



Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

January 2011: Vol. 35, No. 1
Pages 1-12

IN THIS ISSUE

- Keys to surviving and thriving under healthcare reform cover
- No more lost supply charges — Hospital adds \$10 million in the OR 4
- Secrets to cutting OT, saving thousands on equipment . . . 5
- Inventory control system saves \$1 million a year 8
- **SDS Manager:** Watching your finances? How to find a treasure chest 9
- Reducing your procedure time with low back pain injections 10

Financial Disclosure:

Senior Managing Editor **Joy Dickinson**, Executive Editor **Coles McKagen**, Board Member and Nurse Planner **Kay Ball**, and Board Member and Columnist **Stephen W. Earnhart** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor **Mark Mayo** reports that he is an Administrative Consultant to USPI Chicago Market. **Steven Schweitzberg**, MD, Physician Reviewer, discloses that he is on the speakers bureau for Stryker Corp. and Merck & Co., he is a medical advisor to Surgiquest, and he is a stockholder in Starion Instruments.

While waiting for healthcare reform, managers cut costs, boost revenue

Your peers are taking the initiative to improve financial outlook

Are you wondering how health care reform is going to impact your outpatient surgery program? Join the crowd.

“Really, as far as being an industry, we’re not getting a lot of information about how it will impact us,” says **Beverly Kirchner**, BSN, RN, CNOR, CASC, president of Southlake, TX-based Genesee Associates, which develops, turns around, and manages ambulatory surgery centers and prepares them for accreditation. Kirchner is a former member of the board of directors for the Association of periOperative Registered Nurses (AORN) and serves in several leadership positions for that group.

Volumes are likely to increase, Kirchner says. “We’ll see sicker patients, because a lot of people have not had healthcare and have not stayed healthy.”

Increases in volume aren’t likely to translate into increases in revenue,

Same-Day Surgery offers ideas to save millions

This month, our special focus is on saving money and increasing revenue in outpatient surgery.

We tell you how providers are making changes under healthcare reform, including how one facility cut agency use by 70% and made another change that saved \$100,000 a year. We tell you how one hospital put a stop to lost charges and added \$10 million in revenues from the OR. We share how one surgery center reduced overtime from 12 hours per nurse to almost zero and saved thousands on an equipment purchase. We share how a revamped system for inventory control saves one facility an estimated \$1 million per year. For those of you performing spine injections, we tell you eight ways to achieve the shortest procedure times. Finally, we tell you how to avoid a needlestick injury that could result in an expensive lawsuit.

We hope you enjoy this special issue of *Same-Day Surgery!*



NOW AVAILABLE ONLINE! Go to www.ahcmedia.com/online.html.
Call (800) 688-2421 for details.

however, she says. Most of the formerly uninsured will be on a plan similar to Medicare, Kirchner says. “Even now, there are lots of procedures with Medicaid and Medicare we can’t afford to do,” Kirchner says.

Her comments are echoed by **Bobby Hillert**, executive director of the Texas Ambulatory Surgery Center Society, who adds that reform is likely to impact who participates in-network with insurance providers. “Commercial insurance companies have indicated that they will have

EXECUTIVE SUMMARY

As the outpatient surgery field prepares for increasing volumes with no corresponding increase in reimbursement, consider these suggestions:

- Know your costs “down to the penny.” Play hard ball with vendors over implant prices.
- Ensure all vendors are giving you prices you negotiated for supplies.
- Insist that patients pre-pay.
- Consider adding a new product line in a specialty that offers good reimbursement, such as gynecology.

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Same-Day Surgery®, P.O. Box 740059, Atlanta, GA 30374.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S.A., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are \$83 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421, ext. 5491. Fax: (800) 284-3291 Web: <http://www.ahcmedia.com>.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 20 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Executive Editor: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).

Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).

Production Editor: **Neill L. Kimball**.

Copyright © 2011 by AHC Media LLC. Same-Day Surgery® is a registered trademark of AHC Media LLC. The trademark Same-Day Surgery® is used herein under license. All rights reserved.

to offer fewer providers in their network within the exchange in order to compete,” Hillert says. “Some commercial insurance companies are already creating plans with smaller provider networks.”

Kirchner’s advice? Be cautious. Know what cases you can and can’t afford to do, she says. She says that in today’s environment, “you need to know your costs down to the penny.”

With all of the attention to penny-pinching, preference cards will take on an added significance, Kirchner says. “Administrators have to get updated and sophisticated on technology so they can track costs, use bar coding for implants, look at supply costs almost instantly on every case,” she says. “You may find yourself with revenues going down, volumes going up, and you scramble to figure out why.” (*For more on determining cost per case, see story on p. 3.*)

4 steps to controlling your costs

Consider these steps when looking to control your costs:

- **Increase percent of patients who pay upfront.**

The Ambulatory Surgery Center at Kelsey-Seybold Clinic, Houston, TX, performed a process improvement project on improving collections, says **Jebby Mathew**, administrator. Staff call patients and have them prepay the copay and coinsurance before the day of service, which makes check-in more efficient, Mathew says. Collections have increased, he says. Although he doesn’t have a specific figure, he says, “we’re well over budget over what we thought we could collect.”

