Cost Reduction and Benchmarking -10 Key Steps to Immediately Improve Profits

Ann Geier – Chief Nursing Officer
SourceMed (Now part of Surgical Information Systems)
Robert Westergard – Chief Financial Officer
Ambulatory Surgical Centers of America (ASCOA)

ASC INDUSTRY CHANGES OVER THE LAST 5 YEARS

- OON…..GONE
- OBAMACARE…ARRIVED and…repealed/replaced?
- HEALTH PLANS….CHANGED
  - HIGHER PATIENT DEDUCTIBLES AND COINSURANCE
  - BUNDLED PAYMENTS
  - EXCHANGE PLANS
- TECHNOLOGY AND EQUIPMENT COSTS INCREASING
  - EHR IMPLEMENTATION
  - SINUS NAVIGATION
  - FEMTOSECOND LASER
  - TOTAL JOINTS

The Ten Keys…

- Leadership
- Managing Change
- Materials Management
- Case Costing
- Recruiting New Physicians
- Staffing
- Schedule Compression
- Financial Management
- Billing and Collecting
- Benchmarking

Definition of leadership

- Leadership is the process of influencing people to accomplish goals.

Change

- 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

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, including 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

- Keys – Current Inventory, Preference Cards
- Every case, Every specialty, Every month
- Monthly review and discussion
- Best practices
- Start NOW!
- Calculate now for 3 months ago

Case Costing

- Revolves around OR Minutes
- Meter patient time in & time out

- Overhead* = Total Costs – Direct Supply Costs

- OH per minute = Overhead / OR Minutes

- Case Cost = OH per case (OR minutes x OH per minute) + Direct Supply Costs

* Calculate monthly. There are various ways to calculate overhead.

Case Costing

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

Case Costing

Quick and easy calculation:

Cost = Revenue - Supplies - 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

OH Cost = 108,000 / 6,000 = $18 / Minute

Where Does Cost Information Come From?

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

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

$ -	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	Agg 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			Bupivicaine .25% - 10 ml	$ 1.57
Towel, Str Blue 4-pack	$ 2.78	Suture, Prolen 4-0 8682G	$ 3.77				
ABD	$ 0.12	Bupivicaine .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 doctors' names, if needed (recommend not!)
  - Allow doctors to review 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 arrival until departure
- Summary of every case when it leaves OR

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 1-2 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 ASC Administrators manage?

Financial Management

What is financial management?

- Accounts Payable
- Accounts Receivable
- Banking
- Benchmarking
- Billing
- Case costing
- Coding
- Contracts – review and improve
- Cyber security / IT
- Fraud / Asset protection

Financial Management

What is financial management?

- Insurance
- Inventory
- Landlord
- Month-end / Year-end
- Owners
- Reconciliations
- Reports – Daily, Weekly, Monthly, Annual
- Segregation of duties / Internal Controls
- Staff (HR / Payroll)
- Supplies

Financial Management – Bank relationship

- Cash accounts
- Fraud prevention
- Line of credit
- Loan
  - Covenants
  - Reporting
  - Additional financing
- Lockbox
- Positive pay
- Merchant services

Financial Management – Reporting

Daily report:

- Maximum oversight
- New, changing, or troubled centers
- Contents include:
  - # 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
  - # of unbilled claims

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
  - Are you 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
  - Goals / progress

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
- Investigate and understand variances

