Eastern Association for the Surgery of Trauma

Advancing Science, Fostering Relationships, and Building Careers

Leadership in a Complex Medical World
An EAST Leadership Development Workshop

January 9, 2018
Disney's Contemporary Resort
Lake Buena Vista, Florida

Resource Allocation: Dealing with Hospital Administration

Leadership Development Workshop
EAST 2018

Blaine L. Enderson, MD, MBA, FACS, FCCM
Professor of Surgery
University of Tennessee Medical Center, Knoxville

Disclosures

- No Financial Disclosures
- I used to be a working surgeon, but now am a hospital administrator

The Big Question(s)

- Why is it that this entity (hospital, system) that is worth this (huge amount) and has this (huge amount) cash in the bank, can't give me what I need (people, equipment)?
- How can I convince the administration that the investment will be worth it (ROI)?
- Why don't they trust me to spend their money wisely?

Hospital Finance

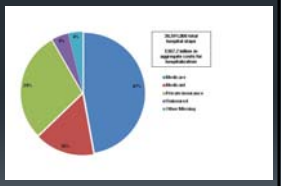
- Not like personal finance or even practice finance
  - Personal or practice—income earned when it is received, expenses occur when paid—cash accounting
  - Hospitals use accrual accounting—compares income vs expenses over time
    - Income is earned when service is provided (patient in bed)
    - Expenses are cost of providing material and services when it is provided
    - Timing of when hospital gets paid for service or pays for materials and services is irrelevant—cash flow is a separate issue
    - Accurate measurement of profits or losses depends upon correct matching of services provided and the costs of providing them
- Governmental regulation
- Changing payment systems

Hospital Revenue

- Multiple ways of being paid for patient care
- Case Basis or Prospective Payment
  - Dominant method now due to Medicare DRG's
  - Set fee paid for patient based on diagnosis, no matter how long LOS is or how many resources are used
- Per Diem
  - Previously was only method of payment—cost per diem, price set by provider
  - Now is rare and is contractual per diem—price set by payer
- Capitation
  - Fixed amount paid per enrolled individual per month or year for specified list of services
  - Provider paid whether or not services are used, but is at risk if cost overruns occur
- Percentage of charges

Hospital Payer Mix

- Government Programs Do Not Cover Hospital Costs
  - Medicare payment-to-cost ratio—91.3%
  - Medicaid—85.8%
  - Private payers—130.3%



Hospital Budget

- Essential tool to monitor hospital performance
- Revenue and expense forecast describing the financial goals for the next year
- Has one year time horizon
- Current budget is a step toward fulfillment of the long range plan
- Cumulative effect of five budgets does not equate to a five year strategic plan
- Frequent changes over 5-year period in assumptions, circumstances, and short-run results alter cumulative effect

Preparing Hospital Budget

- Difficult—must make predictions
- Uncertainty about payment arrangements and rates may delay process
- Requires involvement of staff at all levels
- May not be completed by start of year
- Flexible budgeting allows changes to occur based on volumes
  - Initial budget in unit based on less then full occupancy
  - Flexible budget allows staffing up (or down) based on actual volume
- Our budgeting process starts in July for the next year
  - Key patient stats approved—senior management
  - Patient volumes and net revenue projected
  - Hospital expenses projected
  - Department budgets based on projected census
  - Budget reconciliation
    - Reclass FTE's and non staffing expenses
    - Analyze expenses reduction opportunities
    - Review by senior management
  - Board approval in December (hopefully)

Annual Budget

- 10 Accounting Units
- Biggest are: ED, TSICU, NCC, MCC
- Annual revenue >$100 million—not mine to spend!
- Expenses based on projected volumes
  - 80-82% is salaries, wages, and benefits
  - 16% supplies and stores
  - Remainder—purchased services, insurance and other
- Receive monthly variance reports—if data is not within 5% of target, must submit explanation and plan of resolution

Capital Budget

- Capital expenditures are outlays that provide benefit for more than the year in which they were incurred
  - New buildings, additions to buildings, and facility improvements
  - Equipment—imaging, IT, etc
- Capital expenses are depreciated over their useful life
- May incur ongoing costs, such as labor, supplies, and maintenance which must accounted for in annual budget
- UT capitalization when value >$2500 and has expected useful life >1 year

- In the past, capital expenditures were reimbursed as a pass-through by payers—NO MORE
- Oversight is critical
- Decisions made on ad hoc or political basis—squeaky wheel—not in organization's best interest
- Capital expenditures should increase revenue and/or reduce costs

Capital Budget

- Calculation: Operating margin plus depreciation minus bond payments times 85%
- 2016 and 2017, approximately $30 million
  - $22-$25 million for projects > $100,000
  - 59 projects on the list
    - Examples in my area: ED ultrasound, ECMO program, critical care ventilators, ED upgrade
    - Hospital IT (has over 100 pending projects), GI scopes, stretcher replacement, endovascular room replacement, surgical robot, and many more

- $750,000 for projects $10K-$100K
  - System management team allocates based on priority
- $300,000 for projects $1K-$10K
- Categories for infrastructure upgrades, major maintenance, refurbishing and Joint Commission Improvements

Hospital Creditworthiness

- Profitability Indicators
  - Operating margin—reflects profitability from active patient care
  - Excess margin—profitability from operations and non-operating activities
  - EBIDA—earnings before interest, depreciation, and amortization—ability to pay back debt
- Liquidity Indicators
  - Days cash on hand
  - Cash-to-debt ratio

- Debt Indicators
  - Debt-service coverage ratio—ability of cash flow to meet debt-service requirements
  - Debt-to-capitalization ratio—indicates how highly leveraged (or risky) the organization is
- Other Indicators
  - Average age of plant—indicator of future capital needs
  - Capital spending ratio—measures capital spending as a percentage of EBIDA

Negotiating With Hospital

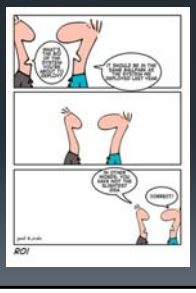
- Can Use Sticks
  - JCAHO or other organization requirements
  - State trauma designation requirements
  - ACS COT verification requirements
- Squeaky wheel
- These are not good long term strategies!

Negotiating With Hospital

- Demonstrate value of trauma service
- Core competency
- Standardization
- Performance Improvement
- Financial value
  - Not "money loser"
  - Significant positive impact
  - Look at payer mix
  - Downstream impact
  - Reputation
- Halo effect

Negotiating With Hospital

- Show them the ROI
  - How will it increase revenue?
  - How will it decrease costs?
  - How will it improve patient flow?
  - How will it improve patient satisfaction?
  - How will it improve staff satisfaction?



How to get involved in EAST

Bruce Crookes, MD FACS
EAST President 2017-2018
Associate Professor of Surgery
Chief, Division of General Surgery
Associate Chief Quality Officer
Medical University of South Carolina

Objectives

- What is EAST's history?
  - Where did we come from?
- What is EAST?
  - What is our Mission?
  - What is our Vision?
- How is EAST structured?
- How do I get involved in EAST?
- How do I succeed in EAST?

Eastern Association for the Surgery of Trauma

Advancing Science, Fostering Relationships, and Building Careers

What is the history of EAST?

The History of EAST

- 1985:
  - No appropriate opportunities for young aspiring trauma surgeons to exchange knowledge, discuss advances in patient care, or develop their careers in this field within the discipline of "trauma surgery."
    - Opportunities to learn the ropes of clinical system development and foster a scholarly approach to the practice, were rare…. and often heavy with laboratory experimental commitment common to academic centers.
    - Trauma centers were self-designated…and propagating

"Few focused on the principles of clinical service development and management……the cornerstones of trauma center development."

