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An Introduction to the Business of Pediatric Hospital-Based Audiology

Yell Inverso, AuD, PhD, MBA, ABAC

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Yell Inverso, AuD, PhD, currently serves as the Director of Audiology at Nemours Center for Pediatric Communication, in the Delaware Valley. She received her Au.D and later her PhD from Gallaudet University in Washington, DC. Dr. Inverso's clinical and research interests include the hearing brain, childhood misophonia, cochlear implantation, and assessment development. In recent years, she has focused her attention on the administrative leadership and growth of the multidisciplinary programs affiliated with pediatric communication. Dr. Inverso has held adjunct faculty appointments at Gallaudet, Salus University and the School of Medicine at the University of Pennsylvania. She has multiple publications and chapters in her areas of interest and mentors young audiologists and researchers. Additionally, Dr. Inverso serves on the advisory boards of the International Misophonia Research Network and Misophonia Kids and in 2016 was elected President of the Society of Ear Nose and Throat Advances in Children (SENTAC).

Disclosures

- **Presenter Disclosure**: Financial: Yell Inverso is the Director of Audiology at Nemours Center for Pediatric Communication, in the Delaware Valley. She received an honorarium for this presentation. Non-financial: Yell Inverso has no relevant non-financial relationships to disclose.
- **Content Disclosure**: This learning event does not focus exclusively on any specific product or service.
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Learning Outcomes

After this course, participants will be able to:

- Explain different ways productivity can be calculated or tracked.
- Define key terms and concepts related to staffing in a pediatric hospital audiology setting.
- Explain a way in which revenue divers are different in pediatric vs adult hospital-based care.

Pediatric Audiology

- What is a Pediatric Audiologist?
  - An audiologist who focusses on the diagnosis and treatment of hearing and balance disorders in infants, children and adolescents.
    - Most commonly 0-21 (depending on work location)
  - Can work in various settings

Hospital-Based Audiology

- Generally, attracts those with a pension for medical environment, more complex cases and the stability of salary as opposed to commission etc.
- Part of a much larger system, small fish, held to more policies, procedures, joint commission standards etc.
- Broad scope of practice often expected/available.
- Presents challenges/opportunities that are different than other settings

Hospital-Based Audiology

- Where do we fit?
  - Therapy Services
  - Communication Center
  - Otolaryngology
  - Autonomous
  - Other??
- Who do we report to?
- How do we bill?
  - Professional Based (individual NPI, RVU driven)
  - Hospital/facility based (hospital NPI, higher reimbursement and charges)

Staffing Classifications

Exempt

- Salary Model”
  - Paid to do a job no matter how much time it takes
- Not eligible for minimum wage, overtime regulations and other protections extended to non-exempt workers.
- Give and take
- Can be full or part time

Non-Exempt

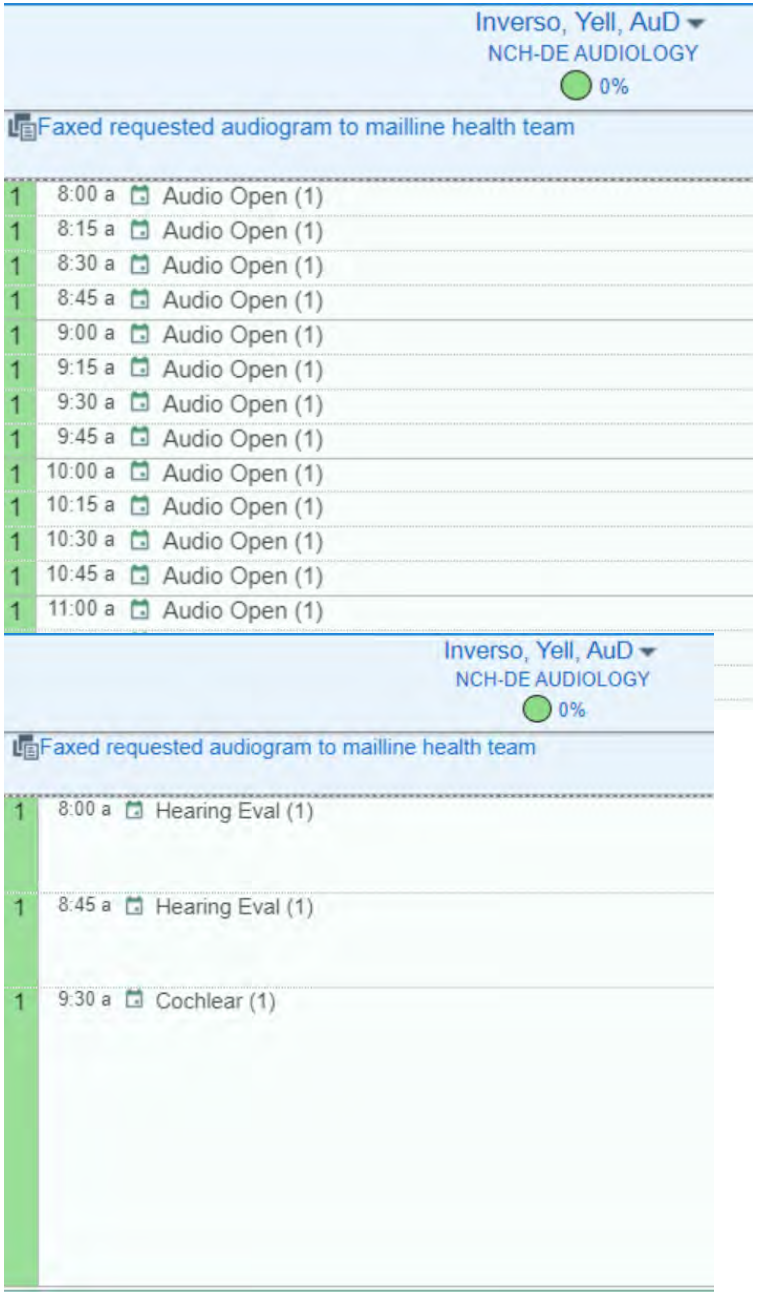
- Hourly/clock in & out
- Eligible for minimum wage, overtime regulations etc.
- Can be full, part time, or casual

Staffing Concepts

- Schedule vs Template vs Work Hours
- Full-Time Equivalent (FTE)
  - 1.0 FTE means full-time (based on 40 hours, even if exempt)
  - To calculate your FTE # hours scheduled/40
    - 30/40=.75 FTE
  - Need to prove, usually with volume estimates that a new Audiologist is needed.