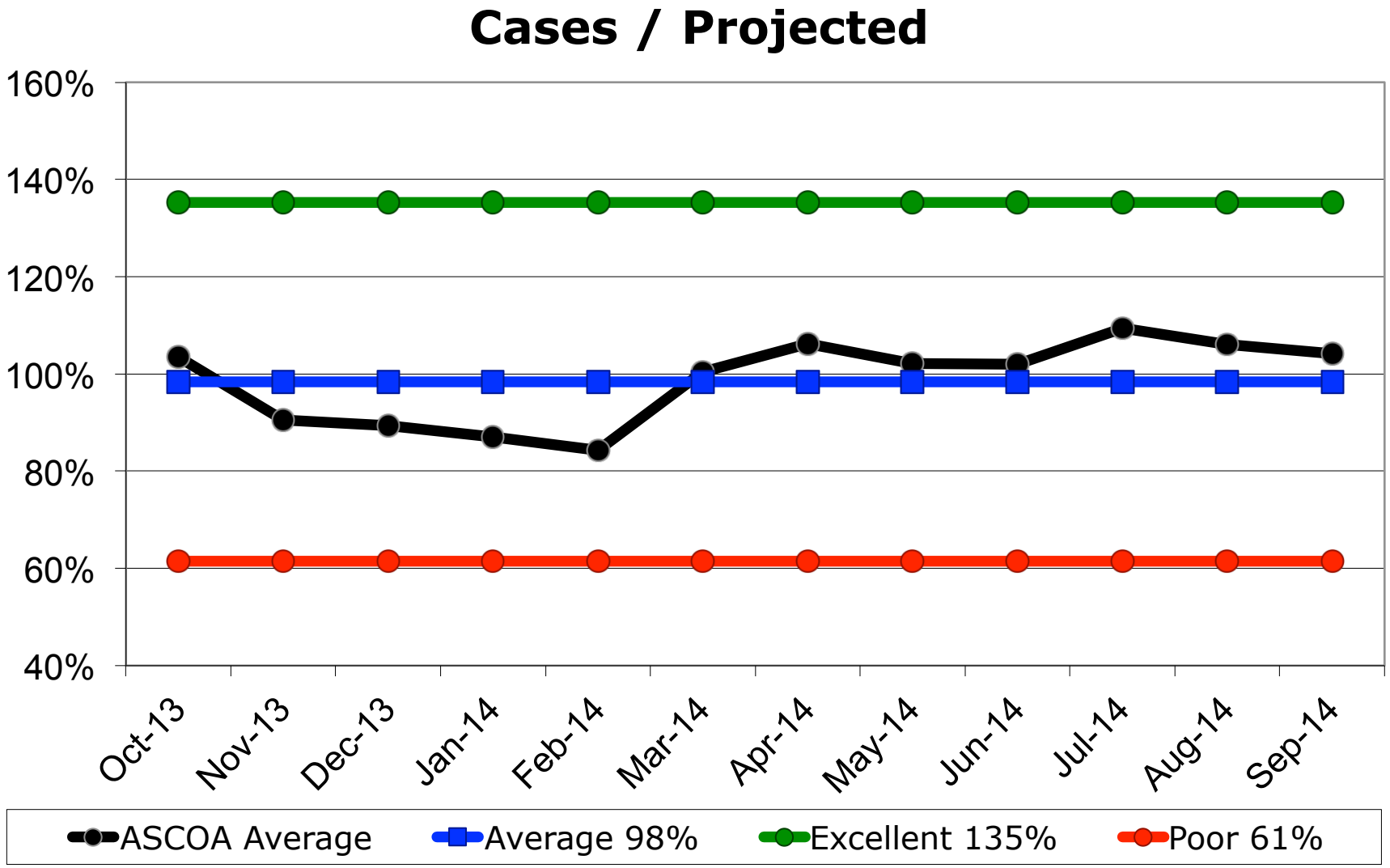
Why Benchmark?

