Healthcare Reform: Strategies to Increase Productivity and Decrease Costs

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Financial Disclosures

I have no financial or nonfinancial relationships relevant to this presentation.
Lecture Outline: Part 1

The Changing Healthcare Environment (What)

A. What is the problem?
B. What has changed?
Lecture Outline: Part 2

Strategies to Deal with Changes in Healthcare (How)

A. How to improve quality
B. How to improve clinical outcomes
C. How to improve patient/family satisfaction
D. How to decrease cost (and increase revenue) of SLP services
E. How to improve program success
A. What is the problem?
What is the problem?

The cost of our healthcare is killing us!!!

My doctor told me to avoid any unnecessary stress...
... so I didn’t open his bill.
Question

What do most Americans know about the changing healthcare environment in the US?
Answer
Everyone has opinions!
When it comes to healthcare... we are all “beggars” and “choosers.”
When it comes to healthcare... we want it all!

• Beggars... because we want low cost.
• Choosers... because we want high quality.

Question: Are we getting what we want?
Why is a change in healthcare financing needed?

Our *healthcare system* is not particularly...

- healthy,
- caring,
- or even a very good system.
Why is a change in healthcare financing needed?

Our healthcare system is broken!
Why is a change in healthcare financing needed?

• The costs are too high!
• The quality is too low!
High Costs
US Healthcare: Skyrocketing Costs

U.S. HEALTH EXPENDITURES 1960 - 2016
On Hospitals, Physicians & Clinics, Prescription Drug by All Sources of Funds (U.S. $ Billions)

Source: Peterson-Kaiser
US Healthcare: Skyrocketing Costs

Source: Agency for Healthcare Research and Quality
US Healthcare: Skyrocketing Costs

Average cost of delivering a baby in the US:
• 2004: $7,700
• 2014: $35,000
• More than 300% increase in 10 years!
• Highest cost in the world!

Source: Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project
US Healthcare: Skyrocketing Costs

Per Capita Spending for OECD* Nations

*Organisation for Economic Co-operation and Development

Source: Kaiser Family Foundation

Source: Cincinnati Children’s
US Healthcare: Skyrocketing Costs

Healthcare as Percentage of GDP

Note: For countries not reporting 2006 data, data from previous years is substituted.
US Healthcare: Skyrocketing Costs

Source: Milliman Medical Index
US Healthcare: Skyrocketing Costs

• The US spends 2.4 times more per capita on healthcare than the average spent in other developed countries!
US Healthcare: Inconsistent Charges

Cost of delivering a baby in California in 2014:
• Anywhere between $3,000 and $37,000

Source: NBC Nightly News, January 16, 2014
US Healthcare: Inconsistent Charges

Cost of an MRI of the knee in Cincinnati in 2015:
• Charge ranges from $329 to $3,310... with no difference in procedure or quality.

Source: Castlight, 2016
US Healthcare: Inconsistent Charges

• Consumer Reports writes, the "contracted prices that health plans negotiate with providers ... have little or nothing to do with the actual quality of services provided and everything to do with the relative bargaining power of the providers."

• Large hospitals or networks have better bargaining power to charge more.

Source: Castlight, 2016
US Healthcare: Considerable Waste

• According to the Institute of Medicine (IOM), 30% of healthcare in the U.S. is not needed.

Source: Castlight, 2016
US Healthcare: Considerable Waste

• There is little evidence as to what constitutes the "right" amount of healthcare (i.e., visits, tests, procedures).

• We err on the side of too much!

Source: Castlight, 2016
US Healthcare: Considerable Waste

WHY????????
US Healthcare: Considerable Waste

• Most healthcare providers are paid per test, visit, or procedure.
  • More visits = more $

• Providers do not know the charges for tests that they order.

• Patients often demand care and doctors provide it, regardless of evidence (i.e., antibiotics for ear infections).

Source: Castlight, 2016
US Healthcare: Considerable Waste

Every unnecessary (wasteful) procedure:

- Increases medical bills and the cost of healthcare for all of us
- Increases the “burden of care” for the family
- Potentially exposes patient to harmful side effects or unnecessary risks
Low Quality
US Healthcare: Not that Good

- US is ranked as 37th in the list of best healthcare system in the world!

Source: WHO, 2013 World Development Indicators
US Healthcare: Not that Good

- Infant mortality rate is better in many other countries, including:
  - Korea
  - Lithuania
  - New Zealand
  - Portugal
  - Singapore
  - Spain
  - Slovenia
  - Sweden
  - Switzerland
  - Uruguay
  - and others

Source: WHO, 2013 World Development Indicators
US Healthcare: Not that Good

- There is a lack of affordable care for a significant number of Americans.
- Many Americans have had NO insurance and therefore, little to NO healthcare.

Source: U.S. Census Bureau
US Healthcare: Not that Good

• 11.3 percent of adults in the US were found to be without healthcare insurance in the 1\textsuperscript{st} quarter of 2017.