Previously some patients would show up for surgery without money and say “no one told me.” Now the center keeps detailed notes on when patients were contacted, what they were told about fees, and how they were given the opportunity to prepay or pay on the day of service.



Editorial Questions

Questions or comments?
Call Joy Daughtery Dickinson
at (229) 551-9195.

“Before, we would go ahead with the case, they would go to bad debt, and we would lose money on those cases.” To avoid issues with bad debt, the staff set up payment plans with some patients.

- **Ensure you are obtaining proper preapproval for cases.**

A lot of outpatient surgery programs are not obtaining proper preapproval, Mathew says. “It was an issue here,” he says.

Implants can cost thousands, he points out, and some insurance companies require physicians to ensure specific situations exist before the procedure is approved. By making sure the predetermination and precertification paperwork is done correctly, through utilization review, you ensure reimbursement, he says.

- **Move to electronic medical records (EMRs).**

“An electronic medical record is the way to go,” Mathew says. They save you time and money, he adds. His center projects that their new system will save five or six minutes of duplicate charting per case. Their total projected savings is about \$50,000 annually just for nursing documentation.

- **Make your staffing more cost-efficient.**

Although Mathew’s center already was profitable, no one was looking at how much money was being left on the table, he says. Mathew cut agency use by 70% by examining his agency use, staff utilization, and productivity. He looked at utilization of per diem staff on a daily average and by doctor block time to ensure his center wasn’t understaffing or overstaffing. He added some necessary full-time positions.

Some outpatient surgery leaders suggest keeping daily data on staff hours per case by staffing department, such as OR, preop, and PACU. Such data can help you determine where you might be able to reduce direct staffing times or cut agency/per diem staffing.

Having the right staff also is key, says Matt Pate, vice president of financial operations for United Surgical Partners International in Addison, TX. “With case volumes fluctuating so often, it is very important to have a staff that is willing to be flexible as volume increases and decreases,” he says. *[For information on adding a new product line, see story, p. 4. For more on the impact of health care reform, see “Is Outpatient Surgery Better Off Under Health Care Reform Law?” Same-Day Surgery Weekly Alert, March 26, 2010. To subscribe to this free weekly ezine, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]* ■

Know your costs — focus on profitable cases

Implants are a ‘huge expense’

Many outpatient surgery programs set up their Chargemaster simply by taking the Medicare list and marking it up by a set percentage, says Beverly Kirchner, BSN, RN, CNOR, CASC, president of Southlake, TX-based Genesee Associates, which develops, turns around, and manages ambulatory surgery centers and prepares them for accreditation.

Kirchner says, “They never test, so are they billing enough to cover their costs, and do they know what their cost is?”

Pricing is critical, she says. “If they are in administration, and if they don’t do anything else in the course of a day, they should know what cases cost them and what they will be reimbursed,” Kirchner says.

Step one: Know your inventory and what you’re using, Kirchner says. Include specialty items such as pump tubing for laparoscopic procedures, she says. Kirchner says, “You also need to look at all implants. That’s a huge expense in any facility.”

Determine who has the same implants under a different name, and examine the cost differences, she says. Surgery centers can learn from tactics that the large hospital systems are using, Kirchner says. They are creating request for proposal (RFP) based on criteria they want addressed including cost, how they can supply the item, and terms of the contract. “Hospital systems are now calling the implant vendor and saying, ‘this is our price point. You can fill out the RFP, but you need to meet our price point. If you don’t, we will work hard to not have you in our facility,’” Kirchner says. For vendors that don’t comply, the hospitals basically are banning use of that implant.

Kirchner says hospital leaders are sitting down with surgeons and saying, “This is what we’re spending in implants. If this is what we’re spending when healthcare reform comes in, with the patient volume we will see, we will have to lay off staff and shut down ORs. You will operate every other week instead of every week.”

“Ambulatory can learn a lot of lessons from that,” Kirchner says.

Matt Pate, vice president of financial operations for United Surgical Partners International in Addison, TX, says, “Sharing cost information with

your physicians can be very helpful in limiting the number of suppliers. As the number of suppliers decreases, price should also decrease.”

Scripps Health in California has cut about three million dollars out of its spine implant costs by working with physicians to achieve standardization. “Therefore they will not have to lay off nurses,” Kirchner says.

At the Ambulatory Surgery Center at Kelsey-Seybold Clinic, Houston, TX, there was no standardized process to ensure all cases with implants were captured properly, says **Jebby Mathew**, administrator. Mathew created a “universal implant calendar” that cleaned up their implant charge capture. “We’re above break even,” Mathew says.

