10 Key Steps to Immediately Improve Profits

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The Ten Keys…

- Managing Change
- Materials Management
- Case Costing
- Recruiting New Physicians
- Staffing
- Schedule Compression
- Financial Management
- Billing and Collecting
- Benchmarking
- Staying focused on…

Manage Change

- Learning Culture
- Leadership
- Communication

Managing Change

"If you use Mom's stove, Mom's recipe, and Mom's ingredients, you'll get her cake."

This cake is flat!

Managing Change

- Foster a Learning Culture…
  - Peter Senge – *a learning culture is a group of people who are continually enhancing their capabilities to create what they want to create*
    - Director of the Center for Organizational Learning at the MIT Sloan School of Management
      - B.S. in Aerospace engineering which proves once and for all…..
    - ***The Fifth Discipline*** & ***The Fifth Discipline Fieldbook***: the art and practice of learning organizations & strategies and tools for building a learning organization

Managing Change

- Leadership:
  - Who spearheads the change?
  - Who needs to buy in?
  - How do you convert others?

Stakeholder Planning

Who has the Power? Who has the Interest?

- What financial or emotional interest do they have in the outcome of your work? It is positive or negative?
- What motivates them most of all?
- What information do they want from you?
- How do they want to receive information from you? What is the best way of communicating your message to them?

Stakeholder Planning

Who has the Power? Who has the Interest?

- What is their current opinion of your work? Is it based on good information?
- Who influences their opinions generally, and who influences their opinion of you?
- How will you win them around or manage their opposition?
- Who might be influencing their opinions?

Power-Interest Grid

with Stakeholders Marked

Minimizing OR Costs

Ladder of Inference*

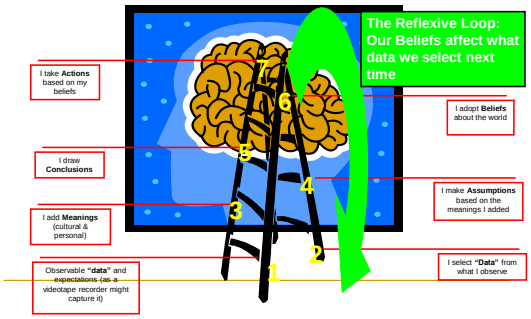
- Our beliefs are *the* truth
- The truth is obvious
- Our beliefs are based on real data
- The data we select is the *real* data

*Senge, Peter, The Fifth Discipline Fieldbook, pgs 242-246.

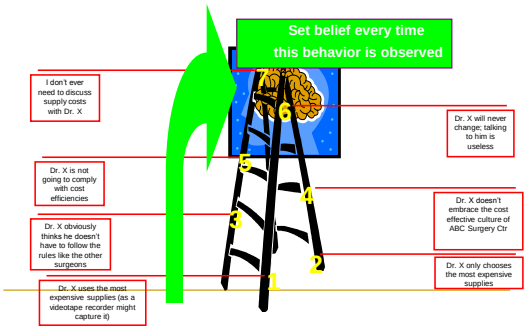
Using the Ladder of Inference: Recalibrate Thinking

- What is the observable data?
- Does everyone agree on what the data is?
- Can you run through the reasoning?
- How did we get from the data to the abstract assumptions?
- When you said (what was inferred), did you mean (what was interpreted)?

Ladder of Inference – How It Works



Ladder of Inference – An Example



Communication - Balancing Inquiry and Advocacy*

- Advocacy: Present and argue strongly for one's position or belief
- Inquiry: Lay out reasoning and thinking to learn about others views and have them learn about yours
- Goal: Create dialogue for movement towards and acceptance of change; road to continuous improvement

14 *Senge, Peter. The Fifth Discipline Fieldbook, pgs. 253-263

Conversational Recipes for Improved Advocacy

What to Do	What to Say
State your assumptions and describe the data that led to them	*"Here is what I think, and here is how I got there?"*
Explain your assumptions	*"I assumed that . . ."*
Make your reasoning explicit.	*"I came to this conclusion because . . ."*

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Conversational Recipes for Improved Inquiry