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

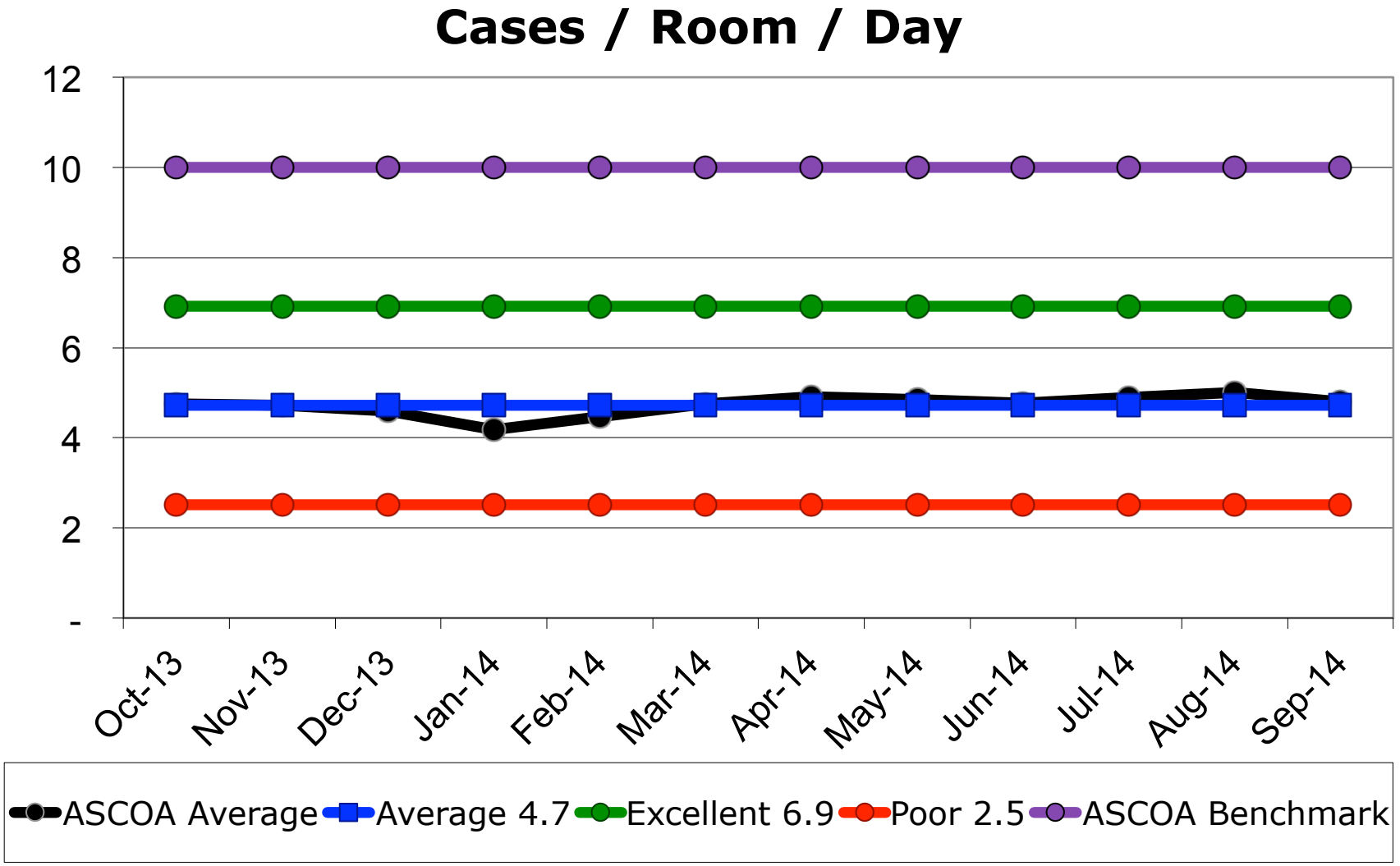
Benchmarking – what to bench

