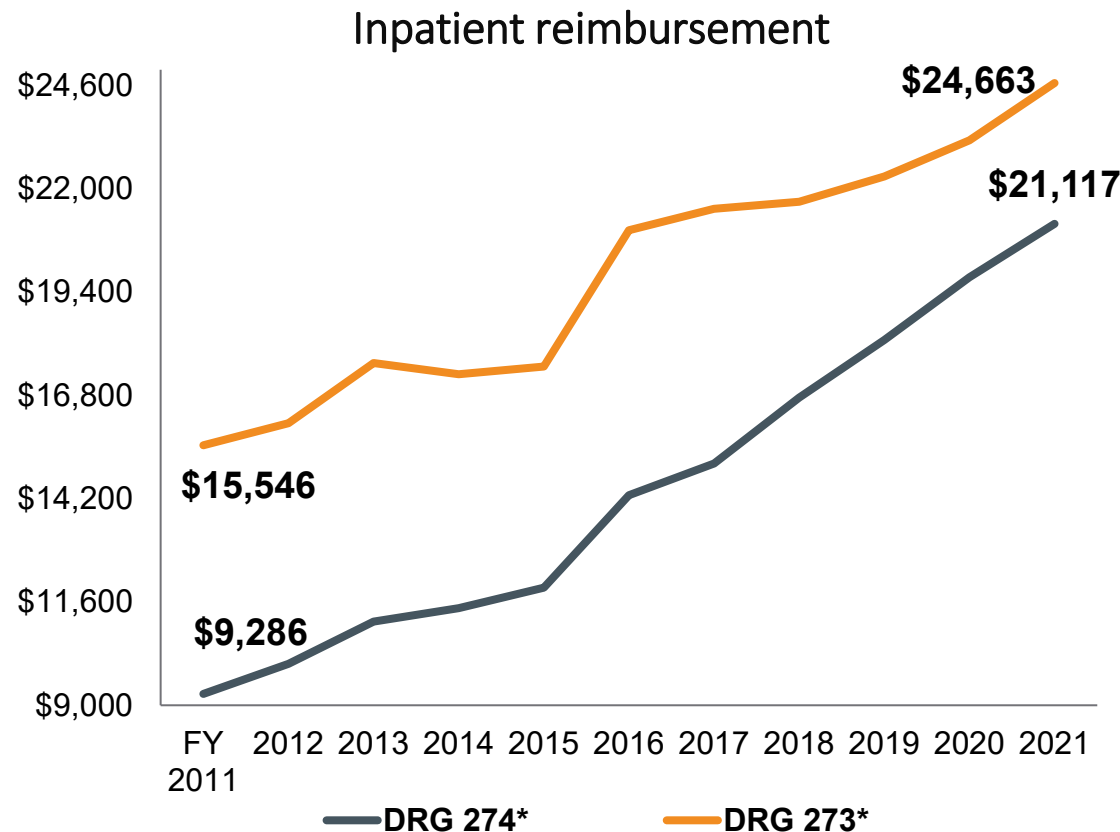
Annual incremental cost of AFib^{1,2}



In the US, the incremental costs for treatment of AFib was projected to be \$37.2 billion in 2020 and is expected to grow to \$65.7 billion by 2035.³