Champion et al. "A Brief History of the Founding of the Eastern Association for the Surgery of Trauma (EAST)"

The History of EAST

- 1985: (cont.)
  - The building of an academic portfolio and advancement in trauma surgery were confined to a few leading universities (i.e. University of California, San Francisco)
  - Careers in colorectal cancer, hepatobiliary, and GI surgery were easier to chart because:
    - these subspecialties had a broader base of academia
    - broad connectivity between leading institutions relative to trauma

"Trauma care remained a stepchild. There was no specialty qualification in trauma. (Any surgeon could do that!)"

Champion et al. "A Brief History of the Founding of the Eastern Association for the Surgery of Trauma (EAST)"

The History of EAST

- Four founding board members:
  - Dr. Howard R. Champion
  - Dr. Lenworth Jacobs
  - Dr. Kimball I. Maull
  - Dr. Burton H. Harris (represented "the little people")
- Discussed concept with Dr. Don Trunkey, then AAST president

Trunkey: "need to have a mission that was supportive of, and not conflicting with those of AAST and WTA."

The History of EAST

- July 17th, 1986:
  - Four board members drafted bylaws for EAST
  - Articles of Incorporation approved
  - Filed as **503c corporation** in the state of Tennessee:
    - "Charitable Organization"
    - Cannot contribution to political campaigns or lobby
  - Founding board members selected
  - Decided to have an annual meeting

EAST Founding Board Members

Raymond Alexander, MD

Andrew Burgess, MD

Howard R. Champion, MD

Thomas Gennarelli, MD

Burton H. Harris, MD

Lenworth M. Jacobs, MD

Kimball I. Maull, MD

Norman E. McSwain, MD

Michael Rhodes, MD

C. William Schwab, MD

The History of EAST

- Annual Scientific Meeting:
  - first to be held in winter of 1987–1988
  - "in a warm climate, probably in Florida."
- Membership would be inclusive.
  - Active members would have to be young – less than 50 years of age.

"Above all the meetings should be FUN but must also be good science."

November 18, 1986

Dear _____,

It is a pleasant task to inform you that a new organization, the Eastern Association for the Surgery of Trauma, is in formation and needs your participation and support. EAST is a scholarly society for surgeons and surgical specialists who share a career interest in trauma care. The association has been formed to stimulate progress, establish a forum for the exchange of ideas, and provide opportunities for self-education.

Under the provisional bylaws membership is generally limited to those who reside east of the Mississippi River. There is an attendance requirement. It is expected that physicians will become eligible for membership after board certification and will become senior members at age 50. On behalf of the organizing group, I am pleased to offer you an opportunity for charter membership. You need only return the enclosed membership form, an application fee of $50 (checks payable to "EAST", and a copy of your curriculum vitae to apply.

The work of young trauma surgeons will be emphasized at our scientific meetings, along with contributions from colleagues in other specialties that directly influence injury control. We hope you will accept this invitation and look forward to welcoming you to membership.

Sincerely,

Howard R. Champion, M.D. — Thomas Gennarelli, M.D.

Burton H. Harris, M.D. — Walt Alexander, M.D.

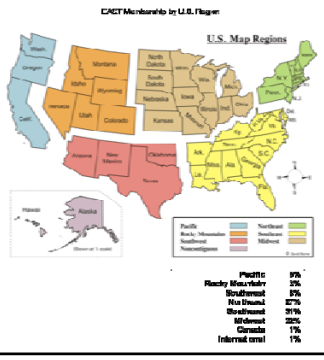
Kimball Maull, M.D. — C. William Schwab, M.D.

Lenworth Jacobs, M.D. — Andrew Burgess, M.D.

Norman McSwain, M.D. — Michael Rhodes, M.D.

What is EAST today?

- 2017:
  - The largest trauma organization in the United States
  - Approximately 2000 members
    - expanding at about 200 members per year
  - 1.7 million dollar per year organization



Eastern Association for the Surgery of Trauma

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What is EAST?

What is EAST?: *exempt purpose*

- **Exempt Purpose:**
  - The purposes for which EAST is organized (**EAST's exempt purpose**) are to furnish leadership and to foster advances in the surgery of trauma; to afford a forum for the exchange of knowledge pertaining to injury control, research, practice, and training in prevention, care, and rehabilitation of injury; to stimulate investigation and teaching in the methods of preventing, correcting, and treating injuries from all types of accidents; to enhance the study and practice of the surgery of trauma by establishing lectureships, scholarships, foundations, and appropriate evaluation procedures to afford recognition to individuals working in these fields by extending to them membership in the association; to do and engage in any and all lawful activities that may be incidental or reasonably related to any of the foregoing purposes.

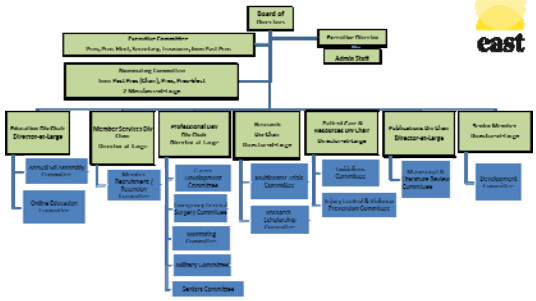
What is EAST?: *mission and vision statements*

- **Mission:**
  - EAST is a scientific organization providing leadership and development for young surgeons active in the care of the injured patient through interdisciplinary collaboration, scholarship, and fellowship.
- **Vision:**
  - EAST seeks to improve care of the injured by providing a forum for the exchange of knowledge in the practice of trauma surgery; to promote trauma prevention, research, and improved trauma systems design; to encourage investigation and teaching of the methods of preventing and treating trauma; and to stimulate future generations of surgeons to meet the challenge.

What is EAST?: *core strategic goals*

- **Core Strategic Goals:**
  - **Leadership:**
    - Prepare young surgeons to become leaders
  - **Development:**
    - Promote unique programs for the career development of young surgical leaders
  - **Scholarship:**
    - Provide education and training across the continuum of acute surgical care
  - **Fellowship:**
    - Encourage a sense of community for personal professional growth
  - **Collaboration:**
    - Work with our stakeholders to advance patient care and trauma systems

Any proposal or idea that is brought before the Board of Directors is analyzed with respect to our Exempt Purpose, our Mission and Vision statements, and our Core Values.



How is EAST Structured?

How is EAST Structured?

- **Call for Volunteers:**
  - Conducted through the EAST mailing list in summer
  - EAST Members are asked to list three committees that they would like to join, in order of preference:
    - Committee appointments are made by the incoming president, based upon organizational needs
      - Three year tenure
      - One committee membership per member
      - Exception: You do not need to be on the guidelines committee to work on a PMG

How is EAST Structured?

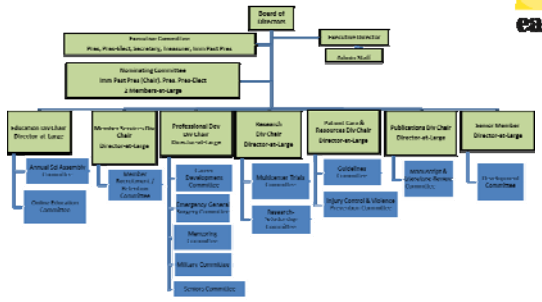
- **Advancement:**
  - All appointments are for a three year term:
    - Committee membership
    - Committee Chairs
    - Division Chairs
  - As terms expire, positions are filled based upon merit:
    - A Committee Chair will ideally be selected from the eligible members of the committee (selected by incoming president)
    - A Division Chair will be selected from the eligible Committee Chairs within the Division (selected by the nominating committee)

Ascension through the "ranks" ranks is merit-based!