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

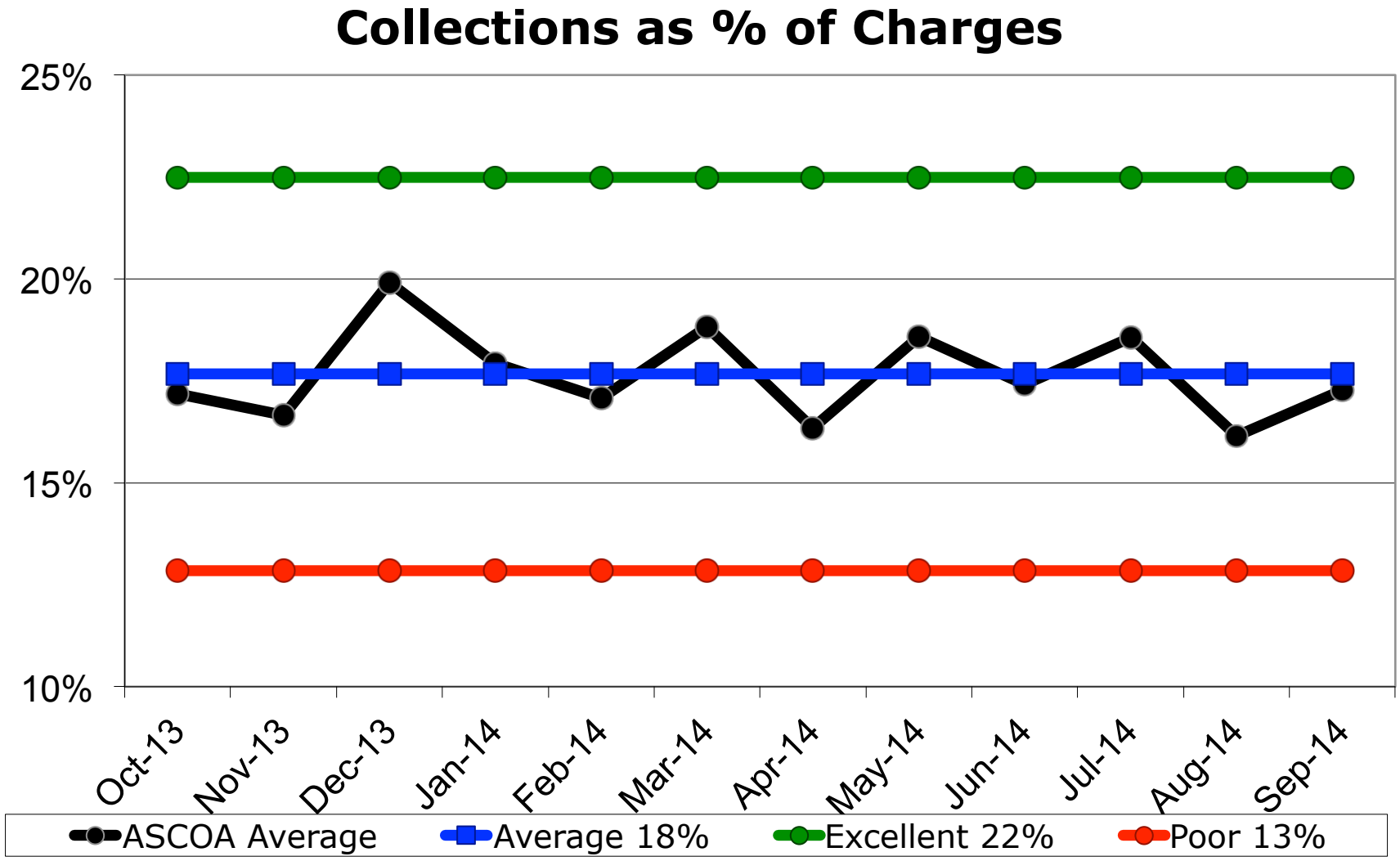
Benchmarking – examples



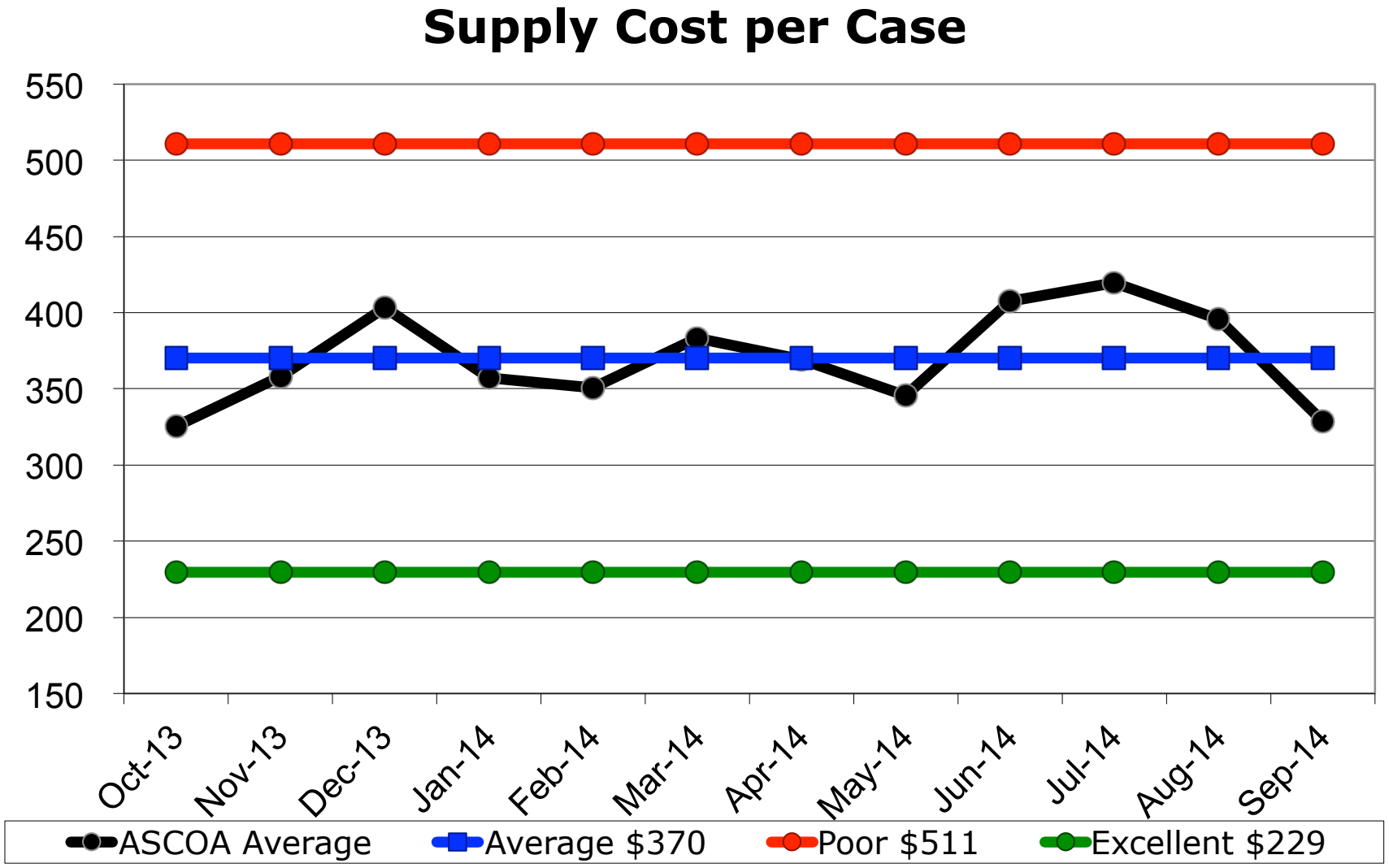