Source: Gallup-Healthways poll, April, 2017
US Healthcare: Not that Good

Many studies have reported:

• Pervasive problems with quality of care
• Uncertainty about best practices that work
• Lack of evidence for many popular procedures
• Widespread clinical practice variation
• Significant disparities in the access to care
US Healthcare: Not that Safe

Landmark reports published by the Institute of Medicine (IOM) in 1999 and 2001:

• **Published report:** *To Err is Human: Building a Safer Health System* and *Crossing the Quality Chasm: A New Health System for the 21st Century*
US Healthcare: Not that Safe

Executive Summary of the number of Americans who die each year as a result of medical errors:

• Colorado and Utah study: 4,000/year
• New York Study: 98,000/year
US Healthcare: Not that Safe

• **Conclusion**: There are major issues with quality and safety in US healthcare across the country.
Overall Problem

• The increase in cost of medical care each year is unsustainable.
• The quality, consistency, and safety of our healthcare system is not that good.
What do we need to do?
What do we need to do?

• No one is arguing for status quo... regardless of party.
• Everyone who pays for healthcare (employers, consumers, and even politicians) wants to pay less!
• Everyone wants high quality healthcare.
What do we need to do?

• Therefore, we need to:
  • decrease costs and
  • increase quality.
What are the barriers?

Is the insurance industry “too ‘pig’ to fail?”
B. What has changed?
Affordable Care Act (ACA)  
AKA Obamacare

• Healthcare reform was signed by President Obama in March 2010.

• It’s actually two separate pieces of legislation:
  • The Patient Protection and Affordable Care Act (PPACA), and
  • The Health Care and Education Reconciliation Act
Triple Aim of the ACA

1. **Improve the patient/family experience** (e.g., increasing quality, outcomes, and satisfaction)

2. **Improve the health of populations** (which includes expanding coverage to all citizens)

3. **Reduce per capita cost of care**
Changes for Consumers*

• Cannot be denied for pre-existing conditions
• Removal of lifetime limits
• Children under age 26 can stay on their parent’s plan
• Preventative care is covered
• Individual mandate for coverage
• Health insurance marketplace for low cost plans

* All of these are subject to change.
Trump Changes for Consumers*

• On December 22, 2017, Trump signed a new tax reform bill* into law.

• The main effect on the ACA: Although the individual mandate for insurance remains, the penalty for going without insurance was reduced to $0.

*Tax Cuts and Jobs Act (P.L. 115-97)
Changes for Consumers

Ultimate goal of healthcare reform:

- High quality, universal healthcare for all Americans at a lower cost
Changes for Providers

• It is expected that the tenets of the Triple Aim will remain as the goals of healthcare reform.
• Strategies will include a primary focus on...
Value in Healthcare

Value-based, accountable care is patient-centered, produces superior outcomes, and is delivered efficiently by streamlining care processes to increase access and reduce waste.

Source: Advisory Board Company
(a national healthcare consulting company)
Value in Healthcare

• Need to consider the cost/benefit ratio of care
Value in Healthcare

Benefit
(quality, outcomes, and satisfaction)

Value = ________________________________

Cost

We need to work on both sides of the equation by:
• increasing the numerator, and
• decreasing the denominator
Value in Healthcare

Need to focus on:

• Quality
• Superior Outcomes
• Patient/Family Satisfaction
• Costs

Numerator: Aim #1

Denominator: Aim #3
Value: Patient/Family
Value: Patient/Family

- Because of high deductible plans, patients/families are “shopping” for healthcare.
- Patients/families want the best services for the lowest cost.
- Information about cost and quality is becoming more readily available and will impact their choices.
Value: Patient/Family

We need to consider the following:

• What influences patient’s/family’s willingness to pay?
• The customer must **want it** AND be **willing** and **able to pay** for it.
Value: Patient/Family

Option 1

Option 2

Option 3

The parent may WANT the sports car, but may not be willing to pay for it, so will purchase a “family car” instead.
Value: Patient/Family

What are patients/families willing to pay an SLP to do?
(Yes, No, Maybe)

• An hour of your time spent in documentation?
• Your time scheduling their appointments?
• Your time practicing a skill that the patient can perform?
• Your expertise, opinions, and advice?
Value: Payers
Value: Payers

• Payers also want superior outcomes at the lowest cost
• Value-based purchasing started by CMS
• Payment is be based on:
  • Results (outcomes) instead of the volume
  • Patient satisfaction and experience
  • Compliance with standard protocols
Value: Payers

“The universal development and reporting of outcomes is the single highest priority to improve the performance of the healthcare system.”

Source: Redefining Healthcare, Michael Porter, 2006
Value: Payers

• With ICD-10, comparison can be made of outcomes and costs for specific diagnoses, including their acuity levels and contributing factors.

• Massive stores of data are now available to analyze practice patterns and outcomes.
Value: Payers

- Payers and consumers are starting to select preferred providers based on ratings of value (outcomes, satisfaction, and costs).
Value: Payers

- Every hospital will have certain standards and metrics to receive full reimbursement.
Value: Payers

• At Cincinnati Children’s, Medicaid reimbursement is linked to quality targets and outcomes regarding:
  • Hospital acquired infection
  • Readmission for asthma
  • Ventilator acquired pneumonia
Value: Providers
Value: Providers

Problems with Fee-for Service system:

• Providers order tests and treatments, but don’t have a clue what they cost!
• The more tests and services provided, the more payment received.
• This rewards high volume of tests and procedures with a fee for each.
Value: Providers

Bundled payment system:

• Reimbursement is based on the median costs of all procedures typically required for each diagnosis.