What to Do	What to Say
Gently walk down the ladder of inference and find out what data they are operating from	"*What leads you to conclude that? What data do you have for that? What causes you to say that?*"
Use unaggressive language, particularly with people you are not familiar with these skills. Ask in a way which does not provoke defensiveness.	"Instead of "*What do you mean?*" Or "*What's your proof?*" Say "*Can you help me understand your thinking here?*"
Check your understanding of what they have said.	*"Am I correct that you're saying . . ."*

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Conversational Recipes for Balancing Advocacy with Inquiry

When . . .	. . . You might say
Strong views are expressed without any reasoning or illustrations	"You may be right, but I'd like to understand more. What leads you to believe . . .?"
The discussion goes off on an apparent tangent . . .	"I'm unclear how that connects to what we've been saying. Can you say how you see it as relevant?"
You perceive a negative reaction in others . . .	"When you said (give example)…I had the impression you were feeling (fill in emotion). If so, I'd like to understand what upset you."

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Materials Management

- Supply costs are one of the 2 largest expenses in ASCs
- Costs are controllable
- Must be closely monitored
- Checks and balances must be in place
- Embrace technology

Materials Management (Inventory)

- Utilize software inventory module
- SourceMedical reports 25% - 30% of centers have a good handle on full perpetual inventory control (tracking quantity on hand)
- QOH – Item in software matches what's on shelf
- Requires that total inventory system is utilized
  - Create POs
  - PO receiving
  - Physical counts
  - Preference cards
  - Adjustments in bulk items
  - Spot inventory checks
  - Par level
  - Location level maintenance

    - Gary Clark, Regional Vice President, Sales, SourceMedical Solutions, Inc., September 7, 2010

Materials Management

- Most centers do some form of inventory maintenance
  - Time and labor intensive
  - Attention to detail is critical
- ASCs cannot afford to ignore the computerized inventory system

The devil's in the details

Materials Management (Inventory)

- Assign one person to enter data
- Use standardized language to build categories of supplies
- Enter current, updated preference cards
- Determine unit pricing
  - Unit of measure: smallest quantity that can be utilized and to which a cost can be assigned; unit used for case costing
- Ensure vendor information is accurate, inc. terms of payment
  - Due on receipt
  - Net 10
  - Net 30
  - 2% discount if paid within 15 days

Materials Management (Inventory)

- Materials Management role
  - Assign to one person
  - Not necessarily a full-time FTE, especially during start up
- Set up internal controls
  - Assigns authorization to purchase, establishes control of assets, allows for valuation of goods
- Maintenance of inventory information
  - Current
  - Loaded in computer system
  - Verified upon ordering and again when invoiced

Materials Management (Inventory)

- Limit inventory on hand
  - Consider how often supplies are delivered
  - Review surgery schedule 1 week ahead
  - Ensure supplies and implants are available to cover scheduled cases
- Consign as much as possible
- Assign a nurse to order drugs
- Do not drop ship
- Use a GPO

Materials Management – GPO (Group Purchasing Organization)

- Requires enrollment for contract implementation
- Tiers affect pricing
- Assistance with contract compliance
  - Pricing audits
  - Velocity reports (usage audits)
  - Resolution of problems (i.e. back orders)
  - Rebates
- Items or manufacturers may not be on contract
  - Request a local contract

Materials Management (Ordering Process)

Consider:

- Cost of items, inc. freight charges
- Frequency of delivery
- Vendor truck vs commercial carrier
- Payment terms
- Return goods policy
  - Restock charges
  - Credit only

Materials Management (Ordering Process)

- Flexibility in UOM orders
- Minimum orders
- Contract price thresholds
- Availability
  - Special orders
  - Non-stock orders
  - Standing order management
- Service
- Back order rate
  - Propofol, Fentanyl
- Invoice accuracy
- Ease of ordering

Materials Management (Storage)

- Control where supplies are stored
- Consider not having cabinets in the ORs or PRs
  - Nurses are hoarders
  - Independently check supply areas for overstocking
- Use movable carts, i.e. suture carts, specialty carts
  - Move them out of the OR when not in use for a case
- Avoid the “Fish Bowl concept”
- Establish par levels
- Put pricing on supplies in storage area

Materials Management – Service Contracts

- Expensive line items
- Review all contracts
  - Do you really need them?
  - New equipment will be under warranty
- Be selective with maintenance contracts
  - Select service option for PM check only, technician labor & travel time
  - Better to take the risk and pay for occasional repair