Benchmarking – examples



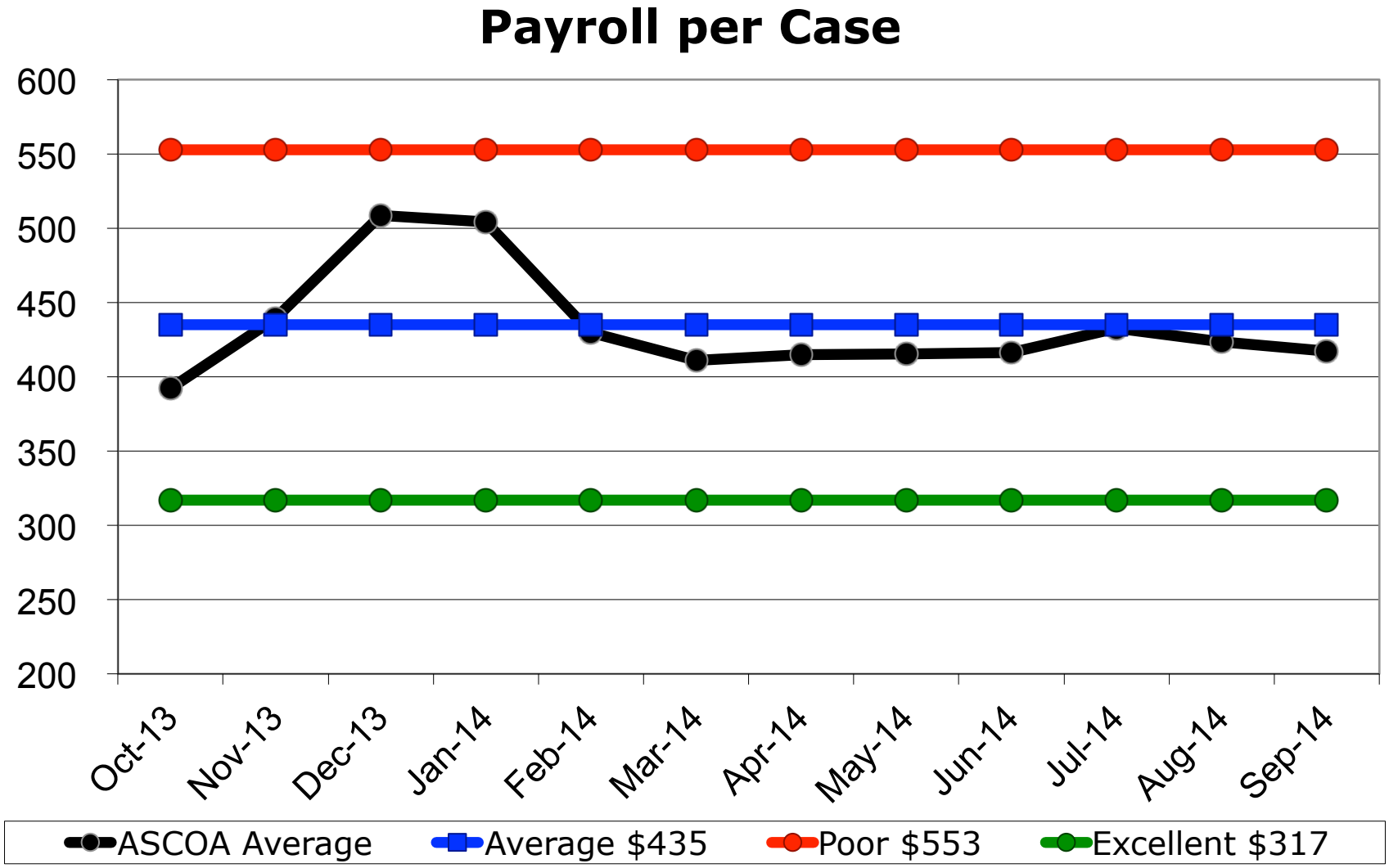
Benchmarking – examples



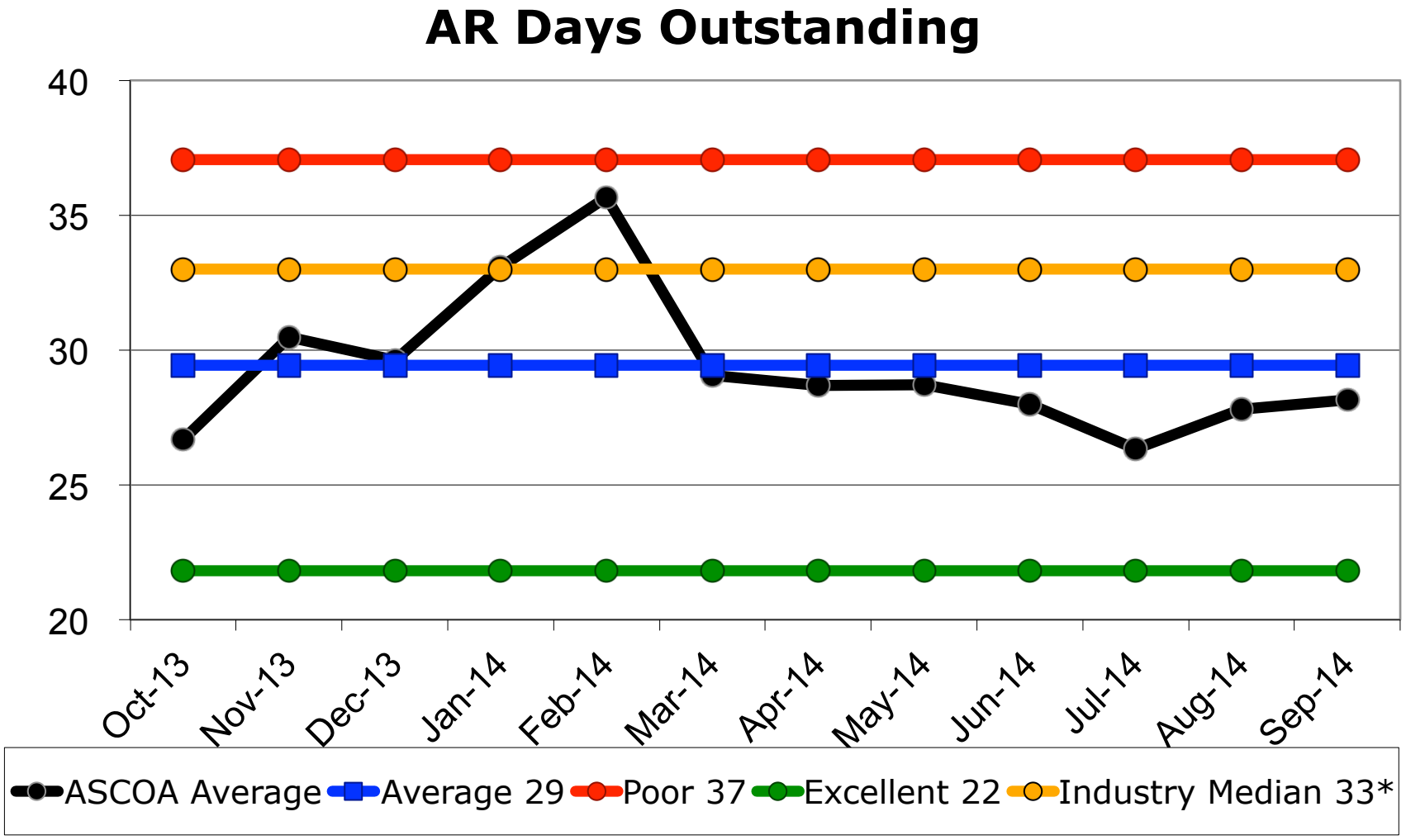
Benchmarking – examples



