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
- Billing and Collecting
- Financial Management
- 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."

<u>This cake is flat!</u>

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

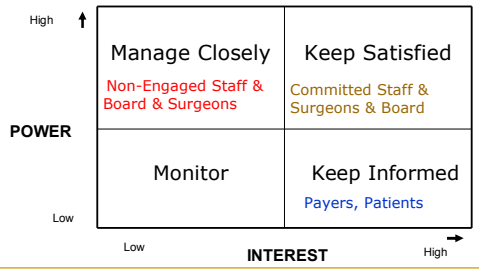
Who has the Power? Who has the Interest?

- 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*

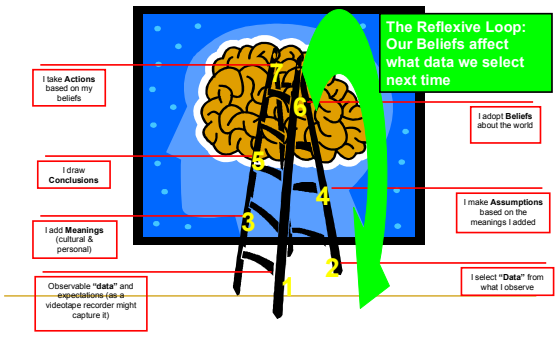
- Our beliefs are *the* truth
- The truth is obvious
- Our beliefs are based on real data
- The data we select is the *real* data

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

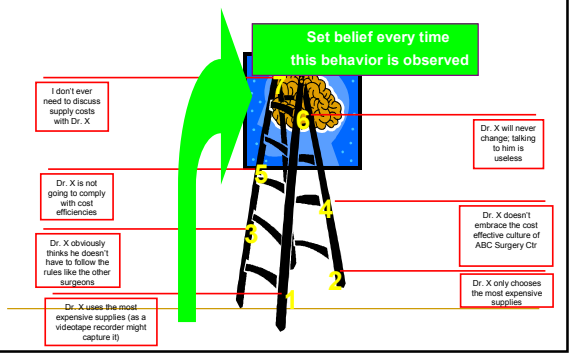
Using the Ladder of Inference: Recalibrate Thinking

- 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

*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 . . ."*

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 . . ."*

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."

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

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

Case Costing

Procedure	Primary Payer	Charge	Supply Cost	OR Time	Overhead Cost	Total Cost	Total Revenue
19120 Breast Biopsy	BCBS	5,677.12	41.49	22	334.22	375.71	572.00

Case Costing

Procedure	Primary Payer	Charge	Supply Cost	OR Time	Overhead Cost	Total Cost	Total Revenue
43239 Upper GI Endoscopy	Medicare	2,286.32	26.12	22	911.60	937.72	380.20

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

Case Costing

Procedure	Primary Payer	Charge	Supply Cost	OR Time	Overhead Cost	Total Cost	Total Revenue
30520 Endo Sinus Surgery	Aetna	19,624.08	236.97	109	1,699.17	1,936.14	9,193.73

Case Costing

Procedure	Primary Payer	Charge	Supply Cost	OR Time	Overhead Cost	Total Cost	Total Revenue
43770 Lap Band	Self Pay	15,000.00	3,594.36	95	1.496.13	5,090.49	6,500.00

Case Costing - Sample

CPT	Procedure	Payer	Standard Charge	OR Mins	O/H Costs $28.66/min	Supply Costs	O/H Costs Plus Supply Costs	Reimb	% Collected	Income (Loss)	Collection Status
28296	CORRECTION, HALLUX VALGUS	MCD	6,662	78	2,235	244	2,480	507	7.61%	-1,973	PAID
28296, 28285 L8699X2	CORRECTION, HALLUX VALGUS	BC	11,412	74	2,121	256	2,377	3,018	26.44%	641	PAID
28296, 28285X2 28270X2 L8699X2	CORRECTION, HALLUX VALGUS	BC	25,786	100	2,866	347	3,213	23,328	90.47%	20,115	PAID
28296, 28126 28288 L8699	CORRECTION, HALLUX VALGUS	BC	15,952	95	2,723	250	2,973	6,592	41.33%	3,620	PAID
28296, L8699	CORRECTION, HALLUX VALGUS	CIGNA	6,662	77	2,207	242	2,449	0	0.00%	-2,449	Carrier Issue- Claim is in process
		TOTALS	66,474	424	12,152	1,339	13,491	33,445	50.31%	19,954	