How is EAST Structured?

- The "under 50" bylaw:
  - "Senior Members" are those members over the age of 50
  - Section 3.1.2:
    - Senior members may not be elected or appointed to an office, but any individual serving as an officer when they become a Senior member may complete their current term in office and any successor office term(s) (i.e., the succession of President-Elect, President, Immediate Past-President).

You must be under the age of 50 to hold office within the EAST….. remember the principles that EAST was founded upon…we are dedicated to the young trauma surgeon.



Ho do I succeed in EAST?

How do I succeed in EAST?

My advice: these rules apply to any academic organization….

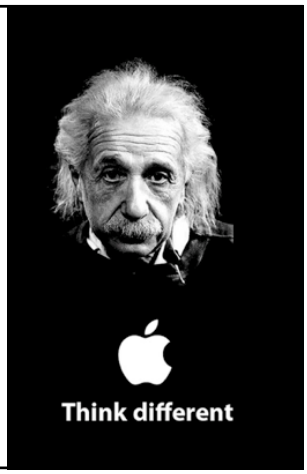
1. Fill out the call for volunteers:
   - Choose the committees for which you have a passion!
     - No committee is "more prestigious" than another
   - Don't volunteer if you do not have the passion or the time (understandable)
- Understand your organization's
   - Exempt Purpose
   - Mission Statement
   - Vision Statement

Don't wait for opportunity.

Create it.

How do I succeed in EAST?

2. Be active!
   - Participate in conference calls.
   - Volunteer to work on your committee's charges.
   - Think different!
   - Do not be afraid of failure.
3. Play by the rules.
   - Follow up on your promises
   - The office staff and Committee Chairs quickly identify the "non-contributors."



How do I succeed in EAST?

- The organization is structured to reward those whom work hard and contribute:
  - **Myth:**
    - ascension within the EAST is "Who you know."
  - **Ascension is merit-based:**
    - The Office Staff, Committee Chairs, and Division Chairs know whom is working hard.
    - The hard workers are identified and relayed to the BOD and the nominating committee.
    - Keep in mind that due to the age restriction in our bylaws, the BOD is very cognoscente of
      - Birth dates
      - How members will "age out."

Eastern Association for the Surgery of Trauma

Conclusions

Conclusions

- How do I succeed in a national organization?
  - Volunteer!
  - Be active on you committee:
    - Work hard
    - EAST: don't be afraid to
      - ask questions
      - change paradigms
      - fail
  - Understand your organization's Exempt Purpose, Mission and Vision Statements

Surgical Advocacy

Michael Sutherland, MD, FACS
Associate Professor of Surgery
Trauma Critical Care and Burns

The Ohio State University
Wexner Medical Center

Introduction

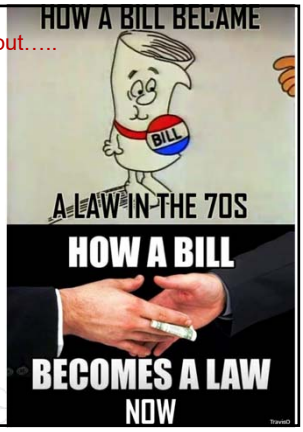
- Why
- Civics 101
  - Structure
  - Timing
  - Function
  - Relevant Committees
- How to get involved
- Now What Do I Do?

Why does this matter to me?

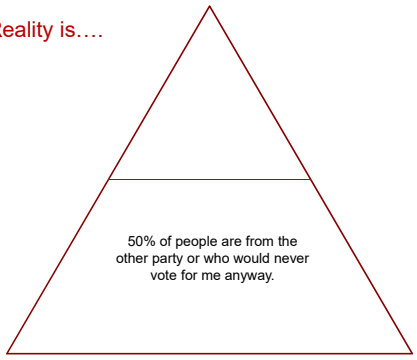
- All I want to do it take care of my patients….
- Politics is dirty….
- Congress is terrible they can't get anything done….
- What I do wont matter anyway….
- I don't have the time….
- I can't afford to get involve….
- They don't care what I have to say…..

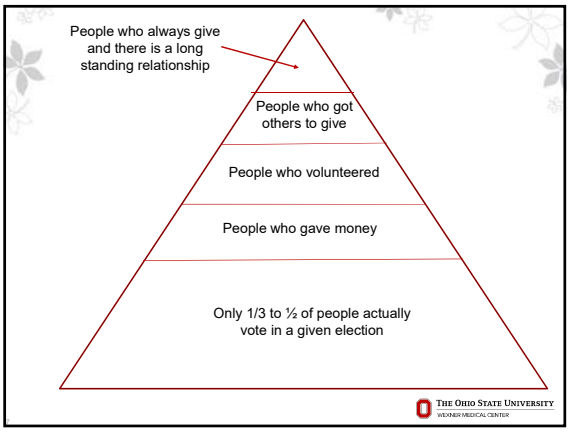
What do you know about civics?

It's not quite this bad, but…..



But the Reality is….





What does this relationship mean

- Its about access and trust
- If your member has a full schedule and you want to visit who meets with the staff and who gets to meet with the member?
- Who does the member call when they have a question about how a piece of legislation will affect their constituents
- Who does the member know and trust because of multiple interactions over time?

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Structure

- House of Representatives
  - 435 Members
  - 2 year terms
  - All seats are up for election in even numbered years
- Senate
  - 100 Members
  - 6 year terms
  - 1/3 of the seats are on the ballot in even numbered years

The Ohio State University
Wexner Medical Center

Leadership Structure

- Speaker of the House and President of the Senate
  - Elected by their respective chamber
  - Determine what legislation is brought to the floor for vote
- Speaker of the House
  - Voted on by all members of the House
  - Appoints Committee Chairs, brings votes to the floor, signs all bills and votes from the house
- Senate Majority Leader
  - Chief spokesman for the majority party
  - Controls the agenda
  - Determines votes and debates

Other Leadership Positions

- Majority Leader
- Minority Leader
- Whips (Majority and Minority)
- Committee and caucus chairs
- Committee Ranking Members

Introduction of Legislation

- Bills are drafted by members, staff and committee staff
- Bills are placed in the Hopper in the House
- Senate bills are submitted to the presiding officer
- Bills that originate in the House are H.R. #
- Bills that originate in the Senate are S.#
- Bills then get sent to a committee of jurisdiction for further action

Committees of Jurisdiction

- **House Committees**
  - Energy and Commerce
  - Ways and Means
  - Budget
  - House Appropriations
  - House Science
  - Government Reform
  - Judiciary
  - Small Business
- **Senate Committees**
  - Finance
  - Health, Education, Labor and Pensions (HELP)
  - Budget
  - Appropriations

What they didn't tell you in High School

- The system is designed to prevent legislation from being enacted!
- There are three key components to successful passage of legislation
  - Policy
  - Procedure
  - Politics

There are three primary roles for surgical advocacy

1. To prevent poor legislation from being enacted
2. To influence good legislation to make it better for our patients and our practices.
3. To enact legislation to effect regulatory issues

So what can I do… I'm just a trauma surgeon in …

1. Accept that the process is what it is... You don't have to like it. You just have to understand it.
2. Get to know your legislators
3. Participate in the process
   1. Contribute to a PAC
   2. Contribute to your legislator
   3. Identify important issues and share with your member
   4. Use good resources for information
   5. Relate to your member how this will effect people (constituents/patients) in the district.