Need more revenue? Add a new product line

Know your vendors, experts advise

The Ambulatory Surgery Center at Kelsey-Seybold Clinic, Houston, TX, has added revenue with new procedures, including a whole gynecology line that includes laparoscopy, diagnostics, endometrial ablation, and the loop electrosurgical excision procedure (LEEP). Several gynecology surgeons have joined the center.

“We’re using OR block time better and getting reimbursed,” says **Jebby Mathew**, administrator.

The managers are looking at expanding into other services in which reimbursement has increased. “Reimbursements are changing all the time, with healthcare reform,” Mathew says. “Look at the kind of cases your program can handle. Do a pro forma on all equipment. Look at how the reimbursement, supplies, and staffing add up. In terms of making a profit, starting new lines can help.”

At the center, more than 60% of the cases were endoscopies, and endoscopy reimbursement is decreasing, Mathew says. To address that change, managers performed a detailed cost analysis on every CPT code for every procedure they performed in the first six months of 2010.

“We try to understand costs per case and look at which cases are we really making money on and which are we not,” based on contracts and actual collections, Mathew says. While some cases only make a profit of a few percent, others are realizing a large profit margin. “We concentrate on those,”

Mathew says. This information has been presented to the leadership board.

With all product lines, you must have payer contracts that provide adequate reimbursement and negotiate proper discounts with your suppliers, says **Matt Pate**, vice president of financial operations for United Surgical Partners International in Addison, TX. *(For information on avoiding mistakes in contracts, see two-part series that ran in the July 2010 and August 2010 issues of Same-Day Surgery.)*

Do you know your vendors?

Know all your vendors, and work with your group purchasing organization (GPO) to ensure it is contracted with all of your vendors, says **Beverly Kirchner**, BSN, RN, CNOR, CASC, president of Southlake, TX-based Genesee Associates, which develops, turns around, and manages ambulatory surgery centers and prepares them for accreditation.

Mathew has created vendor grids so the leaders can understand which vendors they are using and standardize their costs. “All help our bottom line,” he says.

Mathew says his center is examining all of its vendor relationships, including ones that have been in place for years. Members of his staff have determined that in a significant number of cases, there was no follow up to ensure the center was getting the price that was negotiated.

Some vendors and products have changed as a result of this process. The center went from reusable to disposable linens and saved \$100,000 a year. ■

Clinicians put brakes on lost charges

By getting financial staff to understand the clinician’s point of view and finding a way to work together, Scripps Memorial Hospital in La Jolla, CA, has been able to capture millions in additional revenue, including \$10 million just from the operating rooms.

Thousands of charges are lost at hospitals, either because they aren’t inputted correctly or on time, or they don’t adequately reflect the care that was provided. This situation was happening at Scripps as recently as three years ago, says **Lisa Thakur**, CPA, MBA, FACHE, FHFMA, corporate vice president of operations, clinical and support

EXECUTIVE SUMMARY

Scripps Memorial Hospital in La Jolla, CA, formerly would see millions go out the door in lost charges that were never inputted or inputted too late to show up on bills.

- The hospital has instituted a centralized charge capture system and added resources to help clinicians appropriately document care.
- The process is responsible for \$10 million in additional revenues in the OR alone.

service at Scripps Health in La Jolla.

“The individual departments were supposed to be inputting their charges and then reviewing them on a daily basis to ensure their accuracy, but that is not really their focus,” explains Thakur. “We found that a lot of charge sheets were not even getting inputted. They were being dropped or being done after the bill was dropped, which really is not helpful.”

Thakur concluded that tasks such as charge entry should be handled by financial staff and that clinicians need added resources to help with documentation. She implemented a centralized charge capture system that involved assigning two people from revenue cycle to handle all charge entry. This requires people with knowledge of the revenue cycle to have a very different type of relationship with clinical management, says Thakur. “Clinicians don’t understand all the rules and requirements [for billing and reimbursement], and it gets into a lot of details, but you are leaving money on the table because of this.”

According to **Mimi Johnson**, manager, of access and scheduling services at Scripps La Jolla, during the transition they “discovered several areas in need of process change and improvement to ensure charges being entered are accurate, validated, and completed in a timely manner.” For example, inservices on accurate documentation were provided to RNs and their managers. “This includes the OR and the floors and units,” Johnson says.

Documentation specialists were assigned to the ORs across all five Scripps hospitals. They work with clinicians to make sure care is properly documented. Thakur worked with clinical managers to develop a review and audit process. “When they enter the charges, they validate them, and then they are reviewed and audited [by supervisors] so that we can ensure that not only was [the care] documented, but it actually was entered on a timely basis, so we carved out that piece,” says Thakur. “We decided we needed people under revenue cycle to do that type of work rather than assuming that clinical management is going to do

it. We estimate that the net revenue [from this process change] just on the OR piece is \$10 million per year.”