Materials Management – Service Contracts

Recommended contracts:

- HVAC
- Emergency generator
- Medical gas manifold
- Vacuum pump
- Autoclaves
- Anesthesia machines
- Hi-tech equipment where software releases & upgrades are included
- C-arms – calibration only – not the tube

Materials Management – Service Contracts

Contracts are usually not recommended for:

- Microscopes
- Monitors (anesthesia monitors are covered with anesthesia machines
- Cautery
- Video equipment

Non-contract service calls will usually be less expensive than the amount of the yearly service contract

Implement Case Costing

- Key – Current Inventory, Preference Cards
- 3 Everys:
  - Every one, Every case, Every time
- Monthly review and discussion
- Best practice

Case Costing

- Meter time in & time out
- Cost / Minute =

$$\frac{\text{Total Costs – Supply Costs}}{\text{Total O.R. Minutes}}$$

Simple: Everything revolves around the OR Minute

Case Costing: Calculating the OR Minute

Step 1: By accounting period (month)

*Overhead (minus supplies) / OR minutes = OH per OR minute

Step 2: By 1° CPT/Surgeon:

(OR mins x OH per OR minute) + Supplies = Case Cost

*Overhead is the total expense for the month from the P & L statement (cash accounting) minus medical supplies

Case Costing

- Example:
  - Revenue = $300,000
  - Supplies = $77,000
  - Distribution = $75,000
  - Debt Service = $40,000
  - 200 Cases @ 30 Minutes each

Case Costing

Cost = Revenue - Supply - Dist. - Debt Service
Cost = 300,000-77,000-75,000-40,000
Cost = $108,000
Total O.R. Minutes = 200 cases X 30 min.
Total O.R. Minutes = 6,000 Minutes

$$\text{Var. Cost / Min.} = \frac{108{,}000}{6{,}000} = \$18 \text{ / Minute}$$

Where Does the Information Come From?

- Vendors
- Software reports – P & L, OR times, etc.
- Preference cards

Sample of Board Report for Spine Surgeon

Key DOS	Account #	Prim proc	Prim payer	OR Mins	Supp cost	Overhead	Tot cost	Billed Chrgs	Receipts	Profit/Loss
Neuro Spine Surgeon										
12/09/09	9040	22554	Comm2	69	4,034	1,316	5,349	66,941	10,453	5,103
12/09/09	12049	64721	Comm1	30	109	572	681	4,891	-	(681)
12/16/09	7882	63030	Comm3	80	559	1,526	2,084	13,829	1,659	(425)
12/16/09	12067	22554	Comm3	62	3,424	1,182	4,607	60,040	14,138	9,531
12/23/09	11857	63030	Comm4	83	578	1,583	2,161	13,829	7,466	5,305
			G-TOTAL	**324**	**8,703**	**6,179**	**14,882**	**159,529**	**33,716**	**18,834**
		5 case	Average total per case		1,741	1,236	2,976	31,906		

Case Costing

Procedure	Primary Payer	Charge	Supply Cost	OR Time	Overhead Cost	Total Cost	Total Revenue
29826 Arthroscopy, Shoulder	Peerless Insurance	7,743.00	729.18	94	575.28	1,304.46	2,166.80