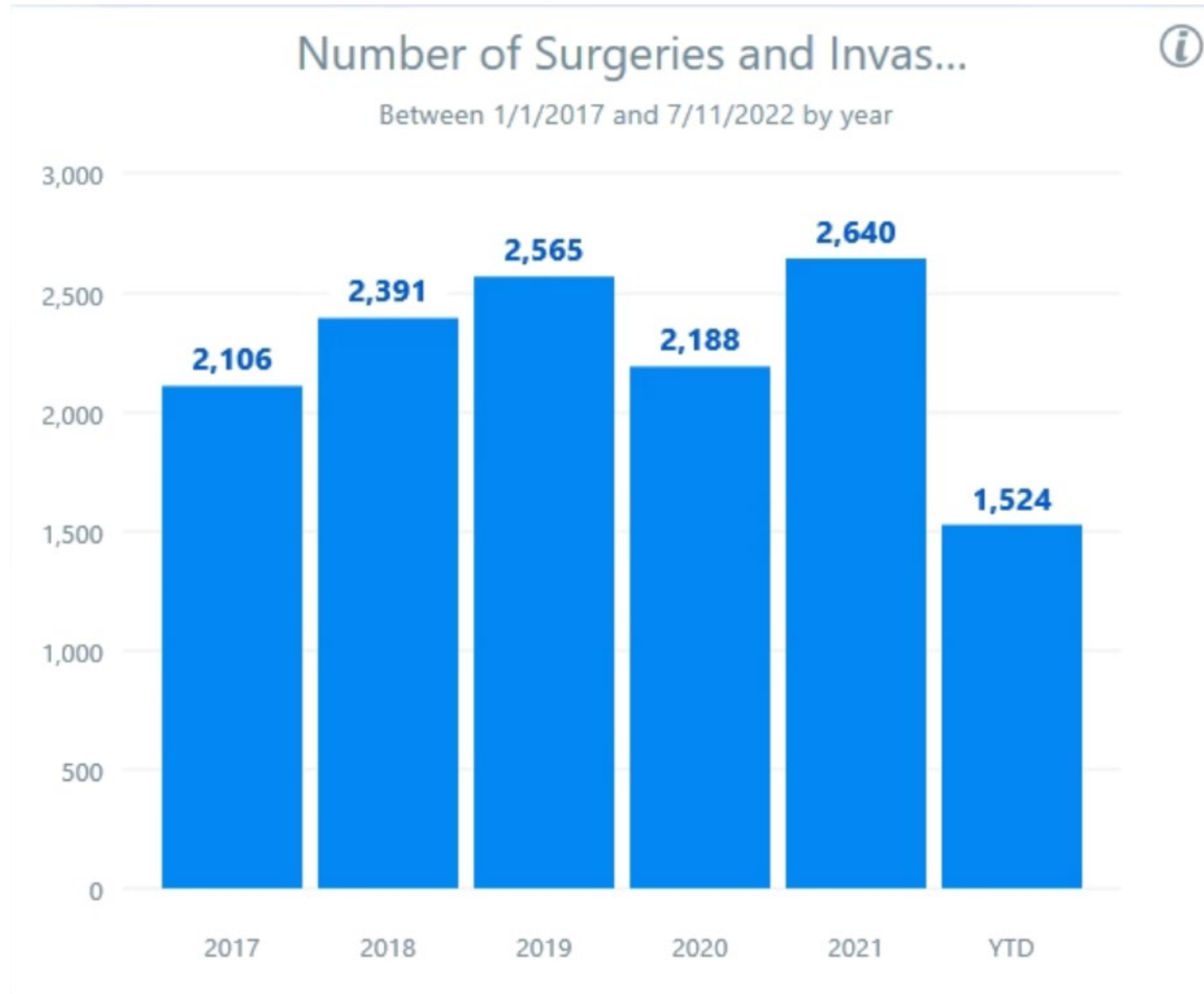
1. Kim MH et al., "Estimation of Total Incremental Health Care Costs in Patients with AF in the US," *Circulation: Cardiovascular Quality and Outcomes*, 4 (2011):313-320. 2. Projections of Cardiovascular Disease Prevalence and Costs: 2015-2035. Sue Nelson, Laurie Whitsel. American Heart Association. RTI International, November 2017. 3. Projections of Cardiovascular Disease Prevalence and Costs: 2015-2035. Sue Nelson, Laurie Whitsel. American Heart Association. RTI International, November 2017. Khavjou, Olga, D. Phelps, and A. Leib. "Projections of cardiovascular disease prevalence and costs: 2015-2035." Dallas: American Heart Association (2016).

Average outpatient ablation Medicare reimbursement has more than doubled since 2011