Materials coordinators work with the leaders of each service line, says **Sally Super**, RN, OR manager, Scripps Memorial Hospital La Jolla. “Prior to this collaboration, many items went shipped overnight, borrowed from other facilities, or cases were having to be cancelled due to the lack of coordination with all responsible staff and physicians,” Super says.

While previously five cases per year were being cancelled due to supplies not being available, now no cases are being cancelled, Super says. “Cancelling cases are a huge dissatisfier for patients’ families and physicians as they make many plans to coordinate their office time and OR time, and families take off from work or drive a great distance to have their procedures done,” she says. Also staff members’ satisfaction increased when they didn’t need to be off work, due to flex time.

Many bills previously were held up because of inaccurate documentation. Now, “that has been eliminated because all members of the team are aware of what needs to be charged, and follow-through from our materials coordinators has been instrumental to the completeness and accurate documentation,” Super says.

The OR staff work weekly, and sometimes daily, with the materials coordinators to ensure materials and supplies are available for specific cases. “Clinicians are able to focus on patient care, and working collaboratively as a team with Charge Master and materials [coordinators] has been a huge payback in terms of reimbursement and accurate documentation,” she says. ■

3-part philosophy cuts OT and costs

\$10,000 saved with ultrasound purchase

Specialty Surgical Center in Sparta, NJ, has used a three-part philosophy process to achieve significant savings, including a drastic reduction in overtime for preop nurses and a \$10,000 savings in an equipment purchase.

Their secret? Stay on top of technology, examine your profit & loss statements on a monthly basis, and engage your staff in the cost-saving process.

SOURCES/RESOURCES

For more information on SourceMedical Vision or One Medical Passport software, go to:

• **SourceMedical**, Wallingford, CT. Phone: (800) 719-1904. E-mail: info@sourcemed.net. Web: <http://sourcemed.net>.

For more information on EdgeSurvey, contact:

• **CTQ Solutions**, Branford, CT. Phone: (877) 208.7605. E-mail: Info@CTQSolutions.com. Web: ctqsolutions.com.

“The goal is to get as much technology in place as possible, in anticipation of all the [health care reform] rules coming out,” says **Bonnie Brady**, RN, CNOR, the administrator of Specialty Surgical Center. “You never have any space for [paper] files, so you want to get away from that as much as possible.”

Technology has had a dramatic impact on the time their preoperative nurses spend making calls to patients, Brady says. Formerly, the center had to pay each preop nurse an average of 12 hours overtime. “We had preop nurses here late at night to do the preop phone call,” Brady says. “Sometimes they couldn’t reach patients, and they would have to call three or four times.” Patients would spend large amounts of time giving histories that often included insignificant details, she says.

The center invested in SourceMedical Vision software, with the addition of the One Medical Passport piece. The software allows patients to submit their medical history online, Brady says. Surgeons’ offices give patients bright yellow cards with information about the secure web site. The card tells patients in a step-by-step process how to complete the process of submitting their history. (*For more on the software, see resources, above right.*)

The software guides patients down pathways, depending on the information they submit. For example, if patients say they are diabetic, it asks whether they have juvenile or adult-onset diabetes.

“Nurses come in in the morning, download histories, and review it,” Brady says. Rather than focusing on unimportant details, they can focus on any problems the patient has, she says. The nurses still make a preoperative phone call, but the call is more defined, Brady says. “Sometimes there’s

no problem, and the nurses just call and tell them when to stop eating,” she says.

Now, the overtime in the preoperative area is “almost negligible,” Brady says. In addition to dramatically decreasing the amount of time spent on the phone, the software has increased the quality of the call nurses make to patients, Brady says.

Patients can complete the process anytime instead of waiting on a phone call, so the system has been well-received by patients, she says. “I thought it would be problem with the elderly, but they’re good,” Brady says. “Ninety to ninety-five percent of our patients are using it, and they like it.”

In fact, the process has helped improve the center’s patient satisfaction scores, which are in the 90th percentile or higher, Brady says.

The center also added EdgeSurvey software from CTQ Solutions to measure patient satisfaction. This software allows patients to go home and complete their patient satisfaction survey online. “I never thought patients would use it, but they use it all the time,” says Brady. In fact, 42-52% of patients are completing patient satisfaction surveys.

“They do all the work,” Brady says. “Before this, nurses were handing out surveys. They had to collect them, collate them, and make a report out of it. This does it all for you.”

The software allows you to benchmark against yourself, in terms of areas where you performed best and worst, and it also allows national benchmarking.

The center also has added a patient tracker system. Patients are assigned a symbol with their initials, which is visible on a screen to their friends and family in the lobby. Nurses move that symbol through the work areas. “Patients families can watch that [symbol] and know the patient is in preop, then moves to the OR, then moves to postop,” Brady says. “They know where their family members are at all times.”

EXECUTIVE SUMMARY

Managers at Specialty Surgical Center in Sparta, NJ, have achieved significant cost savings by staying on top of technology, examining their profit & loss statements on a monthly basis, and engaging their staff in the cost-saving process.