Best Practices - Sample

NAME OF FACILITY

COST COMPARISON

DATE: 8-2005
Procedure: BMTs

SUPPLIES IN COMMON									
Dr. A		Dr. B		Dr. C		Dr. D		Dr. E	
ITEM	PRICE	ITEM	PRICE	ITEM	PRICE	ITEM	PRICE	ITEM	PRICE
Circuit	$ 10.02	Circuit	$ 10.02	Circuit	$ 10.02	Circuit	$ 10.02	Circuit	$ 4.10
Mask	$ 3.56	Mask	$ 3.56	Mask	$ 3.56	Mask	$ 3.56	Mask	$ 2.85
Blade	$ 5.68	Blade	$ 5.68	Blade	$ 5.68	Blade	$ 5.68	Blade	$ 7.20
Mask	$ 0.64	Mask	$ 0.64	Mask	$ 0.64	Mask	$ 0.64	Mask	$ 0.64
Slipper	$ 0.64	Slipper	$ 0.64	Slipper	$ 0.64	Slipper	$ 0.64	Slipper	n/c
Towel	$ 4.87	Towel	$ 4.87	Towel	$ 4.87	Towel	$ 4.87	Towel	$ 2.05
Med cup	$ 0.62	Med cup	$ 0.62	Med cup	$ 0.62	Med cup	$ 0.62	Med cup	n/c
Glove	$ 1.18	Glove	$ 1.18	Glove	$ 1.18	Glove	$ 1.18	Glove	$ 0.31
SUPPLIES THAT DIFFER									
ITEM	PRICE	ITEM	PRICE	ITEM	PRICE	ITEM	PRICE	ITEM	PRICE
Tubes	$ 9.92	Tubes	$ 9.92	Tubes	$ 17.28	Tubes	$ 38.00	Tubes	$ 19.20
Collar Button		Collar Button		Reuter Bobbin		Paparella			
Floxin	$ 39.25	Floxin	$ 39.25	Floxin	$ 39.25			Floxin	2.95
Cannister	$ 5.70	Cannister	$ 2.85	Cannister	$ 5.70	Cannister	$ 5.70	Cannister	$ 2.85
Tubing	$ 1.07	Tubing	$ 1.07	Tubing	$ 1.07	Tubing	$ 1.07	Tubing	$ 1.07
TOTAL COST	$ 83.15		$ 80.30		$ 90.51		$ 71.98		$ 43.02
AVERAGE OR TIME									
	13		17		14		45		16

OPPORTUNITIES:
Use only one suction per case
Change to single use Floxin
ANNUAL REALIZATION IN REVENUE
Proposed change times number of cases annually equals = potential annual savings to facility

Results	Floxin - savings of $11,456.64 annually based on 312/year
	Suction - savings of $1,057.68 annually based on 312/year

Recruit New Physicians

- Constant - cold calling vs. networking
- Target specialties – Ortho, Ent, Spine, Lap band, Gyn
- 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

Billing & Collections Management (Rob)

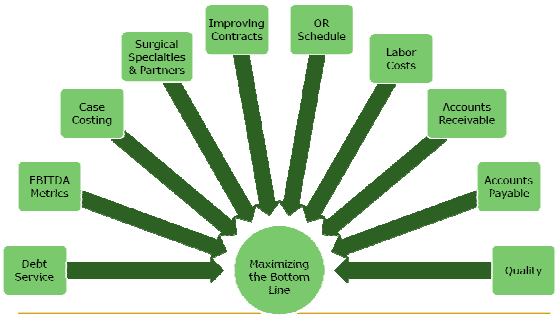
Financial Management (Rob)

Participate in Benchmarking (Rob)

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?