Benchmarking – examples

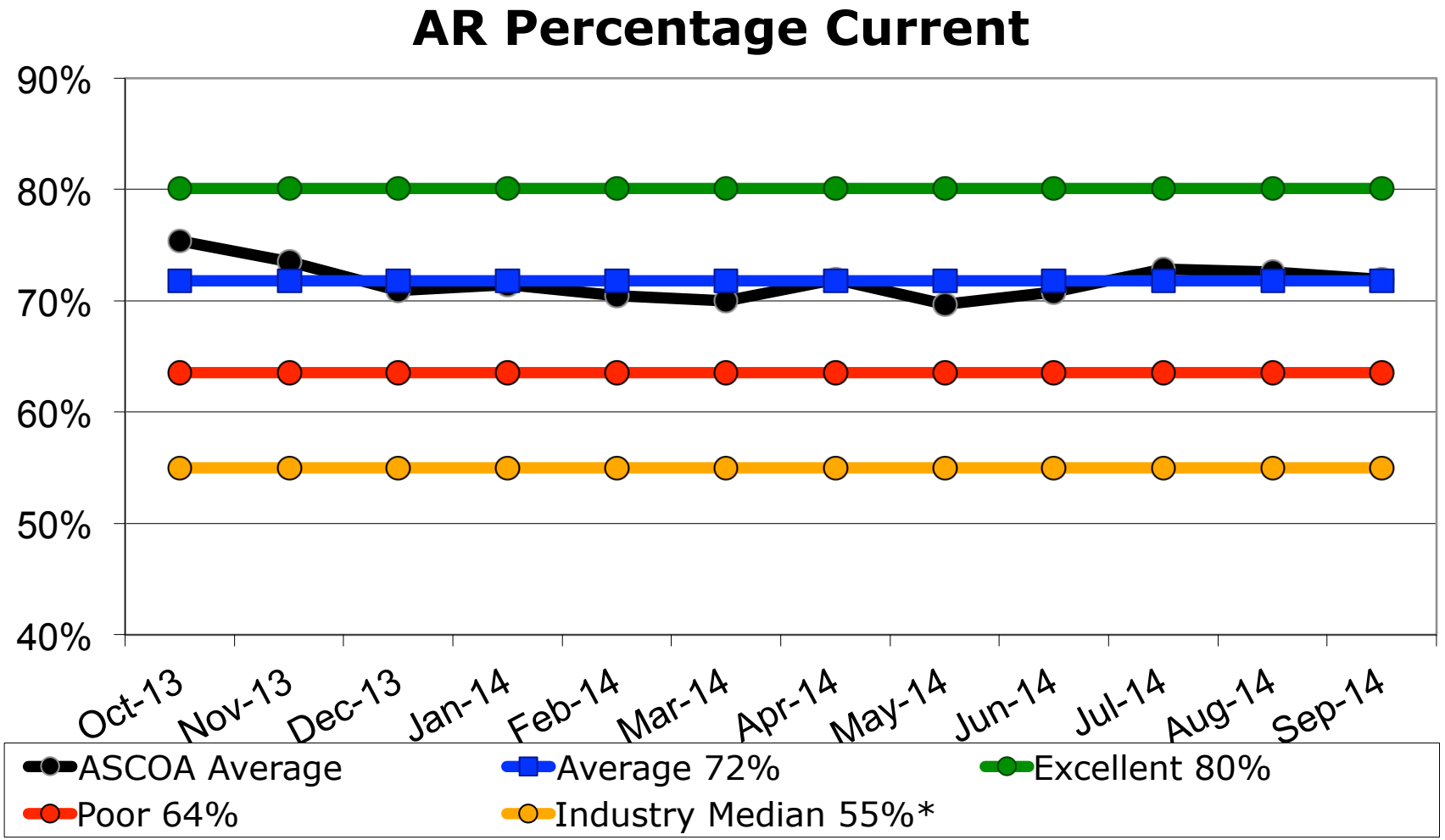


Benchmarking – examples



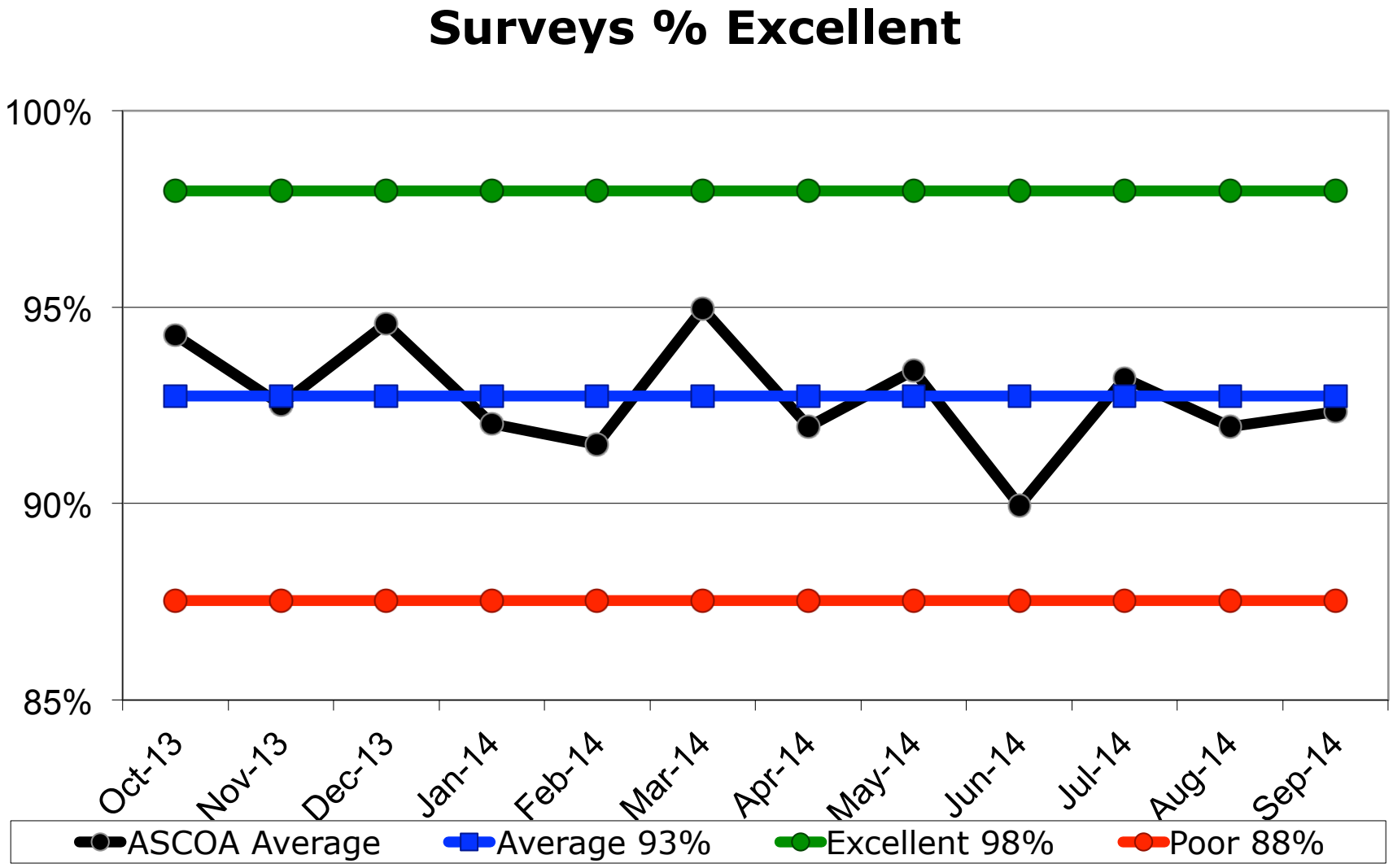