- Obtaining three quotes for a new ultrasound led to a \$10,000 savings.
- Investing in software allowed patients to submit preop questionnaires and patient satisfaction surveys online, which reduced preop overtime from an average of 12 hours overtime per nurse to almost zero.
- Open houses included games related to the prices of supplies and equipment. Members of the staff and community were educated.

Even the central service department has joined the technology age and is scanning manufacturers' instructions, quality assurance documentation, material safety data sheets (MSDSs), and other items into their computer. "The computer is streamlining a lot of processes," Brady says. *(See information on getting your staff involved in cost cutting, below, and using an open house to educate staff and the community about prices, below right.)* ■

Engage staff in cost cutting

Involve your entire staff in cost cutting, advises **Bonnie Brady, RN, CNOR**, the administrator of Specialty Surgical Center in Sparta, NJ.

"They come to me with good ideas all the time," Brady says.

For example, staff members examine every item at the center, from the smallest to the largest, to determine how money can be saved. "We get three quotes on everything," Brady says. "We play one [vendor] off the other."

Even when the center has one preferred vendor, they obtain two more quotes and then go back to the preferred vendor to ask, can you beat this price? "Most of the time, they want your business, and they work something out," Brady says. "Never take the first number."

Recently **Stephen S. Espinosa, RN, BSN, CNOR, RNFA**, director of nursing, saved \$10,000 by negotiating prices for a new ultrasound. "A lot of vendors out there are willing to meet your price or lower their price to get your business," Espinosa says. Know beforehand what you're willing to pay and what quality you are expecting, he advises.

Recently his center examined their 50 cc bottles of contrast media and realized they were paying more than \$30 a bottle. Through its group purchasing organization, the center was able to obtain the "best price in its market" of \$6.19 for the same product, Espinosa says.

The center also uses auction sites, including Centurion Service Group (www.centurionservice.com). The site offers used instruments for less than half price, Brady says. "We look for good deals and bid," she says. "Sometimes we get it, and sometimes we don't."

To ensure you obtain the instrument you are expecting, do your homework and look at photos

of the instrument, Brady advises.

The center also recently switched vendors for disposable arthroscopy shavers. "By switching companies, we saved at least \$40 off of the old vendor," Espinosa says.

The center also has realized success with contracts, which are examined annually. The center saved \$3,000 per year by examining the emergency generator contract and changing vendors.

The center's cost-cutting efforts are continuing. The center has managed to significantly drop expenses by looking at the profit & loss statement every month at the managers meeting. Each area of the center is examined, and goals where the managers want to see decreases are set for the next month.

The center is saving with staffing approaches such as flexible work hours. Brady says they also have cross-trained staff "so we can utilize everyone." At the front desk, the center is using per diem staff to cover for staff members who are out, rather than keeping full-time employees for that purpose.

Espinosa's advice to other managers who want to save money? "Have that attitude, always, that you spend like it's your own money," he says. ■

Games educate staff and community

The managers at Specialty Surgical Center in Sparta, NJ, have found an innovative way to educate their staff, as well as the community, on the cost of items. The center held two open houses as a way to celebrate National Ambulatory Surgery Center Week. The open houses were held after hours and were promoted through the local media.

Staff members marked the prices of items throughout the center. "It was rather eye-opening," says **Bonnie Brady, RN, CNOR**, the administrator. "Now staff know what things cost." For example, many staff members didn't realize that a pack of sutures cost \$22.

During the open houses, the center held games such as displaying three products and having guests price them from the highest to the lowest price. In another game, the center had guests estimate the cost of everything in the room, which was well over a million dollars. "The general public has no idea what things cost," Brady says.

Guests who guessed correctly put their name in a pot to win prizes such as gift baskets at the end of the night. The prizes were donated by local vendors. ■

Inventory control overhaul saves \$1 million a year

Savings attract 'best practice' designation

As part of a hospitalwide focus on improvement, the surgical services department at Barnes-Jewish Hospital (BJH) in St. Louis, MO, began looking into its supply-chain processes. And it wasn't pretty.

"Virtually all aspects of our supply-chain had defects in them that required attention," notes David Jaques, MD, vice president for surgical services at BJH.

For example, while the hospital had an over-supply of many items, there were also times when a clinician would need an item quickly, and it would be out of stock, explains Jaques. The process the department used to assess inventory was time-consuming and tedious. It essentially required someone to count items from all product lines every day, which took about six hours.

Staff examined their supply-chain processes in a process called value stream analysis. One first step involved weeding out supplies that they didn't need. The results were stunning. "When we first stripped out some of that overstock, I think we identified something like \$700,000 worth of overstocked supplies that were on our premises, and that is essentially the same as waste," says Jaques. "The other part of this cleansing was identifying not just overstocks, but things we never even use."