• Specificity of ICD-10 coding allows for comparison of specific diagnoses and contributing factors.

• This rewards less service (efficiency) per diagnosis.
Value: Providers

• Although reducing costs is emphasized, there are penalties to cutting corners on care or poor quality under bundle payments.
  • Example: Penalty for hospital re-admission within 30 days
Value: Providers

• Under the bundled payment system, referring physicians will be asking the following questions before referring to SLP:
  • Does our service provide a difference that is of value to the patient and family?
  • Is our service worth the cost?
Value: Providers

• Coordinated care plans will be more important than ever, particularly for chronic care patients.

• Unnecessary services and duplication of services will be eliminated.

• *Providers with the highest quality and lowest cost for their outcomes will thrive.*
Part 2: Strategies to Deal with Changes in Healthcare
A. How to Improve Quality
Quality: Clinical Guidelines

• The best way to improve quality is to develop “evidence-based clinical practice guidelines.”
Quality: Clinical Guidelines

Clinical guidelines should be:

• Based on systematic reviews with attention to the quality and strength of evidence
• Developed by knowledgeable, multi-disciplinary experts
• Based on a transparent process that minimizes biases and conflicts of interest

Source: Clinical Practice Guidelines We Can Trust, Institute of Medicine, 3/23/11
Quality: Clinical Guidelines

Advantages of clinical guidelines:

• Standardizes care and increases consistency to a level of best practice
• Increases efficiency by eliminating unnecessary procedures
• Decreases costs by cutting waste

Clinical guidelines have been proven to improve clinical outcomes.
Quality: Clinical Guidelines

• Maybe we need that “cookbook” of therapy procedures based on evidence of best practice.
Quality: Provider Specialization

• Provider specialization results in higher quality at lower cost
  • It reduces the provider’s time in offering the service.
  • There is more consistency and less variation.
B. How to Improve Clinical Outcomes
Outcomes: Do they really matter?

• If you do everything right, do the outcomes really matter?
Outcomes: Do they really matter?

One surgeon says to the other:

*You have a truly great technique and amazing skill!*
Outcomes: Do they really matter?

Too bad the patient died!
Outcomes Research

• Needed to determine which treatments work, for which patients, and with what kind of trade-offs
Outcomes Measures

Outcome measures are needed to be able to:

- Establish baseline status
- Determine effectiveness of interventions
- Inform patients and payers of progress in a quantifiable manner
- Provide data over time to improve care
- Develop evidence-based clinical guidelines
C. How to Improve Patient/Family Satisfaction
Patient/Family Satisfaction

What do patients and families want?

• Improved function (quality)
• Convenience
• Low cost
Functional Goals

• Treatment should be focused on what is most important and useful to the patient/family.
Functional Goals
Task-Based vs. Functional-Based Goals

**Task-Based Goals**
- Assesses the patient’s impairments
- Focuses on reduction of impairment
- Focus is on correction first and compensation last

**Functional-Based Goals**
- Assesses the patient’s functional needs
- Focuses on functional skill reacquisition
- Focus is on compensation first
<table>
<thead>
<tr>
<th>Task-Based Goals</th>
<th>Functional-Based Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organizes the treatment plan around patient limitations</td>
<td>• Organizes the treatment plan around patient’s need for adequate function and discharge</td>
</tr>
<tr>
<td>• Provides family teaching at the time of discharge</td>
<td>• Provides family teaching at admission and throughout treatment</td>
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</tbody>
</table>
The International Classification of Functioning, Disability and Health (ICF)

- World Health Organization (WHO), 2001
- Describes functioning of persons 18 years and older

http://www.who.int/classifications/icf/en
The International Classification of Functioning, Disability and Health for Children and Youth

- World Health Organization (WHO), 2007
- Describes functioning of persons from birth to 18 years

http://www.who.int/classifications/icf/en
ICF Framework

Health Condition (Disorder or Disease)

Body Function & Structures (Impairment)

Activity (Disability)

Participation (Handicap)

Environmental Factors

Personal Factors

World Health Organization

Cincinnati Children’s
Body Functions and Structures

• Body Functions
  • Mental functions
  • Sensory functions and pain
  • Voice and speech functions
  • Functions of the cardiovascular, hematological, immunological and respiratory systems
  • Functions of the digestive, metabolic, and endocrine systems
  • Genitourinary and reproductive functions
  • Neuromusculoskeletal and movement-related functions
  • Functions of the skin and related structures
Body Functions and Structures

• Body Structures
  • Structures of the nervous system
  • The eye, ear and related structures
  • Structures involved in voice and speech
  • Structures of the cardiovascular, immunological and respiratory systems
  • Structures related to the digestive, metabolic, and endocrine systems
  • Related to the genitourinary and reproductive systems
  • Structures related to movement
  • Skin and related structures
Activities and Participation

• Activities and Participation
  • Learning and applying knowledge
  • General tasks and demands
  • Communication
  • Mobility
  • Self-care (feeding)
  • Domestic life
  • Interpersonal interactions and relationships
  • Major life areas
  • Community, social and civic Life
ICF Framework

Expected to be used for:

• Clinical purposes: Setting appropriate functional goals for outcome-based treatment and mapping progress

• Data purposes: Providing outcome data to improve processes and compare providers (hospitals and individuals)
Patient/Family Satisfaction
Patient/Family Satisfaction

• Need feedback from our “customers” to help us to improve our services and family satisfaction.