Scheduling Concepts

- Templates (clinical schedules)
  - Overall and then physically in an EMR
  - Open vs block schedules
- ENT & multidisciplinary clinic coordination
  - Blocked schedule, open template, “resource”-based
- Ensuring response to orders and add-on patients (IP and OP)
- Satellite coverage and morning triage for last minute call-outs



Budget Process/Concepts

- Budgeting is often a process with multiple revisions before executive or board approval
- Budget year often calendar year (planning at mid-year) or can be any other 12-month period
- Capital Budget
  - Equipment, new locations, projects
  - Often items over a $ amount (e.g. >$5000)
  - Need to justify and obtain multiple quotes
  - Return on investment (ROI)
    - Performance measure used to evaluate the efficiency or profitability of an investment or compare the efficiency of a number of different investments.
    - How long until project/equipment turns a profit “pays for itself”?

Budget Process/Concepts

- Operating Budget
  - Budget to fund the regular operations of a department/accounting unit
  - Make volume projections for all locations
  - Determine revenue per unit of service based on previous year reimbursement data
  - Estimate for all other expense lines (minor equipment, supplies, office materials, travel, CEU, etc.)
  - Request/justify budgeted FTE increases
  - Factor in salary, merit or cost of living adjustments
  - Defend end of year projections and budget for next year

Clinical Productivity

- Factors for consideration:
  - Staffing
  - Complexity of service
  - Hours of operation
  - Equipment/Resource availability and space
  - Non-billable activities
- Many different methods, some work better in pediatric environments than others.
- Can be further influenced by availability of data such as productive hours (payroll), volume data by providers, etc.

Patient Volume-Based Productivity

- Can be very simplistic
- Number of visits, procedures, encounters, or patients.
- Provides an easily understood indication of the volume of work.
- Primary disadvantage: usually does not consider the complexity of services – all services are counted equally.
- ASHA defines productivity as the percentage of a clinician's day involved in patient care

Slot Utilization/Capacity-Based

- Calculates a percentage of total booked or un-booked time as a function of what was available.
- If provider has open template and their day is divided into 15-minute open slots, it is a very easy calculation if have access to the data.
- Pitfalls
  - Doesn't take complexity of work into consideration
  - Gives "credit" even if nothing is billed so can be inefficient and doesn't account for no-shows.

Time-Based or Workload Units

- Often referred to as Units of Service (UoS), WLU, billed unit volume
- Method that gives a time-value to each procedure (CPT) which then allows for a calculation of productivity based on hours worked.
- Can be estimated (general assumptions lead to a work hour assumption per FTE)
- Can be exact if data is entered into a payroll system which allows for the accounting of unproductive time (PTO, Meetings, etc)
- Generally, there is a stated target for productivity for each Audiologist and/or the department overall

Calculation Example

- CPT codes given a value based on 15-minute units of service (UoS).
- The total available/possible UoS calculated by multiplying every productive hour worked by 4.
- Once compiled, if an audiologist bills 360 units and they worked 37 productive hours, available units would be 555.
- 360/555= 64.8% productive

Medicare Relative Value Units (RVU)

- RVUs are based on a relative value scale that weights all CPT procedure codes.
- The AMA, with input from specialty societies, assigns a relative value to each CPT code.
- Has three components:
  - professional work (time, technical skill, physical effort, stress, and professional judgment);
  - practice expense (overhead costs and non-physician labor);
  - and professional liability (malpractice costs).

Medicare Relative Value Units (RVU)

- Two advantages:
  - Accounts for complexity on a relative scale
  - Can be benchmarked to the productivity of other facilities
- The major disadvantage of using RVUs as a productivity measure is that not all audiology services are captured by CPT codes or covered by Medicare.
- HCPCS codes, which are billed for all hearing aids and other devices, do NOT have RVU associated in this system.

Obstacles Unique to the Business of Pediatrics

- Hearing Aid units dispensed is NOT a success metric that is regularly used in the pediatric hospital community.
  - Small self-pay market
  - Insurance concerns and capitations
  - Payor mix can be Medicaid heavy in many areas as some states, HL is a qualifying diagnosis/disability
  - Reimbursement arrangements make it difficult to break even
  - Often lack of transparency from hospital on payor contracts

Obstacles Unique to the Business of Pediatrics

- Margin is typically created by volume of diagnostic billing.
- Determine if system allows for facility billing which offers higher reimbursement per code as compared to practice billing model.
- Medical model can lead to higher acuity patients which can be time consuming, and hospital compliance often dictates detailed reporting requirements.

Why is it Wonderful?

- Often less of a “sales” model of care
- Work with whole family and patient often for many years
- Stable and allow for a wide variety of professional growth opportunities
- Work in a collaborative TEAM environment
- Children will ALWAYS keep you on your toes!

Thank you!

Yell Inverso, AuD, PhD, MBA, ABAC

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