Knee Arthroscopy

$ -

ABC AMBULATORY SURGERY CENTER

COST COMPARISON

DATE: 2/20/06

Procedure: Knee Arthroscopy 29881

SUPPLIES IN COMMON

Doc Name	1	Doc Name	2	Doc Name	3	Doc Name	4
ITEM	PRICE	ITEM	PRICE	ITEM	PRICE	ITEM	PRICE
		2 Adaptor, Spike	$ 3.50			2 Adaptor, Spike	$ 3.50
Bandage, Coban 4"	$ 8.57	Bandage, Coban 4"	$ 8.57	Bandage, Coban 4"	$ 8.57	Bandage, Coban 4"	$ 8.57
		Blade, Surgical #11	$ 0.22	Blade, Surgical #11	$ 0.22	Blade, Surgical #11	$ 0.22
Bandage, Esmark 6x12	$ 4.61	Bandage, Esmark 6x12	$ 4.61				
		Light handles	$ -	Light handles	$ -		
Needle, Spinal 18x3 1/2	$ 1.08			Needle, Spinal 18x 3 1/2	$ 1.08	Needle, Spinal 18x 3 1/2	$ 1.08
2 Suction Tubing	$ 1.06	2 Suction Tubing	$ 1.06	2 Suction Tubing	$ 1.06	2 Suction Tubing	$ 1.06
Arthroscopy Tubing	$ 87.20	Arthroscopy Tubing	$ 87.20	Arthroscopy Tubing	$ 87.20	Arthroscopy tubing	$ 87.20
Canister, Sctn 2000cc	$ 3.26					4 Canister, Sctn 2000cc	$ 13.04
		4 Sod Chl, 2000 ml	$ 8.20			4 Sod Chl, 2000 ml	$ 8.20
Drape, Arthroscopy Pak	$ 58.50	Drape, Arthroscopy Pak	$ 58.50	Drape, Arthroscopy Pak	$ 58.50	Drape, Arthroscopy Pak	$ 58.50
Dressing, Kerlix 4"	$ 1.08					Dressing, Kerlix 4"	$ 1.08
Sponge, Gze 12 ply 4x4	$ 0.79	Sponge, 12 ply 4x4	$ 0.79				
Suture, Ethlon 4-0 1667H	$ 3.07			Suture, Ethlon 4-0 1667H	$ 3.07	Suture, Ethlon 4-0 1667H	$ 3.07
IV Catheter 20g	$ 1.61	IV Catheter, 20g	$ 1.61	IV Catheter, 20g	$ 1.61	IV Catheter, 20g	$ 1.61
IV Adm set primary	$ 4.35	IV Adm set primary	$ 4.35	IV Adm set primary	$ 4.35	IV Adm set primary	$ 4.35
IV Adm set secondary	$ 1.01	IV Adm set secondary	$ 1.01	IV Adm set secondary	$ 1.01	IV Adm set secondary	$ 1.01
Cefazolin Duplex	$ 5.05	Cefazolin Duplex	$ 5.05	Cefazolin Duplex	$ 5.05	Cefazolin Duplex	$ 5.05
Tegaderm w/w indow	$ 0.30	Tegaderm w/w indow	$ 0.30	Tegaderm w/w indow	$ 0.30	Tegaderm w/w indow	$ 0.30
Lactated Ringer 1000ml	$ 1.03	Lactated Ringer 1000ml	$ 1.03	Lactated Ringer 1000ml	$ 1.03	Lactated Ringer 1000 ml	$ 1.03
LMA	$ -	LMA	$ -	LMA	$ -	LMA	$ -
Adult Circuit 60"	$ 7.92	Adult Circuit 60"	$ 7.92	Adult Circuit 60"	$ 7.92	Adult Circuit 60"	$ 7.92
Propofol	$ 7.72	Propofol	$ 7.72	Propofol	$ 7.72	Propofol	$ 7.72
Fentanyl	$ 0.65	Fentanyl	$ 0.65	Fentanyl	$ 0.65	Fentanyl	$ 0.65
Torodol	$ 1.00	Torodol	$ 1.00	Torodol	$ 1.00	Torodol	$ 1.00
Adult mask anesthesia	$ 3.20	Adult mask anesthesia	$ 3.20	Adult mask anesthesia	$ 3.20	Adult mask anesthesia	$ 3.20
Dressing, 2 x 2	$ 0.03	Dressing, 2 x 2	$ 0.03	Dressing, 2 x 2	$ 0.03	Dressing, 2 x 2	$ 0.03
Large Ice Bag w/ties	$ 0.83	Large Ice Bag, w/ties	$ 0.83	Large Ice Bag, w/ties	$ 0.83	Large Ice Bag, w/ties	$ 0.83

Knee Arthroscopy (continued)