• Tools could include:
  • Patient/family-reported outcomes
  • Satisfaction surveys
Patient/Family Satisfaction

• In 2013, 70% of mothers with children under age 18 were in the labor force.*
• In 2016, 60% of married couple families with children under 18 had both parents in the labor force.+

*United States Department of Labor
www.dol.gov/wb/stats/recentfacts.htm
+ Bureau of Labor Statistics
Patient/Family Satisfaction

• Therefore, we can no longer provide services just from 9:00-5:00, Monday through Friday.
Patient/Family Satisfaction

• Appointments should be scheduled at the convenience of the family, not at the convenience of providers.

• We need to provide “family-friendly” hours, which include evening and weekend appointments.
D. How to Decrease Cost (and Increase Revenue) of SLP Services
Speech-Language Pathology

• Is a service “business”
• Need to “mind our business” to continue to provide service
• Need to make a profit to cover expenses and invest in growth
Old Business Model

Increase revenue:
• See lots of patients
• Provide lots of services and/or visits to each patient
New Business Model

Decrease expenses (costs):
- But how?
Primary Cost in SLP

• Time = Money
• Professional time costs money.
• Professional time (salary) is the biggest expense of SLP services!
How to Decrease Costs

We can either:

• Reduce SLP’s salaries

OR

• Reduce our time needed *per patient* to accomplish our goals
How to Decrease Costs

• **Direct time:** Face-to-face time with the patient that is billable

• **Indirect time:** Time to support patient care and the job, but is not billable (phone calls, documentation, meetings, etc.)
How to Decrease Direct Time
How to Decrease Evaluation Time

• Evaluation CPT codes are procedure-based, not time-based.
  • The more time spent, the greater the cost and the less net revenue.
  • The less time you spend, the lesser the cost and the more net revenue.
How to Decrease Evaluation Time

• Need to test only as much as is needed to:
  • Obtain a diagnosis
  • Develop a treatment plan
• Ongoing assessment to update a treatment plan is done during therapy.
How to Decrease Evaluation Time

- Do you really need to flip through pictures to test articulation?
How to Decrease Evaluation Time

• Repetition of sentences
  • p/b: Popeye plays baseball. Buy baby a bib.
  • t/d: Take Teddy to town. Do it for Daddy.
  • k/g: Give Kate the cake. Go get the wagon.
  • f/v: Fred has five fish. Drive the van.
  • s/z: I see the sun in the sky.
  • ʃ: She went shopping.
  • ʧ: I ride a choo choo train.
  • ʤ: John told a joke to Jim.
  • l: Look at the lady.
  • r: Run down the road. I have a red fire truck.
  • θ: Thank you for the toothbrush.
  • Blends: splash, sprinkle, street
How to Decrease Evaluation Time

• Repetition of syllables
  - pa, pa, pa, pa, ...  pi, pi, pi, pi...
  - ba, ba, ba, ba, ...  bi, bi, bi, bi...
  - ta, ta, ta, ta...  ti, ti, ti, ti...
  - ka, ka, ka, ka...  ki, ki, ki, ki...
  - sa, sa, sa, sa...  si, si, si, si...
  - ša, ša, ša, ša...  ši, ši, ši, ši...
How to Decrease Therapy Time

• Need to decrease the amount of visits per patient to achieve the same (or better) outcomes
• Decreased visits will decrease the total cost of achieving our outcomes.
How to Decrease Therapy Time

True or False?

a) Progress will usually be faster with *intensive therapy.*

b) Progress will usually be faster with therapy as needed and *intensive practice.*
How to Decrease Therapy Time

True or False?

a) Practice can only be done by a qualified speech-language pathologist.

b) Practice can be done with the assistance of a family member.
How to Decrease Therapy Time

• Need to decrease direct time by making the family active members of the treatment team
  • Practice done by family is of no cost.
  • Daily practice at home is consistent with motor learning and motor memory principles for faster progress.
Motor Learning & Motor Memory Principles

• Speech requires motor movement that is fast, complex, automatic and effortless.
• This is accomplished by motor learning and motor memory.
Motor Learning & Motor Memory Principles

- **Motor learning** is dependent on:
  - instructions,
  - trial and error, and
  - feedback
Motor Learning &
Motor Memory Principles

• **Motor memory** is dependent on:
  • practice
Motor Learning & Motor Memory Principles

Practice:

• Results in brain reorganization due to neural plasticity
• Is necessary for learning complicated motor movements and sequences without conscious thought
• Develops the automaticity of the movement and ultimate “carry-over”
Motor Learning & Motor Memory Principles

• Practice is necessary for learning complicated motor movements and sequences without conscious thought.
  • Examples:
    • Ballroom dancing: salsa
    • Sports: shooting a basketball
    • Playing an instrument: piano
    • Speech
Motor Learning &
Motor Memory Principles

Speech therapy is like taking piano lessons...
If you don’t practice at home, you don’t learn to play the piano!
Motor Learning & Motor Memory Principles

- Language learning (for 1st and additional languages) requires instructions, study, and practice (immersion).