www.surgeonsvoice.org

When you participate you move up the pyramid

- Quid Pro Quo is illegal for both parties and despite my slide is not really how this works.
- What you can hope for is:
  - a meeting with the member
  - the member to rearrange their schedule to meet you personally
  - The member to listen to what you have to say and follow up.
  - Ideally they will reach out when they need clarification in your are of expertise….
- Getting to know the staff is just as important as knowing the member

Contribute to your PAC

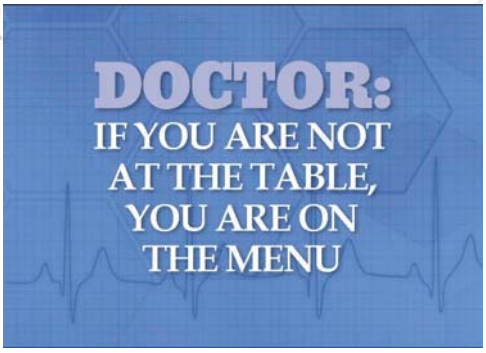
- Political Action Committee
  - Distinct federal entity which may contribute to political campaigns, make independent expenditures, and lobby members on behalf of their associations
- Average contribution for surgeons is ~$250
- Participation rate is <4%
- If 20% of surgeons gave $250 our PAC would be larger than the trial lawyers.

Meet with your member

- Look up tools for who your member is, are on the surgeons voice website.
- Meet with them in the office in the district
- Meet with them on an advocacy trip to Washington DC
  - ACS Leadership and Advocacy Conference is
    - May 19-22 2018 in Washington DC
- Understand better what this type of access can do for you
  - Improved engagement with your member
  - Enhanced ability to effectively message with member
  - Data and talking points are available to you . You only need to set up the meeting and go to sit down what you relate to and share stories of beneficiary/constituents having problems that we needed to fix.

Its all about impact

- You are a direct link to other constituents in their district
- You can relate stories about how policies will impact their constituents
- You are a trusted and respected member of the community and they want to hear what you have to say
- This process is quite easy and should not scare you
  - There are good tools available to help you with specifics
  - Your stories about patients are invaluable
  - If you are speaking from the perspective of the patient you carry a significant amount of impact



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Thank You

Michael.Sutherland@OSUMC.EDU

The Ohio State University
Wexner Medical Center

Crisis Management

EAST Leadership Development Workshop

Joseph P. Minei, MD, MBA, FACS
C. James Carrico, MD, Distinguished Professor
Chief – Division of General and Acute Care Surgery
Surgeon-in-Chief - Parkland Memorial Hospital

Conflict of Interest Disclosure

- Nothing to disclose

Crisis

- Any situation that is threatening or could threaten to harm people or property, seriously interrupt business, significantly damage reputation and/or impact the bottom line.

Examples

- Unexpected patient death
- Faculty affair
- Drug or alcohol use
- Unexpected faculty departure
- Resident or student complaint
- Financial difficulty
- New competition

Overview - Crisis Management

- Prepare
- Manage
- Learn

Who are you?

- Mission statement
- Guiding principles
- Strategic plan
  - Business plan
  - SWOT analysis
  - Tactics to achieve plan

Crisis Preparation

- Crisis vulnerability planning
  - Vulnerability audit
  - Stakeholder survey
- Preventable situations
  - Modification
- Develop response plan (pre-crisis)
  - Crisis communication plan

Communications Plan

- Who?
  - Skills
  - Position
  - Training??
- Other media
  - e-mail
  - Social
  - Departmental web page
  - Institutional web page

Communications Plan

- Focus of communication
  - NOT promotion
  - Preservation
    - Reputation
    - Confidence
    - Financial
  - Don't make things worse!

Communication Plan

- Develop a notification system
  - What do you want to know
  - When do you want to know it
    - What constitutes immediate notification
    - What can be delayed
  - How will you receive communication
    - Multi-modality communication
  - Who else is in the chain
  - Back up plan
    - You're unable to communicate
      - Out of the country
      - Flying cross country

Communications Plan

- Who else needs to know
  - CMO, CEO, Health system administrator
  - Department Chair
  - Dean
  - President

Communications Plan

- Develop holding statements
  - Can be developed generically
  - Used immediately before full facts are known

"I/We have started an investigation that places the highest priority on the students we are entrusted to educate. I/We will be meeting with the student representatives on this matter. I/We will supply further details as our investigation progresses.

Management Strategy

- Alleviate internal fears
- Understand the impact
  - Help to develop response
- Present your position
  - Aligned with mission and guiding principles
    - Honest
    - Avoid inconsistency
    - Solution oriented
- Monitor response to your position
- Learn from the event

Crisis-specific message

- What happened
- How you will address those affected
- How you will prevent reoccurrence

- We were not releasing the students for scheduled lectures. We have been able to redeliver those missed lectures. We have communicated a proscribed daily student schedule to all faculty.

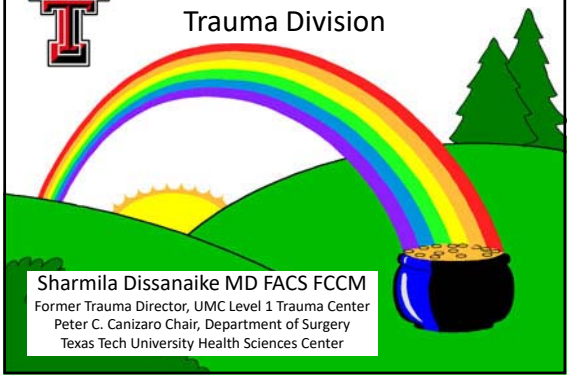
Active crisis management

- Assess the situation
  - Roll out your prepared plan
  - Process the information as it comes in
- Develop crisis-specific message
  - No more than 3 main points
  - Adapt to specific audience
- Post crisis analysis
  - What was learned
  - How do we prepare better for next time

Post–crisis analysis

- What were the warning signs
  - could we have acted earlier
- Organizational weakness/vulnerability
- Effective communication established
- Right people in place
- Leadership performance
- What could have been done differently
- How can we better prepare

Running a Profitable Trauma Division



Sharmila Dissanaike MD FACS FCCM
Former Trauma Director, UMC Level 1 Trauma Center
Peter C. Canizaro Chair, Department of Surgery
Texas Tech University Health Sciences Center

Objectives

NOT a lecture giving you a list of billing codes

- Basics of the Revenue Cycle
- Opportunities to improve profitability
- Keys to a successful initiative
- Profit vs. Risk – why compliance and liability issues matter

Trauma Director Wears Multiple Hats

Financial Sustainability

No Margin No Mission

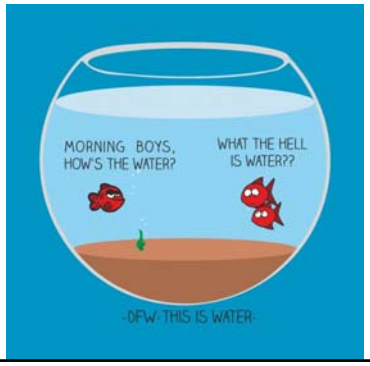
Money is Power and Control..

Why am I not just giving you the magic billing codes?