In fact, these types of items are not uncommon in a surgical setting because research and development often renders products obsolete fairly quickly, explains Jaques.

Once department staff had cleared away the excess inventory, unused items, and expired products, they began to implement a new system of inventory control called kanban (pro-

EXECUTIVE SUMMARY

Perioperative services at Barnes-Jewish Hospital in St. Louis, MO, saves an estimated \$1 million per year through its "kanban" system for inventory control.

- When weeding out supplies they didn't need, staff identified about \$700,000 worth of overstocked supplies that were on the premises.
- The kanban approach reduces what originally took six hours to complete to a 30-minute task.

nounced con bon). Borrowed from Japanese manufacturing techniques, the term refers to a visual cue or signal that it is time to reorder, says Jaques. The kanban approach reduces what originally took six hours to complete at BJH to a 30-minute task, he says. (*For more information, see story, p. 9.*)

"It allows you to understand at a glance that something requires reordering, and this signal is sent exactly when it is needed and not before," adds Jaques. "For us, the visual signal is actually an empty bin, so where we used to have one big bin that was oversized and allowed us to get overstocked, now our bins are really small."

Each bin contains a specific amount of product, and it is divided in half. Personnel know that they should always pull product from the left side of the bin first because that's where the product is more dated, explains Jaques. Instead of counting product daily, staff know to start reordering when the right side of the bin goes empty.

"We run through our storeroom, and we identify through visual cues which areas need resupply," Jaques says. "We do that at a set time of the day, and then we get all of that product coming in late in the day so that it can be restocked overnight and ready for the next day."

Result is smaller inventory

The department has repurposed staff members who used to spend hours counting supplies, and it keeps a much smaller inventory on hand. The department also avoids such problems as expired goods or stockouts. "I know that through a combination of all these efforts, we are most certainly saving \$1 million dollars or even more sometimes per year," says Jaques. "And that's just in the perioperative area."

The department is dubbed a best practice site by the Oak Brook, IL-based University HealthSystem Consortium, an alliance of 107 academic medical centers that acts as a group purchasing organization.

The primary advice that Jaques has to offer is quite basic, but he points out that it is also, for many facilities, the hardest step. "It is really to get rid of all the excess, the unnecessary, because you won't be able to see your defects unless all of the unimportant visual cues are separated out," he says. "This starts with just sustaining a clean workplace." ■

5S Lean Tool makes supplies a 'model area'

Beginning in 2006, administrators Barnes-Jewish Hospital (BJH) in St. Louis, MO, began to embrace lean and Six Sigma approaches to improvement, not only to become more efficient, but also to make strides in patient safety, clinical quality, service, and financial performance. Such efforts are ongoing, but results achieved thus far include a 26% improvement rate in operating margin at a time when many hospitals are suffering setbacks.

One of the most basic lean tools is 5S, a term that stands for a process designed to strip away waste and optimally organize the work process. While the term, 5S, actually stands for five Japanese words, they have been roughly translated into English words that outline the steps that are involved:

- Separate the items you need from the items you don't need.
- Simplify, or arrange the items you need to complete a task.
- Scrub or clean up your work area.
- Standardize or sort and simplify on a daily basis.
- Sustain all of the above activities.

5S forces everyone to get involved, and when 5S is applied in concert with the value stream process, the savings can be impressive. For example, perioperative services now saves roughly \$1 million dollars a year, as a result of getting rid of unneeded supplies and instituting a process for ordering supplies at precisely the time they are needed, explains **David Jaques**, MD, vice president for surgical services at BJH.

"We now have what I consider to be a fairly model area for supplies," says Jaques. "It has helped us from the standpoint of labor productivity as well as our overall expenses because now the process [of assessing inventory] has been reduced from something like a six-hour event of counting thousands of lines down to about a half hour to do the same task."

Representatives from other hospitals are constantly coming through to see firsthand what BJH has accomplished, says Jaques. Such visits are helpful, says Jaques, because otherwise many people don't quite grasp what successful looks like, he says.

"This can appear very daunting to people who

have not started on this journey," Jaques says. "Most places are just so off the mark that they almost can't understand how they can clean their process up. That's why we enjoy having visitors." ■

Same-Day Surgery Manager



Generate new income by cutting your costs

By **Stephen W. Earnhart, MS**
CEO
Earnhart & Associates
Austin, TX

Want to make more money next month? Look at your "variable costs" this month! Many professionals tend to overlook the amount of revenue that is generated by simply not spending money. The treasure chest lies within your own grasp.

What is variable cost within a surgical facility? Actually, there's much more than most realize. I'll share some tricks I use when I evaluate a facility or to see how efficient the management staff performs.

Most expenses in any surgical environment are generated by actual patients having surgery. Makes sense, but it is not all that obvious to some. Some expenses, such as rent, bank notes or loans, and utilities to some degree will be the same if you are doing 100 cases per month or 800 per month. Not much can easily or quickly be done about those costs, but your two biggest items, supplies and staffing cost, are directly related to how much surgery you are performing. I know that you know that, but I do want to point out how much found revenue those costs represent because we typically do not see it as such.