SUPPLIES THAT DIFFER							
ITEM	PRICE	ITEM	PRICE	ITEM	PRICE	ITEM	PRICE
Arthrowand Covac	$201.00	Aug Plus Shaver	$ 95.80	Needle Counter, Foam	$ 1.17	Glove, Surg Est Sz 6 1/2	$ 1.97
Blade, Surgical #15	$ 0.22	Betadine scrub brush	$ 0.60	Needle, Hypo 18gx1 1/2	$ 0.03	Glove, Surg Est Sz 7 1/2	$ 1.97
4 Gloves, Surg Est Sz8	$ 7.88	Needle, Hypo 22gx1 1/2	$ 0.03	Raytec	$ 0.65	Needle, Hypo 22gx 1 1/2	$ 0.03
4 Lac Ringers 3000ml	$ 23.91	Sponge, Raytex 4 x 4	$ 0.65	Bandage, Kling 6"	$ 0.57	Scrubbrush, W/Iodophor	$ 0.66
Marker, Skin	$ 0.61	Tape, Adhsv Foam	$ 2.80	Marcaine .25% W/Epi	$ 1.81	Sponge, Gze 4x4 12 ply	$ 0.79
Sponge, Gze 4"x4"	$ 0.03	Ace Bandage 6"	$ 1.82			Closure, Steri-strip 1/4x3	$ 0.69
Gown, XL	$ 3.00	Pad, Abdominal Tender	$ 0.36			Bupivcaine .25% - 10 ml	$ 1.57
Towel, Str Blue 4-pack	$ 2.78	Suture, Prolen 4-0 8682G	$ 3.77				
ABD	$ 0.12	Bupivcaine .5% w/Epi	$ 1.34				
Bacitracin Ointment	$ 0.06						
Dressing, Adaptic 3x3	$ 0.28						
Bupi w/Epi .25% 30ml 20	$ 2.52						
Epinephrin multi-dose vial	$ 4.85						
TOTAL COST	$451.18		$ 314.52		$ 198.63		$ 218.12
AVERAGE OR TIME	48 min		73 min		68 min		42 min
(Based on 13 cases thus far)		(Based on 10 cases thus far)		(Based on 5 cases thus far)		(Based on 4 cases thus far)	
OPPORTUNITIES:							
ANNUAL REALIZATION IN REVENUE							
Proposed change times number of cases annually equals =potential annual savings to facility							

Next Steps

- Carefully review data
- Look for outliers
- Ensure accuracy
- Present at monthly Board meetings
  - Blind the doctors' names if need be
  - Allow the doctors to see their own case costs in private
- Lead discussion on lowering costs

Recruit New Physicians

- Constant - cold calling vs. networking
- Target specialties – Ortho, Pain, Spine
- Trial 3 x, VIP treatment protocol
- Top managers with new physician from moment enters building until leaves
- Summary of case when leaves OR for every case

Staffing

- One of 2 largest expenses for the center
- Utilize a core staff of full-time employees
  - Base on scheduling assumptions
  - Business Office – usually full-time
- Supplement with part-time & per diems
- Don't guarantee any set hours or schedules
- Cross train
- Business Office (hire lean at first)
  - Scheduler/insurance verifier
  - Biller/collector
  - Business Office Manager not always justified if case numbers are low

Staffing

- RN must oversee clinical operations
- Employees will have multiple roles
  - Infection control nurse
  - QAPI coordinator
  - Safety officer
  - Radiation safety officer
  - Risk Manager
  - Miscellaneous
- Time must be used wisely
- Restrict overtime – should be zero
- Do not use agency employees

Staffing

- ORs/PRs – 1 RN circulator + 1 surgical tech
- IVCS – dedicated nurse
- Instrument tech
- Radiology tech
- Materials Manager
- Nursing assistant/orderly – very cost-effective

Staffing – Whatever It Takes

- Patient transport
- Clean
- Restock
- Relieve co-workers in other areas
- Track supplies used for case costing
- Pre-op calls
- Post-op calls
- Entering case history in computer
- Assist Business Office as needed

Staffing – Whatever It Takes

- ASCs don't have:
  - BioMed in house
  - Maintenance
  - Housekeeping to clean between cases
- ASCs must:
  - Track infections
  - Participate in QAPI program
  - Complete competency training/inservices
  - Complete required drills

Staffing - Challenges

- Keeping staffing lean while completing regulatory requirements
- Preventing staff burnout
- Accommodating employees' need for hours while controlling costs
- Placing people in roles that will enhance their job satisfaction

Schedule Compression

- Analyze cases to determine:
  - Days of the week ASC will open for cases
  - Number of ORs or PRs to open each day
- Solicit preferred operating times from physicians but make no promises
- Do not create "typical" block schedules
- Involve anesthesia providers
- Educate physicians - schedule will be reviewed periodically and blocks will be reallocated

