# Cost Reduction & Benchmarking, 10 Key Steps to Immediately Improve Profits

Ann Geier – Sr. VP of Operations
Margaret Chappell – Sr. VP of Operations
Rob Westergard – Chief Financial Officer
Ambulatory Surgical Centers of America (ASCOA)

## The Ten Keys…

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

## Manage Evolving Workplace*

- Define the Evolving Workforce in Your Market
- Understand the Workforce Demographics
- Use the Work Force Values to motivate for optimal efficiency and production
- Maximize the Generational Differences

*http://www.strickland-associates.com. Sid Strickland, Strickland and Associates, Office: 321.214.0887

## The Evolving Workplace*

- The available US labor workforce declined from 2.5% per year in 1965 to 0% available workers in the 1990's. Younger workers declined by 14%.
- By 2006, 80 million aging baby boomers totaled one-third of the nation's population.
- From 2010 – 2030, the U.S. population over age 65 will grow four times as much as it did in the last 80 years.

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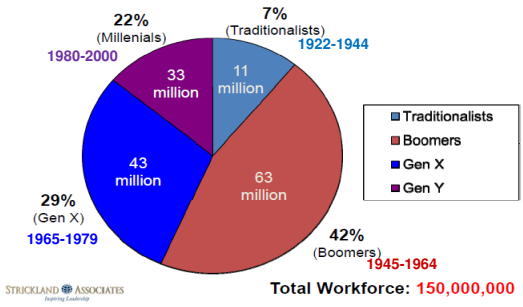
## US Workforce Demographics*

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## Work Place Values*

| | Traditionalists | Boomers | Gen Xers | Millennials |
|---|---|---|---|---|
| Career Goals | Build a legacy | Build a stellar career | Build a portable career | Build parallel careers |
| Rewards | Satisfaction of a job well done | Money, title, recognition, corner office | Freedom is the ultimate reward | Work that has meaning for me |
| Work-Life Balance | Support me in shifting the balance | Help me balance everyone else and find meaning myself | Give me balance now! Not when I'm 65 | Work isn't everything. Need flexibility to balance my other activities |
| Job Changing | Carries a stigma | Puts you behind | Is necessary | Is part of the daily routine |
| Training | I learned the hard way, you can too! | Train 'em too much and they'll leave | The more they learn, the more they'll stay | Continuous learning is a way of life |

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## Minimizing Generational Differences*

- Educate your employees on generational differences.
- Be a good example.
- Utilize multiple types of communication tactics.
- Use varied training approaches.
- Adapt your management style for each generation.
- Emphasize commonality.
- Avoid characterizations based on age.
- Paraphrase before answering.
- Be careful about cultural or historical references.
- Draw on the strengths of each generation.

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## Manage Change

- Learning Culture
- Leadership
- Communication

## 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?

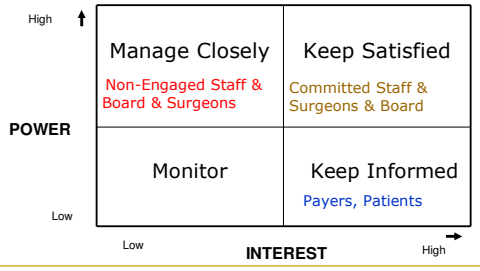
## Stakeholder Planning

***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*

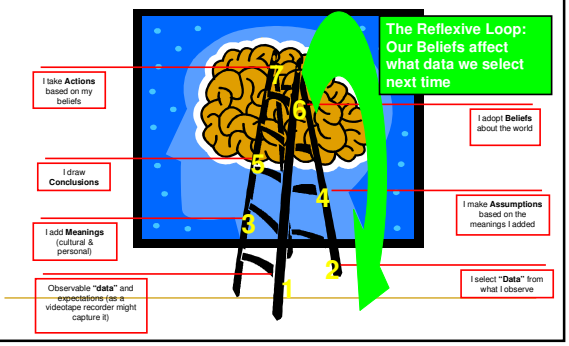
- Our beliefs are *the* truth
- The truth is obvious
- Our beliefs are based on real data
- The data we select is the *real* data