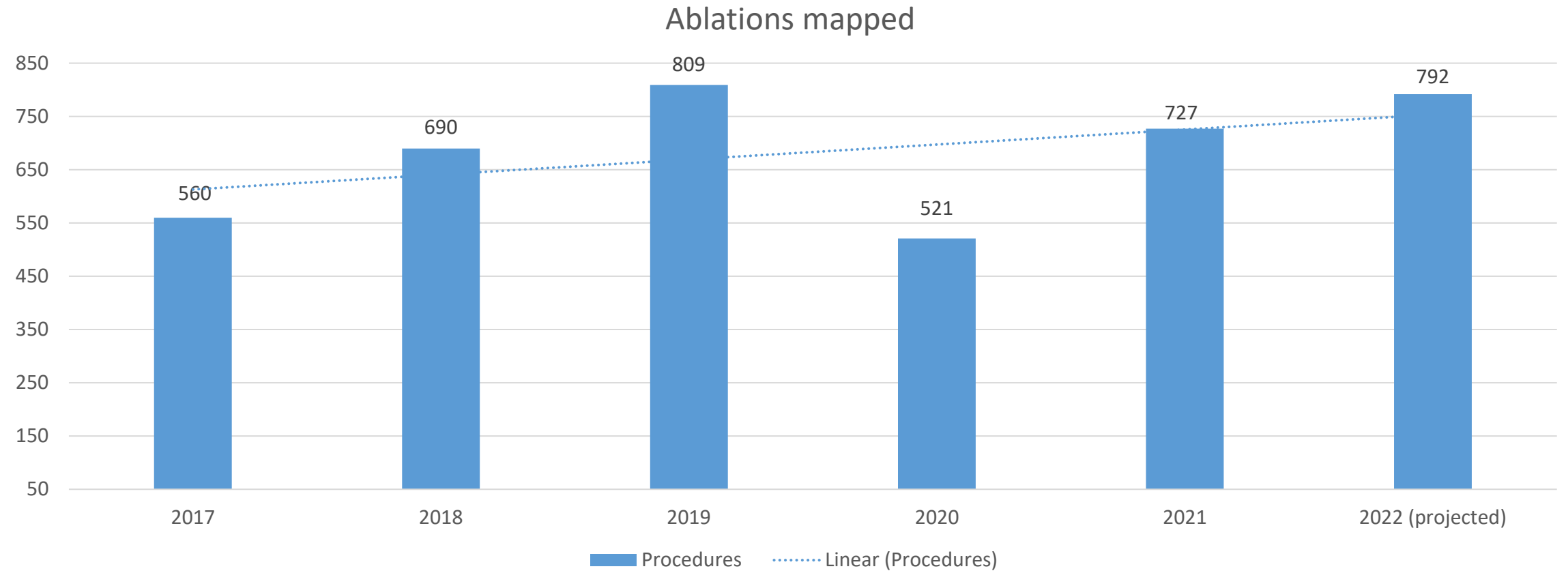


*Prior to 2015, hospital inpatient ablation procedures were assigned to MS-DRGs 250/251. In FY 2016, two new MS-DRGs 273/274 were created to improve clinical similarity and better reflect resource utilization. Prior to 2016, hospital outpatient ablation procedures were assigned to APC 8000 and APC 0086. In CY 2016, ablation procedures were re-assigned to APC 5213. CMS-1735-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2021 Rates. CMS-1736-FC Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System and Quality Reporting Programs Changes for 2021.

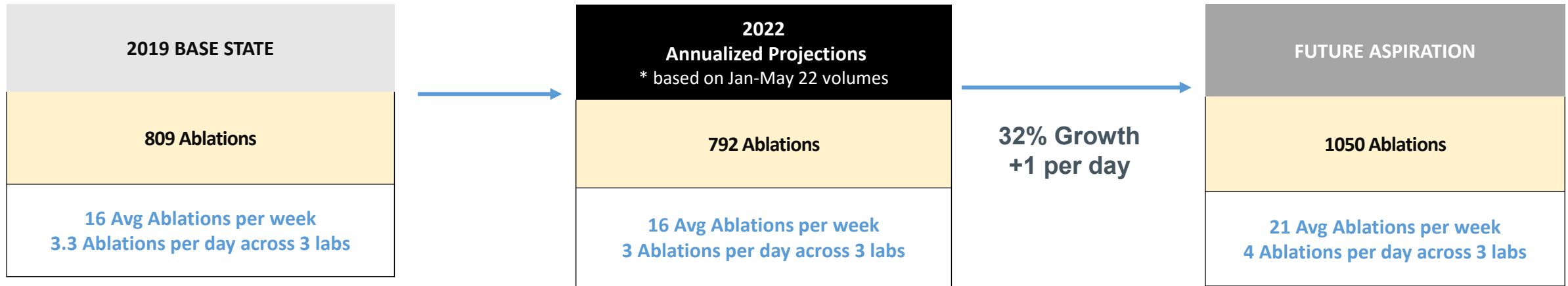
Total EP Lab Procedures



EP Ablation Volume



Maximize resources and time savings to treat more patients



- **Strengths:** 3 dedicated EP labs, excellent procedure times, same-day discharge
- **Bottlenecks:** anesthesia coverage, clinic optimization, staffing, standardized ED protocols