  Puedo tener una bebida por favor?
Motor Learning & Motor Memory Principles

- SLPs should provide only high level instruction (motor learning) which requires the training and licensure.
- Practice and drill work (motor memory) do not require professional services and should be done in the home.
Practice Frequency and Distribution

- Daily practice at home is critically important, although practice sessions can be very short (i.e., 30-60 seconds).
- Frequent sessions should be done throughout each day.
- Distributed practice throughout the week facilitates long-term learning.
**Practice Intensity**

- **Dose**: Number of correct responses in a practice session (in therapy or at home)
- Higher dose per practice session is directly related to the rate of progress
- Drill work is most effective
Family Involvement

- Family involvement is key to increasing the rate of progress and decreasing the cost of achieving desired outcomes.
Family Involvement

• We need to train family members to work with the patient at home.

• To engage families, it helps to use principles of self-management, including motivational interviewing.
Self-management in healthcare:

• Method to help people with chronic conditions manage their (or their child’s) condition more effectively at home
• Is part of patient-centered care
• Results in a partnership between providers and patients/families
Family Involvement

“Feed a man a fish and he’ll eat for a day. Teach a man to fish and he’ll eat for a lifetime.”

(Native American saying, author unknown)
Family Involvement

Motivational interviewing (MI) is a part of self-management:

• Explores and resolves ambivalence to change (i.e., I want to lose weight, but I don’t want to change my eating habits.)

• Determines what motivates the individual to facilitate a change
Family Involvement

MI questions are used to encourage parent engagement:

• What would success look like for you?
• What can you do to help your child reach these goals?
• On a scale of 1-10, how confident are you that you can manage your child’s practice needs at home?
Family Involvement

MI questions are used to determine and mitigate barriers to reaching success, including:

• Transportation
• Child care issues
• Health issues
• Scheduling issues
• Financial challenges
• Communication issues
Family Involvement

SLPs can use self-management to improve:

• Involvement of the parents/family in the treatment process
• Attendance
Family Involvement

Self-management can result in:

• Improved outcomes with fewer sessions and lower costs
• Improved patient/family satisfaction
Decreasing Indirect Time
Decreasing Indirect Time

• HC providers should perform only those tasks that require their professional skills and training. This is called “working at the top of license.”

• HC providers should NOT spend time doing things that can be done by those who are less skilled and lower paid.
Top of License

• For MDs, expanded services can be provided with the assistance of others, such as:
  • Nurse practitioners
  • Physician assistants
  • Pharmacists
  • Social workers
  • Administrative staff
Physician on the phone: *Now make an incision between the 3rd and 4th abdominal muscles.*

Patient: *Shouldn’t you be doing this?*
Top of License

• It’s more cost-effect to have lower paid, less skilled people (i.e., support staff) to provide support services.

• Provider can see more patients (increases access), and generate more revenue.
Top of License

When professional people work at the top of their license...

• Win for the professionals
• Win for the patients
• Win for the business
Top of License for SLPs

• SLPs should provide only those services that require a level of complexity and sophistication that only a licensed SLP can provide.
Top of License

• Dedicated support staff should always do the following:
  • Scheduling
  • Insurance auths
  • Phone calls
  • Mailing of letters, reports, etc.
Top of License

• Pre-visit planning by support staff:
  • Pre-evaluation questionnaire (paper, online, or on phone)
  • Pre-visit parent interview
  • Use of self-management questions when making appointments to ensure commitment and attendance
Top of License

• What if you can’t afford to hire support staff?
• Actually, you can’t afford NOT to hire support staff.
Top of License

- Cost per hour when SLP schedules: $40.00/hr.
- Net revenue per hour when a support person schedules and the SLP treats a patient:
  - Revenue from charges: $250.00
  - Cost for SLP: 40.00
  - Cost for support staff: 15.00
  - $195.00
- Difference to bottom line: $235.00/hr.
What would an SLP prefer to do?

• Schedule a patient
• Obtain insurance authorization
• Produce a diagnostic report
• Treat a patient
Top of License

• SLPs should not do administrative tasks.
  • They are not that good at admin tasks.
  • They are happier doing clinical work.
Top of License

- Clinical support for practice
  - Parents/family members
  - SLP assistants
  - Students
  - Volunteers
Top of License

To increase support and decrease your costs:

• Develop a **Student Volunteer Program**.
Top of License

Use students to:
• Set up and clean up
• Organize materials and cabinets
• Make copies
• Run errands
• Call families
• Make communication boards, handouts, etc.
• Take a history over the phone
• Do literature reviews
• Help with group therapy
Top of License

Advantages for students:

• Offers many observation hours for clinical learning
• Gives insight into the “business”
• Is an advantage when applying to grad school or for a job
• Gives student a “foot in the door”
Documentation
Documentation

• Time spent in documentation is the biggest non-billable cost in an SLP practice!