- Doing it yourself is fine if you're a solo practitioner in a small private practice
  - Otherwise not the best use of your time and energy
- These are easily and universally available, and can be applied by anyone with basic training
- Coding technology (3M) makes it even simpler

DO NOT SQUANDER YOUR TIME DOING WHAT WOULD COST LESS TO BE DONE FOR YOU

What You Do Need to Know

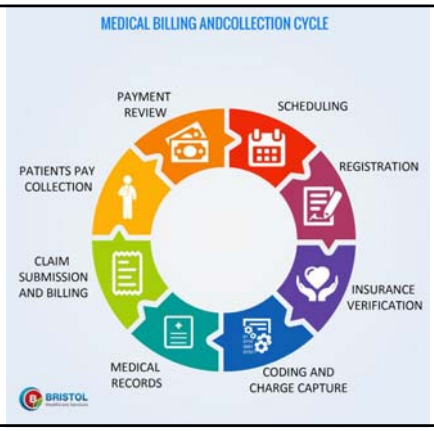


The Water you Swim in

- Medical centers and hospitals highly leveraged
- Declining Bond ratings
- Bundled payment models
- Shift to quality instead of quantity based reimbursement
- Shift from surgery / trauma being a profit center to being a cost center

The Revenue Cycle

- Grown-up version of the Kreb's Cycle
- Flow of funds from start to finish of a patient encounter
- Can be incredibly complex (6-12 steps) especially at academic medical centers
- Need to understand each step so you can identify opportunities to improve



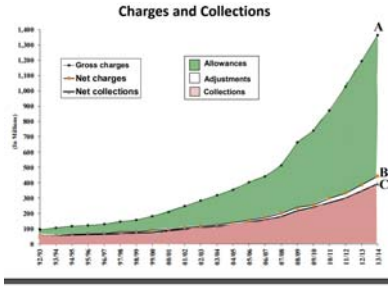
How do we measure the health of the cycle?

FPSC
Performance Benchmarks
FY2015

Key Performance Indicators	Median
Cost per claim (PA + IT) as % of total collections	3.6%
Days in A/R	39.6
% Days in A/R > 180 days	9.2%
Net collection rate	91.3%
Patient collection efficiency	46%
First pass denial rate	5.9%
Terminal denial rate	2.4%

Source: Faculty Practice Solution Center, Billing Office Survey

Gross versus Net Collections



Contracted Payors

Business Efficiency

Identify Extra Revenue Sources

- Contractual revenue
- Technical fees
- Call coverage
- Telemedicine
- Additional service lines

Negotiation

- Crucially important
- Go for an All-Way Win, not a zero-sum game
- Spend time learning & honing your skills
- "Hold your breath until you turn blue" is not a negotiating strategy
- Be aware of relevant laws
  - Eg. Stark Laws

Optimizing Provider Fees

- Initial hospital encounters
- Critical care billing
- Operative billing
- Bedside procedures
- Inpatient visits
- Outpatient follow-up

Reimbursement for ICU, H&P & Consult CPT Codes

	Standard Charge	CMS Reimbursement	Description
99221	$145.00	$99.11	Level 1 H&P
99222	$230.00	$133.98	Level 2 H&P
99223	$292.00	$180.58	Level 3 H&P
99251	$106.00	$50.69	Level 1 Consult
99252	$157.00	$77.68	Level 2 Consult
99253	$203.00	$118.53	Level 3 Consult
99254	$281.00	$171.04	Level 4 Consult
99255	$368.00	$206.78	Level 5 Consult
99291	$431.00	$243.23	Crit Care 30-74 minutes
99292	$199.00	$110.48	Crit Care each add 30 minutes
*Consults not reimbursable by Medicare, use H&P codes instead			
Amounts given are per BCBS reimbursements			

Reimbursement for Bedside Procedures

Reimbursement for Associated Operative Procedures

Example – our ICU billing initiative

Critical Care Charges		February thru July
		2016
99291	Critical Care services for the first 30-74 minutes	89
99292	Critical Care services, each additional 30-74 minutes	65

Results

Critical Care Charges		February thru July			
		2016	2017	% Δ	Est $ Charges
99291	Critical Care services for the first 30-74 minutes	89	817	918%	$313,768
99292	Critical Care services, each additional 30-74 minutes	65	95	146%	$5,970
			Total Δ Estimated Charges		**$319,738**

The Carry-Over Effect

Subsequent Hospital Care Charges		February thru July			
		2016	2017	% Δ	Est $ Charges
99231	Subsequent Hospital Care Visit, Level 1	1379	2926	212%	$119,119
99232	Subsequent Hospital Care Visit, Level 2	731	983	134%	$26,964
99233	Subsequent Hospital Care Visit, Level 3	303	165	-46%	($21,114)
			Total Δ Estimated Charges		**$124,969**

How Did We Do it?

- Identify the problem – know your baseline
- Start with a GROUP meeting to develop a plan
- Do not allow internal finger-pointing
- Create a strategy with precise goals and measureable results (not just "do better")
- Simplify, simplify, simplify
- Stay future-focused, set the next meeting at the end of each one

Don’t try and Climb the Himalayas all at once!

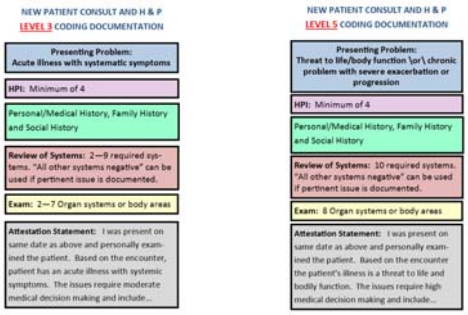
Keys to Success

- Ensure entire team understands the problem
- Involve everyone in the discussion regarding the solution “get buy-in”
  - Don’t try and skip this step!
- Identify key individuals and have “pre-meetings” before the meeting
- Spending extra hours on front end will save you a lot of frustration later

Keys to Success

- Make it as simple as possible for busy surgeons
- Templates, Auto-text and guides
- Invest in the time of a coder/ biller/ consultant to help each surgeon do this step
  - Some will be more self-sufficient than others

Cheat Sheets for E&M coding



NEW PATIENT CONSULT AND H & P
LEVEL 3 CODING DOCUMENTATION

Presenting Problem:
Acute illness with systematic symptoms

HPI: Minimum of 4

Personal/Medical History, Family History and Social History

Review of Systems: 2—9 required systems. "All other systems negative" can be used if pertinent issue is documented.

Exam: 2—7 Organ systems or body areas

Attestation Statement: I was present on same date as above and personally examined the patient. Based on the encounter, patient has an acute illness with systemic symptoms. The issues require moderate medical decision making and include...

NEW PATIENT CONSULT AND H & P
LEVEL 5 CODING DOCUMENTATION

Presenting Problem:
Threat to life/body function \or\ chronic problem with severe exacerbation or progression

HPI: Minimum of 4

Personal/Medical History, Family History and Social History

Review of Systems: 10 required systems. "All other systems negative" can be used if pertinent issue is documented.

Exam: 8 Organ systems or body areas

Attestation Statement: I was present on same date as above and personally examined the patient. Based on the encounter the patient's illness is a threat to life and bodily function. The issues require high medical decision making and include...

ICU Time-based Billing

ICU Critical Care Documentation

Single or multiple organ system failure and/or life threatening conditions

Time documentation must be present

Must spend at least 30 minutes providing critical care, face-to-face.

Document **all critical systems and stabilization techniques** used to treat them

Attestation Statement: I personally saw and examined the patient with the Resident on the above date and agree with the Resident's note and plan. I personally spent ___ minutes of critical care time, exclusive of time spend on any procedures, in evaluation and management of this critically ill patient's condition of _____. I provided the following critical care treatment_____.