1

Lab Efficiency

- Optimize scheduling to avg 4 ablations per day across current 3 labs

2

Staffing

- Dedicated anesthesia and EP Staff to adequately staff 3 labs until 5pm

3

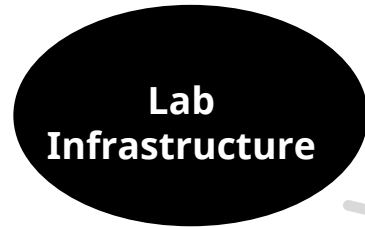
Clinic Optimization & Staffing

- Ensure patient intake/practice structure can support increased ablation volume created by enhanced operational efficiencies and staffing
- AF Coordinator
- APP Led AF Clinic

2022 Trajectory

2022 Current Projections
792 Ablations
16 Avg Ablations per week

- Execute New Staffing Plan
- Staff Retention
- 3 Dedicated CRNAs



- AFib Coordinator
- APP Led AFib Clinic
- PCP/ED Pathways



- Continue with current staffing
- Loss of Lab Time
- Staff Burnout



- Increase Diagnosis to Ablation Time
- Increased Wait Times
- EPs Spending More Time in Clinic

FUTURE Potential State
1050 Ablations
21 Avg Ablations per week

32% Annual Growth

FUTURE Potential State
750 Ablations
15 Avg Ablations per week

5% Annual Decline

Leadership Strategy & Physician Alignment

Desired State

- Run 3 EP labs from 7:30AM – 5PM Monday – Friday
- One simple procedure room (Cardioversions, tilts, loop recorders) from 7:30AM-5PM
- Device interrogations on floors and MRI department 7:30AM – 5PM
- One charge nurse daily to coordinate staff in all 4 labs
- One PA assigned to each lab
- Anesthesia needs to mirror the EP lab staffing plan with 3 CRNA's working 10 hour shifts and dedicated EP anesthesia team

Current State of EP Lab Staffing

Staff on leave and resignations

- Two EP lab Techs are on medical leave
- One nurse resigned and left for traveling opportunity
- EP lab tech resigned and took job at another hospital back in May – position still not filled
- Another nurse is going to part-time in August and is nearing retirement
- Nearly lost another experienced nurse to the office

Why?

- Illness & Injury
- Travelers being paid up to 4x salary
- Burnout due to understaffing
- Poorly designed staffing model – 8 hour shifts do not work for the case volumes we have been doing.
- Lab staff productivity has been ranging from 120-140% due to call and overtime.

EP Lab Staffing Crisis

- Due to inadequate staffing, we have had to close one EP lab in 17/30 days in this block of scheduling.
- For next 6 week block, one EP lab will be closed in 25/30 days.
- We anticipate a decrease in >100 cases over the next two blocks of scheduling! Approximately 4M in lost revenue.
 - Many of the cases being postponed are the higher revenue outpatient/elective ablation cases.
- Leading to a delay in patient care, decreased patient satisfaction, and diminished volumes.