Schedule Compression

- Implement vertical scheduling
  - Schedule physicians in sequence to fill ORs/PRs
  - Open rooms only if you can fill them
- Use historical case time to allocate times to physicians
- Involve the Clinical Coordinator
  - Schedule affects staffing
  - Impacts hiring
  - Consider case mix and equipment conflicts

Schedule Compression - Physicians

- Talk with physicians often
- Assumption: Many won't be happy
  - They aren't used to this concept
  - Delusions of grandeur ("I need more time"; "I can do more cases than time allotted"; "It doesn't take me that long to do the case".
  - Can't/won't change office schedule
- Develop schedule to allow enough time for physicians to change office schedule

Schedule Compression - Physicians

- Meet with and adjust schedules for those who won't budge, especially if center has been operating under "old rules"
- Go back and forth until the schedule is "set"
- This process takes time & energy
- Obtain physician signatures of approval

Schedule Compression - Schedulers

- Meet with office schedulers
  - Make sure they understand - their physicians have signed off on the schedule
  - Doctors may need to intervene with their schedulers
- Provide them with surgery time slots
  - Explain that this is a ramp up schedule and will change several times in first year; less often after that
  - Explain importance of releasing blocks

Schedule Compression - Schedulers

- Provide list of payer contracts & keep this list current
- Explain OON protocols, if applicable
  - ALL outpatient cases should be scheduled at ASC
  - ASC will verify benefits within 24 hours and get back to the office if case cannot be done at center
  - In some cases, promise a 4 hour turn around, especially at the beginning of operations

Schedule Compression – Computer System

- Create surgery schedule in software system
- Involve Clinical Coordinator re: frequent review of schedules
  - Look for equipment conflicts
  - Staffing issues
- Review schedule regularly
  - If physicians aren't using allotted time
    - Has there been ongoing conversation? One-sided or dialogue
    - Are there extenuating circumstances? Vacation, sick leave
    - How much time are they leaving unused?
- Reduce allotted times
- Discuss scheduling at every Board meeting to increase awareness and attempt to increase cases

Schedule Compression

- When does opening an additional OR make sense?
  - Scheduled rooms are %%% full (Board decision)
  - Busy surgeon joins the medical staff
- Don't open additional room to flip cases except in unusual circumstances
- Consider opening an extra OR one day per week; not every day

Schedule Compression - Considerations

- Scheduling affects anesthesia providers
  - Running several rooms for ½ days increases anesthesia providers' costs
  - Requires more anesthesia providers who are billing < full days
  - Closing one – two days per week allows anesthesia providers to work elsewhere

Schedule Compression - Considerations

- Office schedulers
  - have the physician's ear & lots of history from working with doctor;
  - are probably comfortable booking at the hospital or other ASCs;
  - see this as a LOT of extra work; and
  - may be passive aggressive about not complying with physician's instructions

Schedule Compression - Considerations

- Office schedulers
  - Loyalty requires some work-around
  - Help schedulers as much as possible
  - Do what you promise (insurance verification within 24 hours – happens within 24 hours)
  - If MD tells you that this isn't happening, ask to see the scheduling sheet in order to research the situation – then get back with the physician

Financial Management

What finances do you manage?

Financial Management

What finances do you manage?

- Accounts Payable
- Accounts Receivable
- Banking
- Benchmarking
- Billing
- Case costing
- Coding
- Contracts – review and improve
  - Payer
  - Vendor

Financial Management

What finances do you manage?

- Fraud
- Inventory
- Landlord
- Month-end / Year-end
- Partners
- Reconciliations
- Reports – Daily, Weekly, Monthly, Annual
- Segregation of duties
- Staff
- Supplies

Financial Management – Bank relationship

- Cash accounts
- Line of credit
- Loan
  - Covenants
  - Reporting
  - Add-on financing
- Lockbox
- Positive pay
- Merchant services

Financial Management – Reporting

Daily report:

- Maximum oversight
- New, changed, or troubled centers
- Contents:
  - # of cases (MTD, scheduled, next month)
  - Staff hours (Clinical, Admin)
  - OR patient time
  - Charges
  - Payments
  - A/R Days
  - A/P Balance
  - Cash Balance
  - Average turnover time

Financial Management – Reporting

Weekly report:

- Standard – required report
- Bonus contingency
- Contents:
  - # of cases (Week, MTD, activities to increase)
  - Contracting
  - Recruitment
  - Goals for the week
  - Report on last week's goals
  - Bank balance
  - A/R balance, Days A/R Outstanding
  - A/P balance
  - Collections
  - Case costing?