Keys to Success

- Designate a point-person who will collect data and provide feedback
- Schedule quick follow-up meetings as a group
- Share individual results & overall numbers
- Always look forward, not back
- Set a reasonable time-frame (3-6 months)

Motivating Your Team

- Leverage 2 key traits:
  - Self-Motivated & Competitive
- Transparency
- Equality
- Set Clear Expectations
- Use fair benchmarks (eg. MGMA or FPSC)
- Work smarter, not harder

Follow-up meeting

- Ensure a "quick win", however small, & Celebrate it
- Harness our natural competitiveness but don't be overt about it
  - let it be natural & friendly, don't pit members against each other
- Consider small group reward if successful
  - Lunch, swag, bragging rights

Why not just pay everyone more?

- Have to be careful about incentives – often don't work as intended

More Unanticipated Consequences

- Our 160% increase triggered an audit – as it should have
- It's your job to manage risk
- Large institutions tend to hew conservative
- Compliance is not negotiable – but ensure accurate and fair interpretation of rules
- Involve people from these areas of your institution beforehand

How to Avoid Trouble

- Ensure entire team understands
  - Need to monitor time strictly, not double-bill
  - Over-lapping operations & procedures
  - Don't exceed realistic time estimates
  - Attending time, not resident time is what counts
  - Success will increase risk of audit
  - Schedule your own audits

Conclusion:

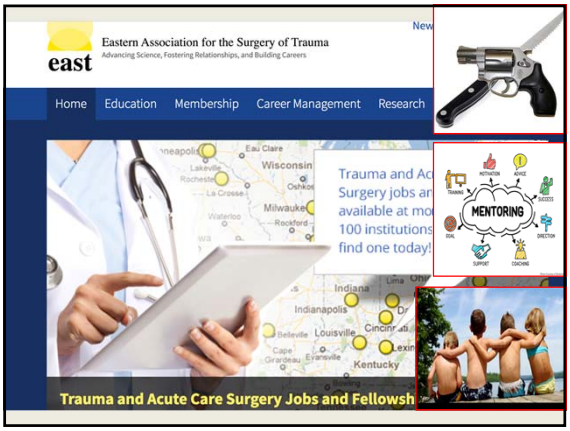
- Focus on what you need to know
- Optimize provider billing & collections as your mainstay
- Investigate alternative opportunities for $
- Know how to identify a $ problem and lead a team in fixing it
- Understand the balance between risk and opportunity and how to manage it

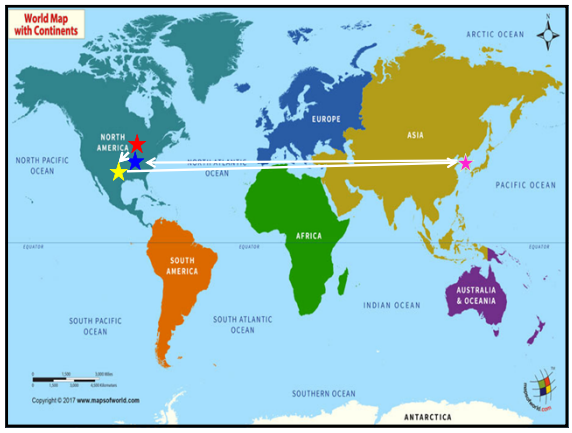
THANK YOU!

Should I Stay or Should I Go?

Career Moves That Make Sense.

Stephanie A. Savage, MD, MS
Indiana University School of Medicine




World Map with Continents
ARCTIC OCEAN
EUROPE
ASIA
NORTH AMERICA
NORTH PACIFIC OCEAN
PACIFIC OCEAN
AFRICA
SOUTH AMERICA
AUSTRALIA & OCEANIA
INDIAN OCEAN
SOUTH PACIFIC OCEAN
SOUTH ATLANTIC OCEAN
SOUTHERN OCEAN
ANTARCTICA
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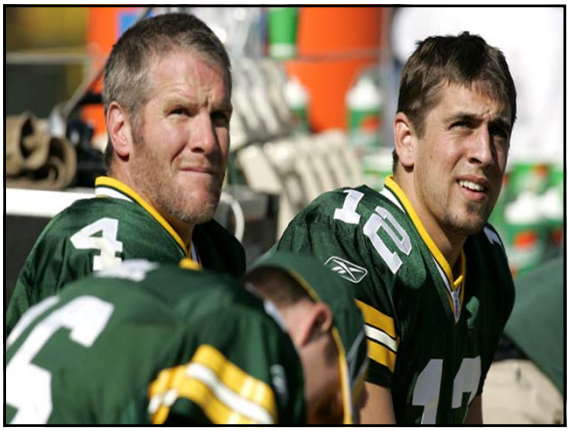
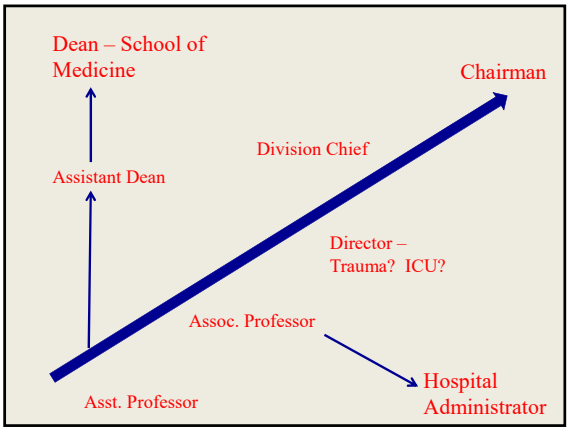
U.S. AIR FORCE


Elvis Presley
MEMORIAL
TRAUMA CENTER



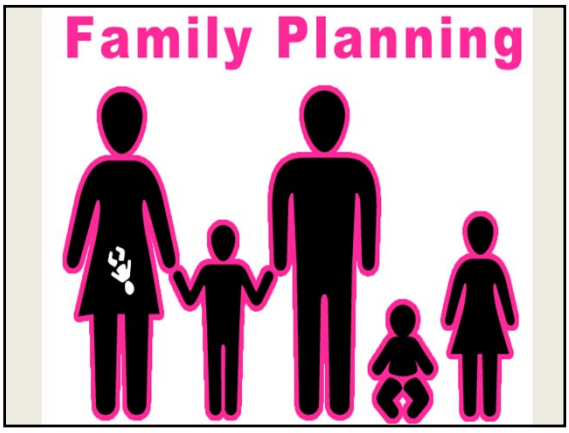
Stay or Go?

- 1st job, lost job, mandatory family issues, military
- 1. Money or Lifestyle choices
- 2. Promotion/Leadership opportunities
- 3. Mentorship
- 4. Protected time/opportunities to pursue interests
- 5. You are miserable in your current situation


Dean – School of Medicine
Chairman
Division Chief
Assistant Dean
Director – Trauma? ICU?
Assoc. Professor
Hospital Administrator
Asst. Professor

Checklist

1. How many years out from fellowship am I? How many years have I been at my current job?
2. What is my ultimate career goal (right now)?
   Where do I think I need to be in 5 years? 10 years?
3. What gaps do I possess that might prevent me from progressing along this path?
   What special attributes do I have that will make me more recruitable?
4. Can my current position offer me a logical step towards my career goal? If no, is there room here for negotiation?
5. What are the must-haves if I move?
   What are the would-be-nices?