• Cutting documentation time increases clinical time (e.g., access for more patient and more revenue) and decreases costs.
How much of your time is devoted to paperwork? (N = 251)

<table>
<thead>
<tr>
<th>Percent of Respondents</th>
<th>Percentage of Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>Less than 1%</td>
</tr>
<tr>
<td>34%</td>
<td>10-25%</td>
</tr>
<tr>
<td>43%</td>
<td>26-50%</td>
</tr>
<tr>
<td>18%</td>
<td>51-75%</td>
</tr>
<tr>
<td>4%</td>
<td>More than 75%</td>
</tr>
</tbody>
</table>
How much of your time is devoted to clinical documentation? (N = 595)

Average Percentage of Time: 20%
What factor causes the most stress for you in your job? (N = 219)

<table>
<thead>
<tr>
<th>Percent of Respondents</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>Caseload size</td>
</tr>
<tr>
<td>49%</td>
<td>Paperwork</td>
</tr>
<tr>
<td>5%</td>
<td>Difficult patients</td>
</tr>
<tr>
<td>5%</td>
<td>Turf battles</td>
</tr>
<tr>
<td>11%</td>
<td>Work environment</td>
</tr>
</tbody>
</table>
Why do we spend so much time in documentation?
Because we have all had an old professor who told us to!
Staff Comments

- If a report isn’t long, the family and payer will think that they were overcharged.
Cost of Getting an MRI
# MRI Charges (2017)

<table>
<thead>
<tr>
<th>Procedure Name</th>
<th>Technical Charge</th>
<th>Professional Charge</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain MRI</td>
<td>$3,525.00</td>
<td>$869.00</td>
<td>$4,394</td>
</tr>
<tr>
<td>Abdominal MRI</td>
<td>$3,844.00</td>
<td>$364.00</td>
<td>$4,308</td>
</tr>
</tbody>
</table>
Brain MRI Report

COMPARISON: None
PROCEDURE COMMENTS: MRI of the brain was performed before and after administration of intravenous contrast.
FINDINGS:
The ventricles and extra-axial spaces are normal in size and shape.
There is no mass lesion or evidence of intracranial hemorrhage.
Parenchymal signal and morphology are normal.
There are normal flow voids in the intracranial vessels.
There are no foci of abnormal enhancement.
There are no regions of restricted diffusion.
A few small mucous retention cysts are seen within the adenoids.
IMPRESSION:
Normal MRI examination of the brain without and with contrast.
CLINICAL HISTORY: Patient with chronic abdominal pain, mouth ulcers, ulcers in transverse colon.
COMPARISON: Abdominal ultrasound 2/13/2014, showing renal stones, bladder debris, and prominence of common bile duct.
PROCEDURE COMMENTS: MRI of the abdomen and pelvis was performed with and without Magnevist intravenous contrast. VoLumen was used as the oral contrast agent. One 0.3 mg dose of glucagon was administered subcutaneously at the beginning of the exam, and a second 0.3 mg dose of glucagon was administered intravenously prior to gadolinium injection.
FINDINGS:
LOWER THORAX: Normal.
LIVER AND BILIARY SYSTEM: Normal.
SPLEEN: Normal.
PANCREAS: Normal.
ADRENAL GLANDS: Normal.
KIDNEYS, URETERS, AND BLADDER: Normal.
BOWEL: Normal. There are segments of proximal jejunum and terminal ileum which are poorly distended. Within these limitations, no mucosal hyperenhancement, mural stratification, bowel wall thickening, strictures, or fistula. The bowel peristalses normally. The terminal ileum is normal.
PERITONEAL CAVITY: Normal. No inflammatory stranding, lymphadenopathy, engorged vasa recta, fatty proliferation, or abscess. No free fluid, focal fluid collection, or free air.
UTERUS AND OVARIIES: Normal.
VASCULATURE: Normal.
LYMPH NODES: Normal.
ABDOMINAL WALL: Normal.
OSSEOUS STRUCTURES: Normal.
IMPRESSION:
Essentially normal MR enterography without findings of inflammatory bowel disease. There are segments of terminal ileum and proximal jejunum which are poorly distended, but no secondary findings of inflammation are present.
Cost of Getting an MRI

MRI charges are based on:

• Time spent
• Degree of clinical expertise
• Degree of technology
• Expense of equipment
• Additional overhead
Staff Comments

- A report has to be long to convey all the necessary information for our customers.
Documentation

• If you get a psych report, what do you read?
• What do you remember?
  • History
  • Examination and test results
  • Summary
  • Recommendations
Documentation

• Have you ever received a formal written report from your primary care doctor?
• If so, was it in paragraph format?
• How many pages was it?
Survey of Physicians (1996)

What do you want in our reports?
Survey of Physicians

What sections of a diagnostic report do you always read? (Check all that apply.)