* VMG Intellimarker 2011

Benchmarking – examples

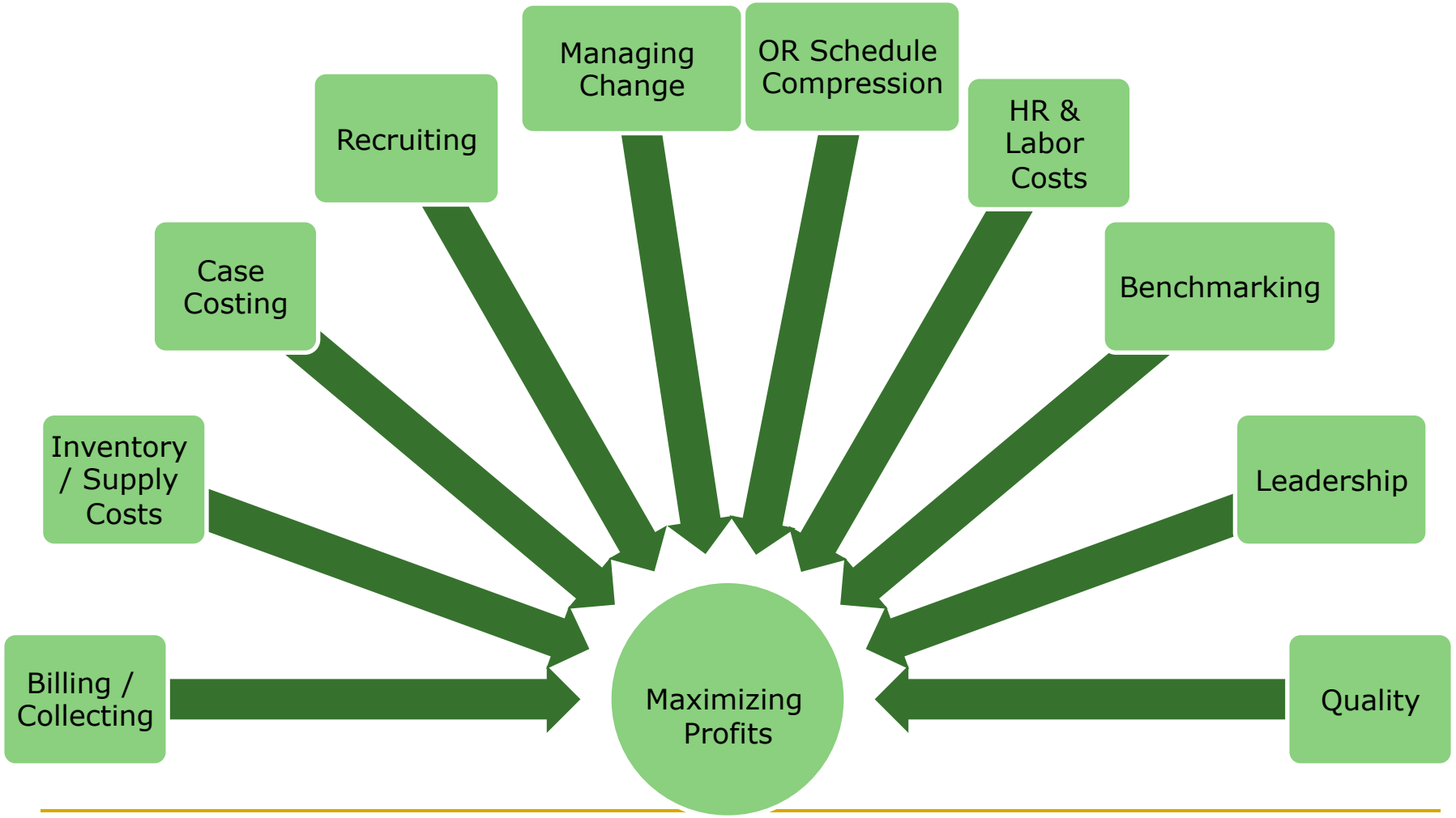


* VMG Intellimarker 2011

Benchmarking – examples



The BIG Picture…



Questions?

Contact

- Ann Geier, MS, RN, CNOR, CASC
  - Ann.Geier@sourcemed.net
- Robert Westergard, CPA, CGMA
  - rwestergard@ascoa.com