Negotiation

Negotiation

Academic Rank ⟷ Compensation

FTE = Clinical Requirements

Culture

Negotiations : Positional vs Principled

Research Report

Negotiation in Academic Medicine: Narratives of Faculty Researchers and Their Mentors

Dana Sambuco, MPPA, Agata Dabrowska, MPH, Rochelle DeCastro, MS, Abigail Stewart, PhD, Peter A. Ubel, MD, and Reshma Jagsi, MD, DPhil

There's just a really lot that nobody tells young people about how the game works. So, in a variety of situations, this idea of what's it like to go out and seek an academic position and how and when do I discuss the parameters of the job, what's reasonable for me to expect, what's not reasonable…. So, those sorts of negotiations I'm involved in a lot. (Female, Mentor)

It was just offered; I didn't know that I could negotiate things like that…. I didn't realize I could or should. (Male, K awardee)

I had no experience asking what I should be negotiating for and so that would have been much more helpful, to get a sense of what it is really that I need to do. (Male, K awardee)

Academic Medicine 2013;88(4): 505-11.

Research Report

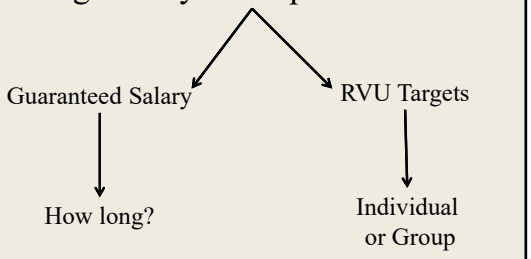
Negotiation in Academic Medicine: Narratives of Faculty Researchers and Their Mentors

Dana Sambuco, MPPA, Agata Dabrowska, MPH, Rochelle DeCastro, MS, Abigail Stewart, PhD, Peter A. Ubel, MD, and Reshma Jagsi, MD, DPhil

I provided them a list of things I needed, including … some pretty big ticket items. [T]hat's the way I negotiated it, and then they sent me a proposal with various things outlined and … I sent them a counter proposal and they met my demands on almost every point. (Male, K awardee)

Academic Medicine 2013;88(4): 505-11.

Making Money : Compensation Model

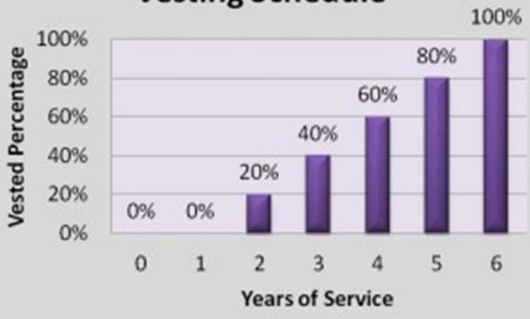


Making Money : RVU targets

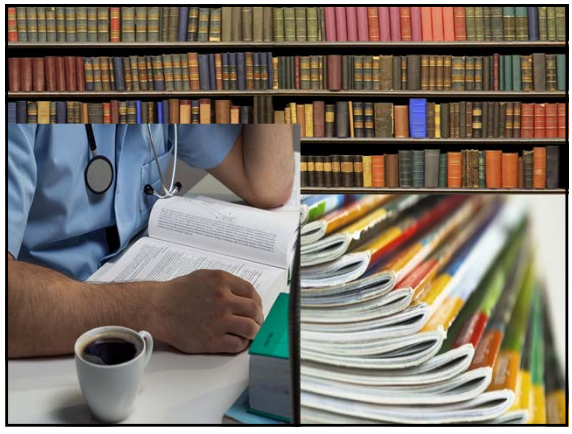
of months for annualized calc: 9

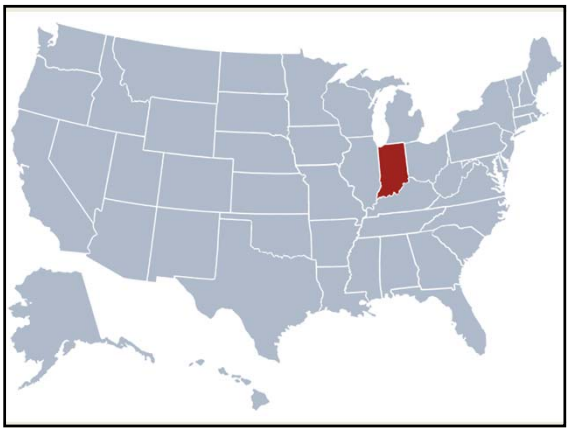
YTD wRVU	Annualized wRVU	clinical FTE	imputed FTE (based on 60th %tile)	capacity (imputed FTE / cFTE)	wRVU normalized to 1.0 cFTE
5,516.36	7,355.15	1.00	1.06	105.9%	7,355.15
4,217.42	5,623.23	0.80	0.81	101.2%	7,029.03
4,146.99	5,529.32	1.00	0.80	79.6%	5,529.32
5,340.20	7,120.27	1.00	1.03	102.6%	7,120.27
3,162.15	4,216.20	0.50	0.61	121.5%	8,432.40
3,170.32	4,227.09	0.89	0.61	68.4%	4,749.54
3,154.77	4,206.36	0.60	0.61	101.0%	7,010.60
4,845.86	6,461.15	1.00	0.93	93.1%	6,461.15
3,657.51	4,876.68	0.65	0.70	108.1%	7,502.58
	0.00		0.00	0.0%	
37,211.58	49,615.44	7.44	7.15	96.0%	6,798.89 average

6-Year Graded Vesting Schedule




Professor
Associate Professor
Assistant Professor
Instructor
STEPS OF PROMOTION






TRAUMA

Dealing with the Inevitable: Malpractice

Richard S. Miller, MD FACS
Professor of Surgery
Chief, Division of Trauma, Surgical Critical Care and Emergency Surgery
Vanderbilt University Medical Center

EAST Leadership Development Workshop
Orlando, Florida
January 9th, 2018

Disclosure

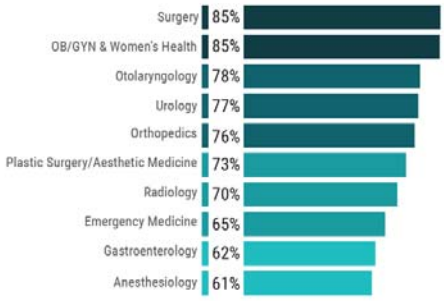
- None

Malpractice-bad news

- Confronted with many challenges in our career
- Malpractice lawsuit considered one of most stressful
- "Disruptive and humiliating"
- "Constant uncertainty and dread"
- "One of the worst experiences of my life"
- Potential of catastrophic outcome, loss of license, practice, etc.

Were Physicians Surprised by the Lawsuit?

Top 10 Specialties for Lawsuits



What Was the Reason for the Lawsuit?

Malpractice- good news

- 2/3s medical malpractice lawsuits-
- Dropped
- Dismissed
- Withdrawn
- Victory- depends to great extent ON YOU!!
- Behave- reassuring and responsible manner
- No matter how poorly you may be treated

What the Plaintiff Must Show

- Physician acted negligently
- Negligence resulted in injury
- Injury resulted in damage

Proving Negligence

- Heart of malpractice suit
- Must prove departure from accepted standards of practice
- Standard of Care (SOC)- In legal terms
- ** The level at which the average, prudent provider in a given community would practice.
- What similar, qualified practitioners would manage the patient's care under the same or similar circumstances.**
- Bad outcome does not equal win by plaintiff
- Must prove "Proximate Cause"
- Injury must be caused by deviation from SOC

Proving Negligence

- Plaintiff must only show- “preponderance of evidence”
- “More likely than not” (>50%) that malpractice took place
- If hint of negligence, carrier may press for early settlement.
- Don’t get dispirited by allegations of incompetence
- Don’t have to hit the ball out of the park to win
- As long as you were within the SOC

Linking Injury to Damage

- Must prove “quantifiable proof of harm”
  - Income lost or will lose- unable to work
  - Cost of additional medical treatment
  - “Pain and Suffering”