Financial Management – Reporting

Monthly report:

- Standard – required report
- Bonus contingency
- Contents:
  - # of cases
  - Days of surgery
  - Charges / Collections
  - Medical supplies
  - Payroll
  - Distribution
  - A/R aging balances
  - Board meeting agenda items
  - Patient satisfaction surveys

Billing & Collections Management

Keys to Success:
- **Administrator**
- Staff
- Process
- Transcription
- Coding
- Training
- Outsourcing
- Quality control

Billing & Collections - Administrator

The most important factor in successful AR:
- Administrator is ***responsible***
- Administrator ***knows*** the AR protocol
- Administrator is ***consistently involved***
- Administrator ***monitors*** the AR process
- Administrator ***follows up***
- Administrator ***tracks*** success
- Administrator ***reports*** results

Billing & Collections - Staff

- Hire the right people
- Pay extra to keep good staff
- Don't scrimp
- Train regularly
- Challenge
- Motivate

Billing & Collections - Process

Accounts Receivable Protocol:

- **Pre**-verify benefits
- **Pre**-notify patients
- **Pre**-collect patient amounts
- Transcribe timely
- Code accurately
- Post payments timely
- Follow up

Billing & Collections - Process

Accounts Receivable Protocol:

- Follow up
- Follow up
- Follow up
- Follow up
- Follow up
- Follow up
- **Follow up !**

Participate in Benchmarking

What is benchmarking?

- Compare yourself to your peers
- Identify good and bad perfomances
- Understand differences

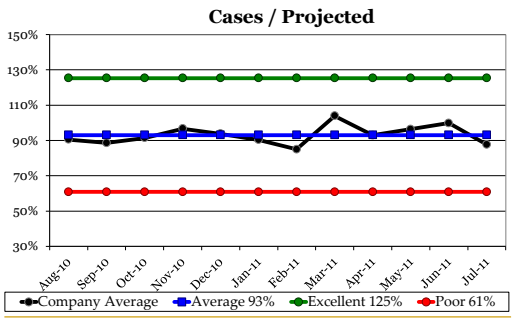
Why Benchmark?

- Improve quality
- Improve performance
- Improve profit
- Accreditation REQUIREMENT
- Learn how your center *should / could be* running

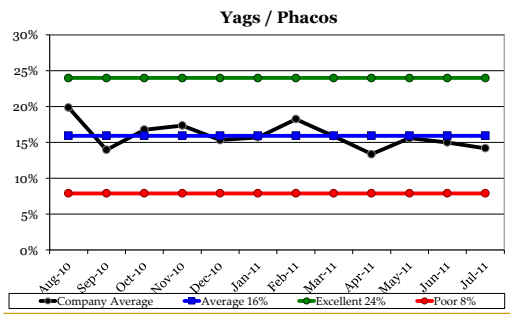
Benchmarking – what to bench

- CRITICAL CONTROLLABLES, such as:
- Clinical indicators
- EBITDA Margin
- Case volume
- Efficiency / throughput
- Collections
- A/R days outstanding
- Supplies $ per case
- Payroll $ per case
- Patient satisfaction surveys