The average surgical department or surgery center will spend about \$1 million to \$5 million dollars each year in staffing. If your surgical volume is down 30% as some centers are reporting, then if you have your staff set up as "flex" or "per diem," you should furlough about that percentage of staff to represent your surgical volume. The savings can be as significant: \$25,000 to \$125,000 each month! Supply costs, for many cost centers, tends to equal staffing cost. So using the same example, you can save the same amount each month. Total

so far = \$50,000 to \$250,000 each down month. Add in other variable patient-related costs such as linen, transcription, postage, paper forms, bad debt, medical gases, medical waste, and other expenses, and it starts to add up.

So, let's see how much "revenue" we were able to generate by reducing costs:

Personnel cost: \$25,000-\$125,000

Supply cost: \$25,000-\$125,000

Miscellaneous: \$6,000-\$36,000

Total potential "new revenue" equals between \$56,000 and \$286,000 each month!

So, now let's pretend that those savings were actually new cases. With average net reimbursement per case at around \$2,000 per case, we have actually generated the equivalent of between 28 and 143 cases each month! None a bad month, all things considered.

I know what some of you are thinking: Imagine how much we could save if we did no cases each month! Doesn't quite work out to the same.

Now ... reality. Clearly this is not the case with all hospital and surgery centers around that country. This example will not work for you if your staff is all full time and you have not built in a flexible staffing schedule. Maybe it's time to consider that schedule. Staffing is far and away the greatest expense we have in any facility, but our staff is also what helps to make us successful! Without great people within the walls, we have nothing. So how do you reduce or at least give yourself the option of flexing your staff during down time? It could be far, far easier than you think: Ask them! With the holidays and nasty weather ahead of us, what better time to work a four-day workweek or to take some time off?

I was with the administrator of a center a couple of weeks ago and let her know she was over-staffed during slow periods and that it was hurting her numbers significantly. I suggested the model explained above. She said her staff needed the hours and the money and that it would not work. I asked her if she would at least bring it up at the staff meeting the next day. She did, and more than 60% of her staff said they would cut back to four days per week and take time off to get things done outside of work. So, unless you ask, you just don't know. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Tweet address: Earnhart_EAI.]* ■

Strategies to cut time for spinal injections

Save money by reducing OR time

The first study of low back injection for pain management by the AAAHC Institute for Quality Improvement, a not-for-profit subsidiary of the Accreditation Association for Ambulatory Health Care (AAAHC), found eight common factors among organizations with shortest procedure times:

- following a strict schedule for patient appointments, physicians and other staff avoid over-scheduling to decrease patient pre-procedure wait times;
- calling patients the day before the procedure to confirm their appointments;
- doing telephone pre-assessment and registration prior to the patient's appointment date;
- having staff members who are familiar with each physician's preferences and how they perform their procedures;
- having preoperative staff work together so at least two patients are ready for the procedure at any time;
- using an electronic health record so physicians can complete their procedure reports at a computer station in the procedure room;
- having all available staff help with turnover, including nurses, radiation technologists, and physicians.

About 80% of patients were contacted within 7-10 days of the procedure to obtain information on outcomes.

Naomi Kuznets, PhD, senior director and general manager of the AAAHC Institute, said, "More than 1.5 million spinal injections as a treatment for pain and other back problems are performed each year, and that number is expected to rise as the population ages. Nearly two-thirds of these procedures are performed in the outpatient setting. As the leader in ambulatory care accreditation, AAAHC believed it was important to gather data and benchmark results for low back injection, which is increasing in prevalence and associated costs."

More than three-fourths (78%) of patients reported their pain had improved, and 82% said they were able to perform their daily activities after undergoing spinal injections for back pain. However, only about half (53%) said they were able to reduce their pain medications after the procedure.

Girish P. Joshi, MBBS, MD, FFARCSI, who was a member of the AAAHC Institute work group that designed the study, said, “Low back injection was very effective in managing pain in this patient population. Although only about half of the patients were able to reduce their pain medications, more than eight out of 10 were able to return to their normal activities. That increase in physical activity may account for the need to continue the medications.” Joshi is professor of anesthesiology and pain management and director of perioperative medicine, University of Texas Southwestern Medical Center, Dallas.

Additional findings include:

- The most frequent symptoms for which the procedure was performed were pain (96%), limited range of motion (47%), spinal tenderness (28%), weakness (28%), a positive straight-leg test (21%), a test in which the leg is raised upward with the knee unbent (the test is positive if there is pain down the back of the leg), and numbness (5%). Some patients reported more than one symptom.
- 53 percent of patients rated the severity of their symptoms as greater than “5” on a scale of 0-10, with “10” being the most severe.
- 91% of patients received three or fewer injections.
- 89% of injections included local anesthetics, and 95% included corticosteroids.
- 63% of patients received intravenous sedation.
- 98% of injections were guided by X-ray imaging.