Role of Expert Witness

- Proving negligence vs absence of negligence
- Through testimony of expert witnesses
- Battle of Experts!!!
- Did or did not breach the SOC
- Hiring expert witness one of most expensive items of case- $500/hr
- Good track record
- Make complex medical information understandable to jury
- Indelible impression- remember when they make decision
- Jurors cite testimony of expert as key reason for their verdict
- CHOICE OF EXPERT WITNESS- KEY

How a Malpractice Lawsuit Starts

- Summons or Notice of Intent delivered to you
- Inform your malpractice carrier immediately
- Speed is of essence
- 20-30 days for your lawyer to issue response
- 1st legal defense of case written by your lawyer
- DON'T TALK TO ANYONE about the case
- Don't try reach out to plaintiff or their lawyer
- BAD IDEA- could be used against you!!!
- Don't alter medical record in any way
- Worst thing possible!!
- Alter or hide evidence- likely lose case
- Forensic methods/already have MR before summons

Meritless Suits

- 30 states require plaintiff to file Certificate of Merit = "Affidavit of Merit"
- 16 states- screening panel of experts to examined the lawsuit
- Reduced malpractice lawsuits by 20-53%

Mediation or Arbitration

- Settles many lawsuits
- Reduces costs and speeds up resolution
- Mediation
  - Nonbinding
  - Without lawyers
  - Majority settled
  - Less time and expenses
  - Average $50,000
- Must be reported to National Practitioner Data Bank (NPDB)

- Nonmonetary solutions
  - Safety protocols
  - Expression of sympathy

Discovery Process

- Each side asks for information
- Interrogatories- requests for information
- Help your lawyer answer questions with honest and appropriate replies
- Deposition
  - Most significant part of discovery process
  - The Heart of the Case!!
  - Helps determine if lawsuit dropped, settled
  - 30% settled after depositions
  - 20% dismissed
  - If go to trial, deposition play key role in outcome
  - * Segments may be presented as evidence*

Deposition

- Most important and hardest part- Plaintiff's Attorney interrogation
- Under oath, audio or video
- Great detail of case and treatment
- Be thoroughly familiar with all aspects of case
- Know medical record like back of your hand
- Know disease process involved in the case
- Rehearse- preparation is invaluable
- Can throw you off your game, comfort zone
- Well rested, confident and alert
- No distractions
- Competent, unflappable, warm and friendly

Deposition- Don't

- Don't be sarcastic or contemptuous
- Don't be brash or dismissive
- Don't imply that a question is stupid
- Don't let your guard down
  - Will try to trick you, very bizarre situation
  - Each word that you say measured and evaluated
- Don't contradict yourself
  - Stick to your story
  - New version = Lying
  - State facts clearly
  - If you don't recall say so, consult record

Deposition- Don't

- Don't guess what is being asked
- Don't walk into open-ended questions
  - "Wouldn't you agree that…"
  - Let your attorney help you
- Don't endorse a specific source
  - Don't offer an unqualified endorsement of material, ex. Textbook, Author, etc
- Don't volunteer information

Should you Settle or Go to Trial?

- Most cases get settled before trial
- Best for both sides BUT
- Settlement still reported to NPDB
- Most policies have clause stipulating that insurer must get your consent before settling
- If good chance of winning, stick to your guns
- GO TO TRIAL!!
- Most malpractice trials are won by the defendant

Going to Trial

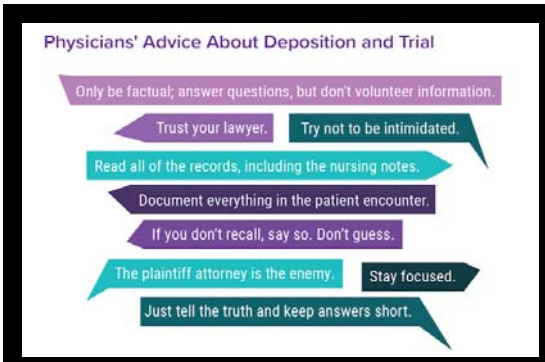
- Most trials last at least one week
- You probably will be called to testify
  - Especially if believe make bad impression
- Same behavior as deposition but look at jury
- Try to attend all or most session
  - makes good impression on jury
- Jurors often follow their emotions rather than facts
- Emotional response tends to help plaintiff

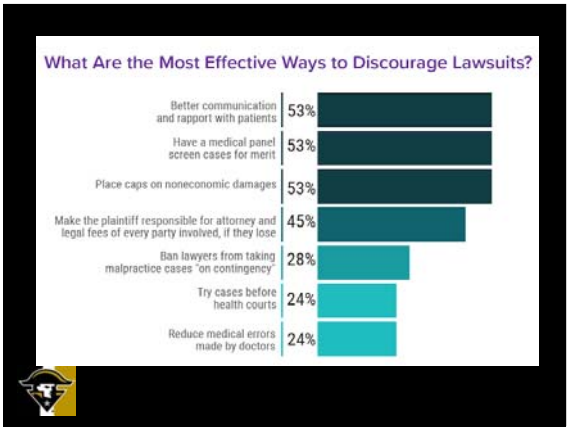
The Verdict and the Award

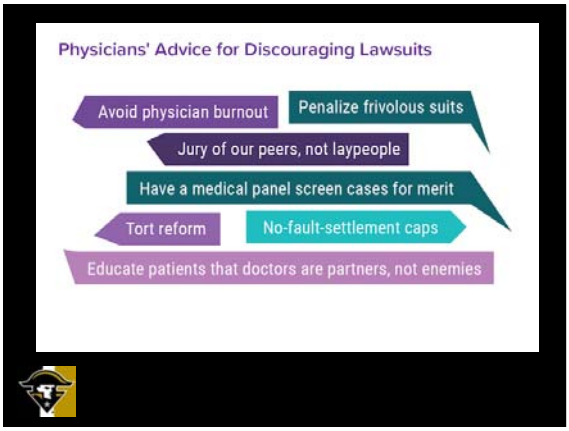
- If you lose- jury determines award- $ the patient (and lawyers) will receive
- Economic- loss of income/medical expenses
- Noneconomic
  - Less definable
  - Wide discretion by jurors
  - Permanent disability, disfigurement, loss of limb, paralysis, pain and suffering
  - Some states set limits- CA,TX $250,000
- Punitive damage
  - Defendant's conduct "egregiously insidious"
  - Surgery while drunk
  - Behavior bordering on intent to harm

High/Low Agreements

- Settlement negotiations- made at anytime,often at 11th hour
- Not easy win for either side
- Juries are unpredictable
- Verdict often surprise
- Thus both side may agree on payment range
- Supersedes the jury award
- If win, still have to pay low but NOT reported to NPDB
- Your option to appeal
  - Gamble
  - Can take 1-2 years
  - Carrier may not want to spend more $$$
  - Might lose again







How to Avoid Getting Sued

- Be friendly and helpful
  - Much less likely to be sued
  - Even if clearly at fault, patient often will not sue doctors they like
  - Cold and dismissive- more likely to get hit
  - Asked why they sued doctor
    - Doctor deserted them
    - Unhelpful, devalued their views
    - Did not acknowledge their perspective

How to Avoid Getting Sued

- Communicate Well
  - Essential part lawsuit prevention
  - Make sure patient understands what you are saying
  - Explain technical jargon- careful phrasing
  - Go over diagnosis, treatment and plan
  - Clear idea what can be done, what can't
  - What are the risks
  - Take your time, don't be in a hurry!!
- Document Thoroughly- date, time and sign. EMR
  - Crucial, avoids he said/she said disputes
- Communicate well with other caregivers
  - Key in handoffs and joint care