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

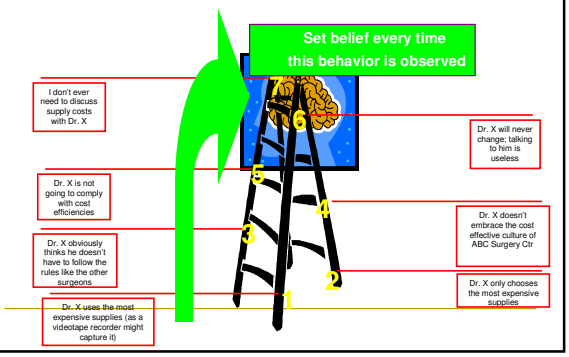
## Using the Ladder of Inference: Recalibrate Thinking

- 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

Var. Cost / Min. = $\frac{108,000}{6,000}$ = $18 / 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, Ethilon 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 Admset primary | $ 4.35 | IV Admset primary | $ 4.35 | IV Admset primary | $ 4.35 | IV Admset primary | $ 4.35 |
| IV Admset secondary | $ 1.01 | IV Admset secondary | $ 1.01 | IV Admset secondary | $ 1.01 | IV Admset 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 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

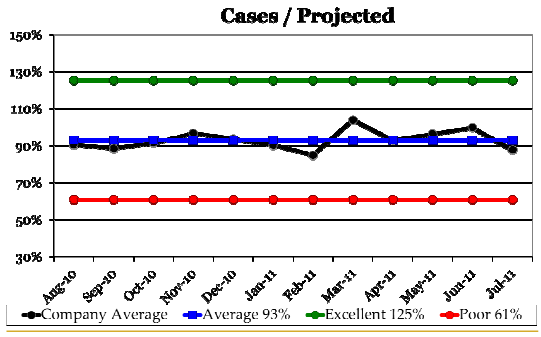
Why Benchmark?