Benchmarking – examples



Benchmarking – examples



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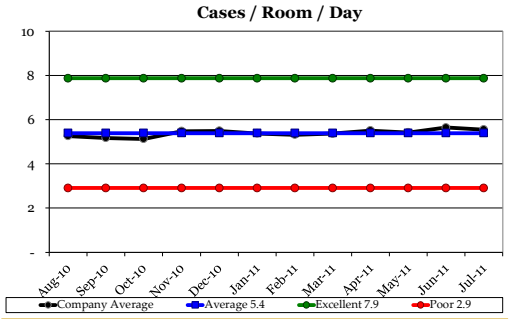
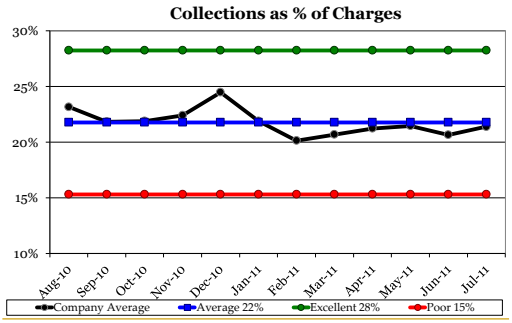
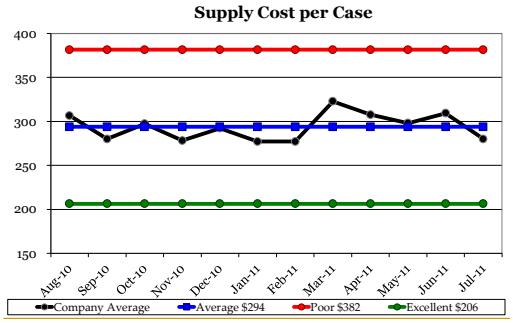


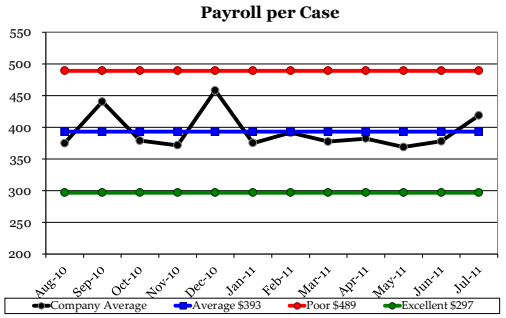
Benchmarking – examples



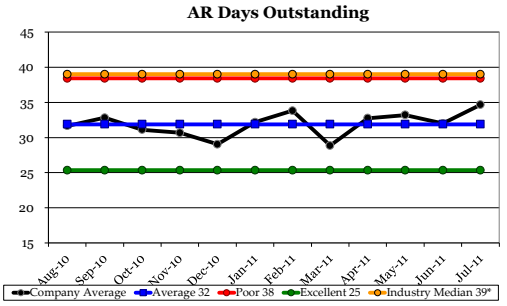
Benchmarking – examples



Benchmarking – examples

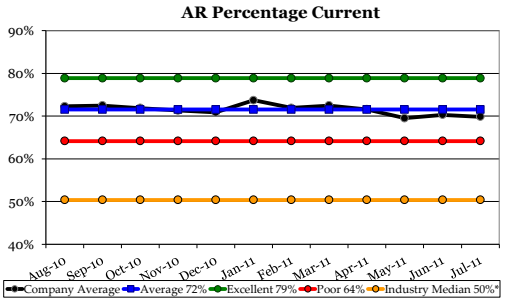


Benchmarking – examples



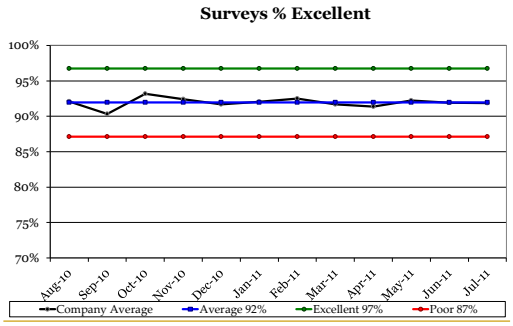
* MGMA 2009 ASC Survey.

Benchmarking – examples



* MGMA 2009 ASC Survey.

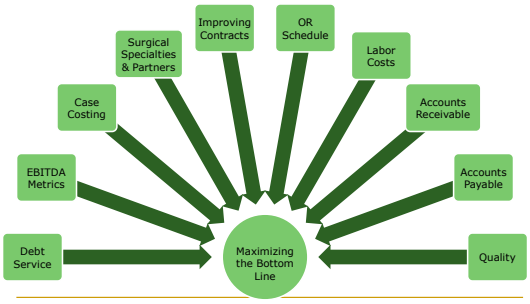
Benchmarking – examples



Stay Focused on…

- Partner cooperation & education is key.
- Avoid votes at partnership meetings.
- Avoid a "Representative" Board.
- Pay for new equipment with cash.
- Recruit 1 to 2 new partners per year.
- Weekly visits to partners' offices.
- Did I mention Case Costing?

Stay Focused on…



Questions?