<table>
<thead>
<tr>
<th>Section</th>
<th>Percentage (Count)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertinent History</td>
<td>41% (44)</td>
</tr>
<tr>
<td>Examination</td>
<td>27% (29)</td>
</tr>
<tr>
<td>Summary and Impressions</td>
<td>99% (107)</td>
</tr>
<tr>
<td>Recommendations</td>
<td>100% (108)</td>
</tr>
</tbody>
</table>
Survey of Physicians

Do you read the detail regarding the types of tests given, test scores, normative data, observations, etc.?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually</td>
<td>25% (27)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>60% (65)</td>
</tr>
<tr>
<td>Never</td>
<td>15% (16)</td>
</tr>
</tbody>
</table>
Survey of Physicians

If information is included regarding formal tests, how would you prefer it to be displayed?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
<th>Survey Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paragraph form within the report</td>
<td>31%</td>
<td>(34)</td>
</tr>
<tr>
<td>Check list form as an attachment</td>
<td>69%</td>
<td>(74)</td>
</tr>
</tbody>
</table>
Survey of Physicians

What kind of language do you prefer in the reports?

<table>
<thead>
<tr>
<th>Language</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical language</td>
<td>30% (32)</td>
</tr>
<tr>
<td>Common or simple language</td>
<td>70% (76)</td>
</tr>
</tbody>
</table>
Survey of Physicians

Which type of reports do you prefer?

<table>
<thead>
<tr>
<th>Long and detailed (3 or more pages)</th>
<th>12% (13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short and concise (1 page)</td>
<td>88% (95)</td>
</tr>
</tbody>
</table>
Documentation

• How much are patients/families willing to pay for a professional to compose a report?
• What do our customers (referral sources, families, other SLPs) really want and need from our documentation?
Documentation:
What our Customers Want

• **Physicians**: Summary of impressions and recommendations

• **Patients/families**: Info about the diagnosis and what can be done about it

• **SLPs**: Eval data presented concisely

• **Payers**: CPT code and ICD-10 code for auths; Progress data for reauths
• Physicians: One page summary letter
• Patients/families: Copy of letter and plus handouts regarding diagnosis and treatment
• SLPs: Copy of letter and attachments with scores and checklist info
• Payers: Copy of letter with ICD-10 and CPT codes for eval. Table of goals and progress for therapy.
Documentation

We need to:

• Meet the needs of our customers
• Cut cost by decreasing time spent on writing manuscripts instead of usable reports
• Increase time spent in clinical care
Documentation

How do we streamline documentation?

- Computerized templates with select lists
- Informational handouts for families
Productivity

• Measurement of the *collective efficiency* of a clinician, program, department, or organization in delivering products or services

• Gives an indication of the *financial health* of a program or organization
Business Productivity Measurement

• Measured by the relationship (ratio):

  Achievement of desired results (revenue)
  Expenditure of resources (expenses)

• Examples of revenue/expense ratios:
  .75, 1.00, 2.50
Business Productivity Measurement

• Productivity for SLPs:
  
  *Billed hours (revenue)*
  *Hours worked (expenses)*

• Productivity is a measurement of the fiscal health of the program or organization.
Business Productivity Measurement

- Productivity is NOT a measurement of work or effort.
- Productivity “credit” should never be given for non-billable hours (i.e., meetings, project work or documentation).
- Non-billable activities are just a cost and not a measure of the health of the program or organization.
Productivity Business Model
True or False...

• Productivity should be a major component of the performance evaluation.

• There should be consequences for an SLPs who has low productivity.
Productivity

Productivity should be a major component of the performance evaluation.

1. True
2. False
There should be consequences for an SLPs who has low productivity.

1. True
2. False
Productivity

- Productivity is a major stressor for SLPs!
- Can we remove this stressor?
Productivity

• If all scheduling is done by support staff, then both statements are FALSE.

• SLPs cannot be responsible for productivity if they have no control over their schedules.

• The scheduling staff, not the SLPs, should be responsible for productivity.
Productivity

• SLPs should only be responsible for discharging patients who are poor attenders.
Scheduling

- Efficiency and effectiveness of scheduling procedures directly impacts productivity and revenue!
Scheduling

- Professional schedulers are cheaper and do a much better job of it.
- SLPs will be able to see more patients and generate more revenue if they do not schedule.
- SLPs will be happier and less stressed, which makes them provide better service.
Scheduling

• Make support staff accountable for scheduling each week.
  • Number of new patients scheduled
  • Number of remaining open slots
  • Number of patients rescheduled when calling in
  • Number of cancelled slots refilled
Scheduling

• Schedule to compensate for cancellations and no-shows.
  • If the goal is 65%, schedule at 82%.
  • If an SLP’s typical cancellation rate is low, the scheduling percentage is decreased.
Minimizing Cancellations/No-Shows

- Inform families of attendance policy...
  - when making the appointment.
  - when sending reminders or mailed info.
  - on first day of therapy.
Minimizing Cancellations/No-Shows

• Change a cancellation into a rescheduled appointment.
• Have a cancellation “hot line” and a scheduling on-call list.
Productivity and Scheduling

