Keys to Conducting Case Costing for ASCs

Ann Geier – Chief Nursing Officer; Surgical Information Systems
Don’t try to do too much, too quickly.
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

- Start here
Materials Management (Inventory)

• Utilize software inventory module
  » SIS reports 25% - 30% of centers have a good handle on full perpetual inventory control (tracking quantity on hand)

• Quantity on Hand (QOH) – Item in software matches what’s on shelf

• Total inventory system must be utilized
  » Create POs
  » PO - receiving
  » Physical counts
  » Preference cards
  » Adjustments in bulk items
  » Spot inventory checks
  » Par level
  » Location level maintenance
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
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
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
  - Ex. Propofol, Fentanyl, Caines
- 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
• 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 preventive maintenance (PM) check only, technician labor & travel time
  » Better to take the risk and pay for occasional repair
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
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
- Every case, every month
- Monthly review and discussion
- Best practices
Case Costing

- Revolves around OR Minutes

- Meter patient time in to patient time out

- Total costs – direct supply costs = Overhead*

- Overhead/OR Minutes = Overhead cost per minute

- OR minutes x Overhead cost per minute = Overhead cost per case

- Overhead cost per case + direct supply costs = Case cost

*Calculate monthly. Get these numbers from the P & L. There are various ways to calculate overhead.
Case Costing – Another Calculation

• Example:
  » Revenue = $300,000
  » Supplies = $77,000
  » Distribution = $75,000
  » Debt Service = $40,000
  » 200 Cases @ 30 Minutes each
Quick and easy Overhead (OH) calculation

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

Overhead Cost = $108,000 = $18/minute
               6,000
Where Does the Information Come From?

- Preference cards
- Reports – P & L, OR times, etc.
- Vendors
Sample of Board Report for Spine Surgeon –

OR Cost Minute ($19.07)

<table>
<thead>
<tr>
<th>Key DOS</th>
<th>Account #</th>
<th>Prim proc</th>
<th>Prim payer</th>
<th>OR Mins</th>
<th>Supp cost</th>
<th>Overhead</th>
<th>Tot cost</th>
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<td>559</td>
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<td>13,829</td>
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<td>1,741</td>
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## Case Costing

### OR Cost Minute ($19.07)

<table>
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<tr>
<th>Procedure</th>
<th>Primary Payer</th>
<th>Receipt</th>
<th>Supply Cost</th>
<th>OR Time</th>
<th>Overhead Cost</th>
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<td>29826 Arthroscopy, Shoulder</td>
<td>Peerless Insurance</td>
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<td>729.18</td>
<td>94</td>
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### OR Cost Minute ($16.00)

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<td>2233.18</td>
<td>66.82</td>
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Consider the implications if the OR time was shorter or reimbursement was higher.
Analyzing Case Costs

[Name of Facility]
Case Cost Comparison

Date: ________________
Procedure: Knee Arthroscopy with Menisectomy (29881)

### SUPPLIES IN COMMON

<table>
<thead>
<tr>
<th>Item</th>
<th>Dr. A</th>
<th>Price</th>
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<tbody>
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<tr>
<td>ANESTHESIA MEDICATIONS</td>
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<tr>
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<tr>
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<tr>
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<tr>
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### SUPPLIES THAT DIFFER

<table>
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**TOTAL SUPPLY COST**

Dr. A: 138.50
Dr. B: 132.39
Dr. C: 136.68
Dr. D: 142.57

### AVERAGE OR TIME

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<tr>
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<tbody>
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<td>39</td>
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<td>45</td>
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<tr>
<td>34</td>
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<tr>
<td>45</td>
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<tr>
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<td>810</td>
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<td>942</td>
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ANNUAL REALIZATION IN SAVINGS:

Potential Annual Savings = Proposed Change x Number of Annual Cases
Next Steps

• Carefully review data
• Look for outliers
• Ensure accuracy
• Present at monthly Board meetings
  » Blind the doctors’ names if needed (recommend not!)
  » Allow the doctors to review their own case costs in detail in private
• Lead discussion on lowering costs
**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

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

• Ann Geier, MS, RN, CNOR(E), CASC™
  » Ann.Geier@SISFirst.com
  » 843-303-0008

Resources, eBooks
Thank You