The 107 ambulatory organizations that participated in the study perform approximately 139,000 low back injections annually. The organizations submitted data on a total of 2,227 routine, uncomplicated procedures for inclusion in the study. Not every organization and/or every patient was included in every measure. *(The benchmarks from this study were published in the Dec. 3, 2010, issue of Same-Day Surgery Weekly Alert. To subscribe to this free weekly ezine, contact customer service at customerservice@ahcmedia.com. To order copies of the report or for more information, visit www.aaahciqi.org. On the left side of the page, select “Order Products.” At the bottom of the page, under “Pain Management — Low Back Injection January — June 2010,” select “purchase product” for the PDF or CD-ROM product. The price is \$85 for the PDF and \$110 plus \$15 shipping for the CD-ROM.)* ■

Joint Commission launches new web site

The Joint Commission has launched a new Web site (www.jointcommission.org) that it says improves access to information about health care quality and safety.

The improvements were based on extensive research with health care organizations, health professionals, consumers, the business community, and state and federal health agencies, The Joint Commission said in a released statement. The web site improvements include:

- sign-ups for updates and alerts related to upcoming events, field reviews, FAQs, and newsletters;
- a “Daily Update” section that highlights new information posted within the last 24 hours;
- enhanced multi-media functionality for videos, podcasts, and RSS feeds;
- interactive opportunities such as blogs, discussion forums in real time, speaker’s bureau request forms, and options to share information with other people. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this activity with the June issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter will be mailed to you.

COMING IN FUTURE MONTHS

- | | |
|--|---|
| ■ Outpatient surgery providers offer amenities to patients | ■ Computer-based informed consent programs |
| ■ Results of 2010 Salary Survey | ■ Lessons learned from whistleblower lawsuits |

EDITORIAL ADVISORY BOARD

Consulting Editor: **Mark Mayo**
Executive Director
Ambulatory Surgery Center Association of Illinois

Kay Ball

RN, PhD, CNOR, FAAN
Perioperative Consultant/
Educator, K&D Medical
Lewis Center, OH
E-mail: KayBall@aol.com

Stephen W. Earnhart, MS
President and CEO
Earnhart & Associates
Austin, TX
E-mail: searnhart@earnhart.com

Ann Geier, RN, MS, CNOR
CASC
Vice President of Operations
Ambulatory Surgical Centers
of America
Norwood, MA

Kate Moses,
RN, CNOR, CPHQ
Chair, Ambulatory Surgery
Specialty Assembly
Association of periOperative
Nurses, Denver
Quality Management Nurse,
Medical Arts Surgery Centers
Miami

Roger Pence

President
FWI Healthcare
Edgerton, OH
E-mail: roger@
fwihealthcare.com

Steven D. Schwaitzberg,
MD
Chief of Surgery
Cambridge (MA) Health
Alliance

David Shapiro, MD,
CHCQM, CHC, CPHRM,
LHRM
Partner, Ambulatory Surgery
Company, LLC
Tallahassee, FL

Rebecca S. Twersky, MD
Medical Director
Ambulatory Surgery Unit
Long Island College Hospital
Brooklyn, NY
E-mail: twersky@pipeline.com

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511

Fax: (800) 284-3291

Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer

Phone: (800) 688-2421, ext. 5482

Fax: (800) 284-3291

Email: tria.kreutzer@ahcmedia.com

Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com

Website: www.copyright.com

Phone: (978) 750-8400

Fax: (978) 646-8600

Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

CNE/CME QUESTIONS

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

1. How did managers at Specialty Surgical Center in Sparta, NJ, save \$10,000 when purchasing a new ultrasound?

- A. They were a beta site for a new product.
- B. They obtained three price quotes.
- C. They bought a used ultrasound.
- D. None of the above.

2. How did perioperative services at Barnes-Jewish Hospital in St. Louis, MO, save an estimated \$1 million per year?

- A. Using a "kanban" system for inventory control.
- B. Changing vendors.
- C. Reducing staff
- D. Eliminating per diem staff almost completely.

3. Which of the following is NOT part of the lean tool 5S?

- A. Separate the items you need from the items you don't need.
- B. Simplify, or arrange the items you need to complete a task.
- C. Scrub or clean up your work area.
- D. Stop practices that are time-intensive with little reward.

4. In the first study of low back injection for pain management by the AAAHC Institute for Quality Improvement, a not-for-profit subsidiary of the Accreditation Association for Ambulatory Health Care (AAAHC), which of the following were factors among organizations with shortest procedure times?

- A. Following a strict schedule for patient appointments
- B. Calling patients the day before the procedure to confirm appointments
- C. Doing telephone pre-assessment and registration prior to the appointment date
- D. All of the above

Answers: 1. B; 2. A; 3. D; 4. D