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

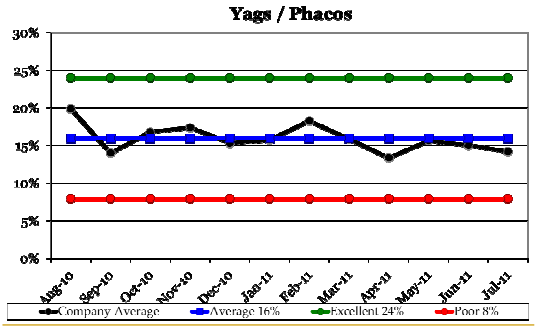
## Benchmarking – what to bench

- 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

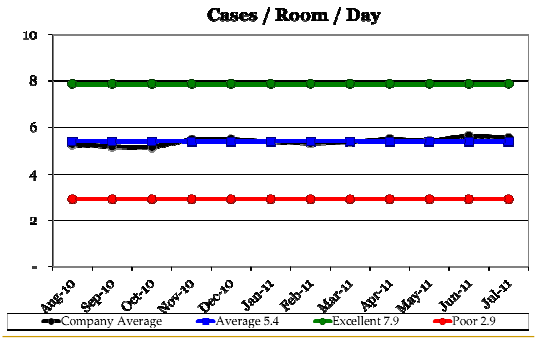
## Benchmarking – examples



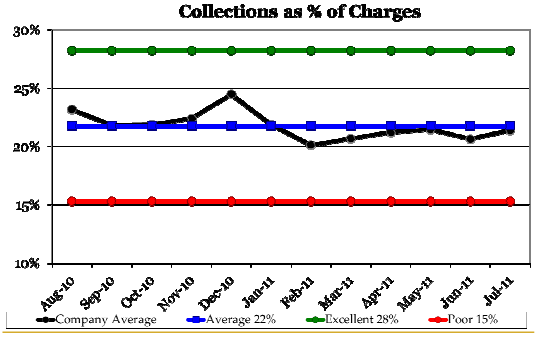
## Benchmarking – examples



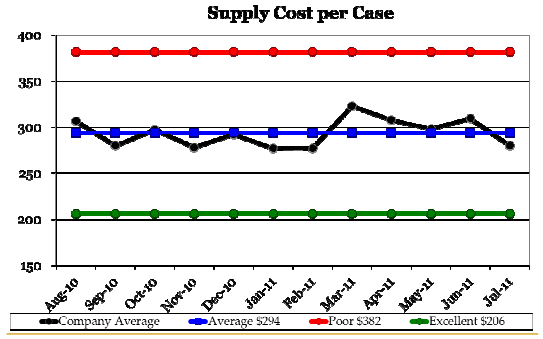

## Benchmarking – examples



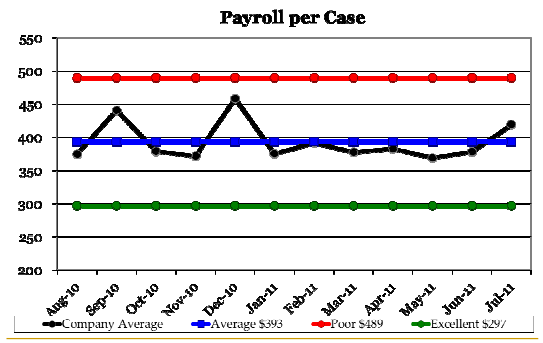

## Benchmarking – examples



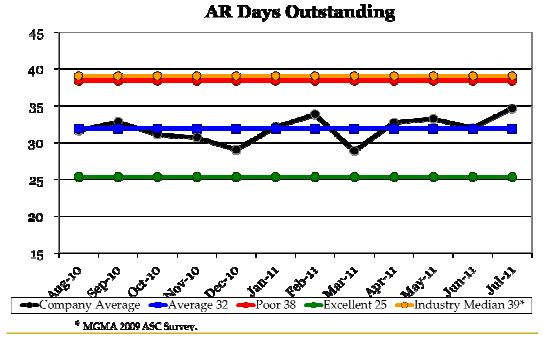
## Benchmarking – examples



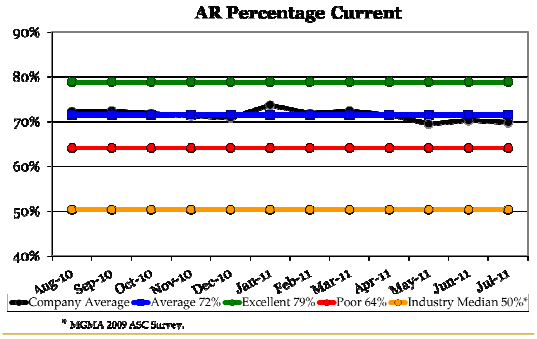

## Benchmarking – examples



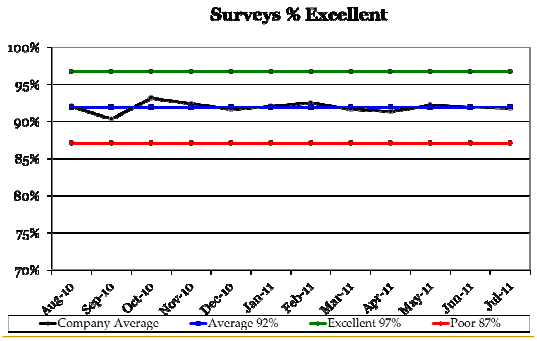

## Benchmarking – examples



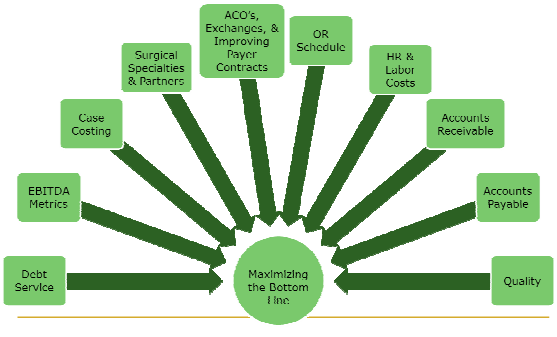
## Benchmarking – examples




## Benchmarking – examples




## Stay Focused on…



## Contact Information


- Ann Geier, MS, RN, CNOR, CASC
  - Sr. VP of Operations
  - ageier@ascoa.com
- Margaret Chappell, MS, BSN, RN, CASC
  - Sr. VP of Operations
  - mchappell@ascoa.com
- Rob Westergard, CPA, CGMA
  - CFO
  - rwestergard@ascoa.com



## Questions?