• Do block scheduling (4, 8, or 12 sessions) of therapy at a time and then a break of a block

• Short-term scheduling:
  • Increases commitment and attendance
  • Allows more practice and habituation of skills at home
  • Allows other patients to receive therapy in the off time
Scheduling

• Develop a Diagnostic Clinic for routine evaluations
  • Have several SLPs assigned.
  • Schedule patients to clinic, but not to an SLP.
  • Overbook the clinic slightly.
Scheduling

- Offer consultative therapy.
  - SLPs design the treatment plan and teach the skill.
  - SLPs train the parents/family members to work with the patient at home.
  - Patient returns for a therapy session when ready for the next step.
Scheduling

• Develop a Family Initiated Treatment (FIT) Program.
  • Some families cannot commit to a regular weekly time due to changing schedules, transportation issues, etc.
  • Allow families to call each week to schedule appointments at their convenience.
  • This fills in open times and cancellations.
Scheduling

- Schedule patients based on each SLP’s competencies and interests.
- Have staff cover for each other rather than cancel patients.
- Need to make sure treatment plans are clear and notes are current.
Scheduling

• Encourage staff to take off during low attendance times (i.e., holidays and snow days).
  • They use PTO and don’t feel obligated to come in.
  • You don’t pay for non-productive time.
  • Families don’t feel obligated to come around holidays or during bad weather.
Long-Term Therapy

• Some disorders cannot be corrected with therapy, but instead will be a chronic life-long condition.

• When is it time to quit?
Problems with Long-Term Therapy

ASHA Code of Ethics:

• SLPs should not deliver therapy without a reasonable expectation of achieving an outcome.
Problems with Long-Term Therapy

• We devalue the profession by “practicing” with patients or keeping patients in therapy who are not making progress.
Problems with Long-Term Therapy

• Parents/family members are more likely to disengage and cancel more frequently.

• If there is a wait list, keeping patients who are not making progress deprives other patients from receiving services who could benefit.
Problems with Long-Term Therapy

- It can cause unrealistic hopes and expectations.
- Regardless, we should never allow parents/family members to prescribe treatment or dictate the “dose.”
Problems with Long-Term Therapy

- Long-term therapy can:
  - overburden the family emotionally and financially.
  - overburden the healthcare system with minimal benefits.
Instead of Long-Term Therapy

• Work on realistic, functional goals that will improve communication.
• Discharge when there has been minimal or no progress for a month or more.
Instead of Long-Term Therapy

• Consider the following alternatives:
  • Episodes of care, rather than continuous care
  • Less frequent sessions to allow more practice at home
  • Home program
  • Discharge with periodic rechecks
Telehealth

Advantages:
• Can increase access and patient populations
• Can fill in cancellations and open times
• Can schedule shorter, more frequent sessions
• Parents are often more involved
• Can reduce the need for clinic space and allow employees to work from home
Telehealth

Barriers:

• Third party payment is currently limited
• Licensure is required for both state of the provider and patient
Telehealth

Barrier Work-Arounds:

• Can have a lower charge for telehealth sessions for private pay patients
Reducing Wasted Time

• Awareness of the cost of time is important.
• Being busy is not the same as being productive.
• Should analyze what is done in non-billable time.
Reduce Meeting Times

• Avoid unnecessary (and usually boring) meetings when written communication (i.e., newsletter, email, etc.) is sufficient.
Managing Meetings

• Consider the cost vs. the importance of each meeting.
  • One hour meeting with 100 employees
  • One hour travel (to and from) for 80 employees
  • Charge per hour: $250.00
  • 10% no show rate
  • 80% reimbursement rate
Managing Meetings

• What is the approximate lost revenue for that meeting?

$32,400!
Managing Meetings

• Hold “virtual” meetings through conference calls or online.
Managing Meetings

• Replace an information-giving staff meeting with a newsletter or a video for staff to view during down times.
Managing Meetings

• Hold stand-up meetings, which tend to be shorter and more focused (and also burn more calories).
E. How to Improve Program Success
Marketing SLP Services

It’s time to market our services!

Speech R Us Therapy Services
Speech Therapy BOGO Sale
Buy One Session
Get the Next Session Free
Marketing SLP Services

• Need to educate referral sources, parents and public about our services and our value

• For physicians and other referral sources:
  • Lectures
  • Email blasts with handouts or brochures
  • Visits

• For parents and the public:
  • Bookstore events
  • Free screenings
Make Staff Partners in the Business

• All staff should be knowledgeable about the business, including the opportunities and threats.
• Help staff to feel a sense of pride and ownership in the program.
Make Staff Partners in the Business

• All staff should see the revenue/expense information to help them to...
  • feel that they have a personal stake in the business.
  • see how they are doing as a team.
  • celebrate success as a group!
Summary

• The goals of healthcare and methods of reimbursement are changing dramatically.
Summary

• To respond to the changes, SLPs need to...
  • improve quality.
  • improve clinical outcomes.
  • improve patient/family satisfaction.
  • decrease costs, but increase patients served to improve margins.
  • improve program success by marketing our services and effectively running the business.
In the end, we will be better providers of healthcare, and also... healthier and happier consumers.