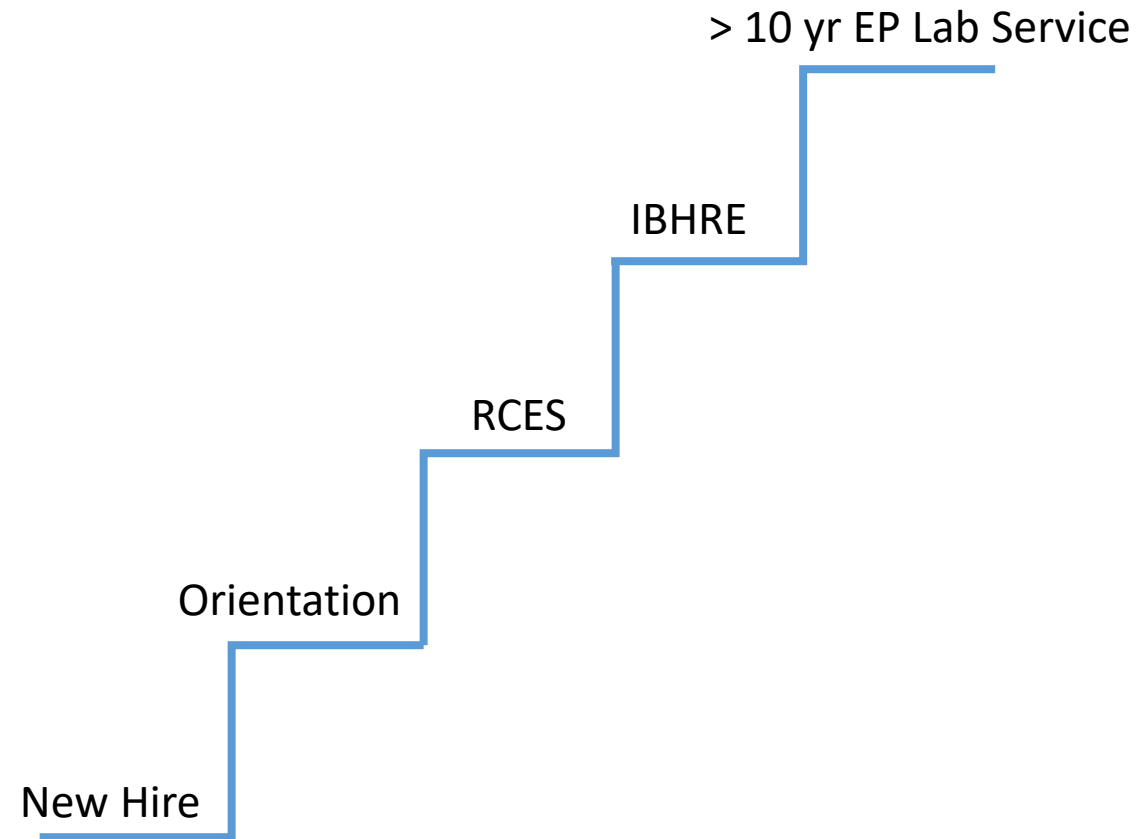
Staffing Model

Position	# Staff per day	Hours per week	# Staff Needed	Current Staff
EP Lab Staff	4x3=12	600	19	14 (budgeted)
Simple Procedure Room	2	100		
Charge Nurse	1	50		
Device Specialist	2 (M,W,F) 1 (T, TR)	80	2	1
Physician Assistants	4	200	5	1

Opportunities for More Effective Partnership

Clinical Ladder and Staff Retention

- Takes 6 months for new hires to make it through orientation
- Specialty pay has diminished with new contract
- Propose a clinical ladder
 - Specialty pay re-established for staff that make it through orientation
 - Certification and Years of Experience Rewarded with Increase in pay



Specific Asks for Procedural EP Services

- 5 staff for EP lab
 - 2 nurses
 - 2 technicians or technologists
 - 1 echo tech
- 1 Device Specialist
- 4 Physician Assistants
- 1 Cardiac Transporter Tech
- 3 Schedulers (either inpatient or under medical group/outpatient)
- Anesthesia commitment to staffing 3 labs from 7am-5pm
- Renovation of EP lab 4 and construction of procedural area for cardioversions, tilt table tests, and loop recorder implants

Outpatient Staffing Ratios

Position	Staffing Ratio Based on National Survey	AGH Current	Deficit
APP	2:1	8.5 (no open) 1 on leave	5.5
Scheduler	1:1	4 2 inpt and 2 outpt – one being used for authorizations	3
RN's	2:1	9 (2 open and one on leave)	5
MA's	2:1	1 (1 open)	12

Outpatient Practice

- >90% slot utilization in clinic
- Current providers are maxed out
- Nurses and NP's spend much of their time screening phone calls, scheduling patients, and prepping charts.
- 4 nurses have quit in past 2.5 years due to inadequate ancillary support and excessive work for a single nurse.

Atrial Fibrillation Clinic and Outpatient Practice Optimization

1

Increase Patient Access through Standardized Care Pathways

AFib clinics were associated with an **average reduction of 10 weeks** in wait time³

2

Create capacity through clinic and lab optimization

Following implementation of an AFib clinic, up to **82% reduction** in AFib-related ED visits²

3

Decrease Diagnosis-to-Ablation Time

AFib clinics had **58% shorter** diagnosis-to-ablation times.⁴

4

Improve Patient Satisfaction and Outcomes

Diagnosis-to-ablation times of ≤ 1 year are associated with a **27% less risk of AFib recurrence** compared to >1 year.⁴



“The goal of an AF “center of excellence” (CoE) is to **improve outcomes** by providing a **better patient experience** and delivering **high-quality, guideline-recommended, state-of-the-art care.**”¹

Additional slides

Minimum Staffing Ratios

EP Lab/inpatient

Position	Staffing Ratio National Survey (per lab)	AGH Current	Deficit
APP	1:1 (4 MD's present per day)	1	4
RN	3:1	10 (1 in training)	3
Scrub Tech	2:1	6 (1 open)	2
CRNA 1.5:1	1.5:1	3	1.5