An Introduction to the Business of Pediatric Hospital-Based Audiology

Presenter: Yell Inverso, AuD, PhD

It is my pleasure to introduce Doctor Yell Inverso. Today she'll be talking about an introduction to the business of pediatric hospital based audiology. If you'd like to learn more about Doctor Inverso, you can read about her on the course registration page at this time. I'll hand the mic over to you, doctor Inverso. Welcome everyone.

I hope you can hear me okay, and I look forward to taking questions as we go throughout today, if you have any. You know, my background really, I consider myself a pediatric audiologist. I have been in a leadership role for the past 14 plus years and I absolutely love it. I love the diversity of being able to be in a hospital, that energy being with kids, but also I do enjoy the business side of things. This topic is near and dear to my heart, primarily because it always, you know, there's only so much you can learn in your education and only so much you can kind of absorb when you're focusing on your clinical skills.

There's just so much about the rest of the world of audiology, that big, wide world that you don't learn about. And I've had associate staff members who have worked even at this institution for 20 years that I was really surprised to know didn't fully have as deep of an understanding of even how they are paid and how the department functions. And it kind of led me to talk about this type of topic quite a bit. So thank you for joining. Next we'll me go ahead and get started.

These are my disclosures, you know, no significant, you know, financial or content disclosures because we're not talking about anything really super specific to a product or anything like that today. Our learning outcomes, you know, my goal is at the end of the course, you'll be able to explain different ways productivity can be calculated or tracked, define some key terms and concepts related to staffing in a pediatric audiology setting in a hospital, and kind of think through and explain at least one way in which revenue drivers are different in pediatric versus adult hospital based care. So, you know, pediatric audiology, I always say, you know, you know, pediatric audiologist

when they call themselves that. The bottom line though, is that within our licensure and, you know, as our education as audiologists, we don't have to, for example, do a specific pediatric fellowship in order to be a pediatric audiologist. We are trained to be able to care for patients throughout the lifespan.

However, for individuals that really have focused their career and their practice on diagnosis and treatment of hearing imbalance in infants and children and adolescents, that's really what we think of as pediatric audiology, the age range can differ depending on where someone works and their policies and procedures. Typically, it's either zero to 18 or zero to 21, and with potential for exceptions outside of that, pediatric audiologists can work in a lot of settings. You can be in a private practice, an Ent practice, a pediatric hospital, or a broad service hospital where you might be the audiologist that focuses primarily on kids. There's really a lot of options, and there's a lot of potential diversity in the type of work and the type of audiology services that can be provided in pediatrics, but it is different. We're going to be focused today on hospital based audiology with a focus on pediatrics.

But I'll try to point out some of the differences and things in between adult and pediatric hospital based audiology. Now, hospital based audiology in general, I think, typically, generally attracts those with a real pension for the medical environment, potentially more complex cases, and the stability of a salary versus, for example, maybe a commission. Now that's not to say that there aren't audiologists, especially in the adult world, who get commission for units dispensed and so forth. But in general, that true hospital based department often is slightly outside of the sales model, especially in pediatrics, which I love.

It's important to understand that when you're part of a larger institution, audiology can be kind of a small fish. And in general, when you're part of a hospital specifically, you really are held to very specific policies, procedures, documentation, standards. A lot of

that relates to regulatory, such as joint commission standards, but also there's less fly by the seat of your pants. I think maybe you can do that clinically, but as far as documentation and policies, procedures and so forth, when you're part of a larger institution, hospital based audiologists can have a really broad scope of practice. And in pediatrics, I think that is really, you're an audiologist, you're subspecialized in pediatrics, maybe you, like me, love cochlear implants.

But when you work with kids, if you're in a full service department, you might be doing all types of diagnostics and electrophysiologic and treatment and so forth, or you might be in an institution that segments it. There are pediatric hospitals that might have their diagnostic and their rehabilitative or rehabilitative team separate. So it's kind of important to understand, especially if you're looking for this type of position, you know, how things are structured and if it works for you, there are certain, you know, challenges which I like to think of as opportunities but that are different than other settings. And we'll talk about some of those as we go through. I love this picture because I always say audiology in a hospital, it's kind of like a square peg, and there are a bunch of round holes, and so a score, a square peg will go into a round hole.

It's just not necessarily going to hold water. And so we find ourselves as audiologists and hospitals, often as part of maybe therapy services or a communication center, maybe part of otolaryngology or even autonomous. And there's probably, you know, a million other possible scenarios of where audiology tends to fall within these larger institutions. A lot of different models can work, I think. One thing to kind of think about, though, as far as autonomy of practice, is, you know, who do the audiologists report to?

Is it up through ENT, which is part of the department of Surgery, which is going to have potentially different standards? And sometimes you might struggle a little to have what we do fully understood. Or are we reporting to a business manager? Or do, you know,

are you reporting to an audiologist that reports up to somebody else? That reporting structure can really shift and change the way that things are done in the department itself.

Another piece that kind of can define a little bit of audiology within a hospital is how do we bill? You know, there's generally, you can think of it as professional based billing. Sometimes it's referred to as PB, where as an audiologist, you're billing under your own individual NPI. You have to panel with different insurance companies and possibly third party payers. It's often RVU or relative value unit driven.

And, you know, that's, that's one way to do it. Often, though, if you're physically in a hospital or if you're in a hospital system, you can also be hospital or facility based billing. And, you know, then while you're still practicing under your own license as an autonomous professional, you're billing under the hospital's NPI. There are those facility charges which can the higher reimbursement, also higher charges. So you might think of it as if you've ever been to a doctor's office or you've had a procedure at a hospital or a hospital stay.

You might receive different bills. You could receive a bill from the provider, say the physician or, you know, individual that you saw, and then also a facility charge. And, you know, this is the model that I work under. I've done both. But we do hospital based facility billing.

We're a hospital department and there's definitely a lot of pros and some potential drawbacks, especially as consumers are becoming more and more aware and cost shopping for their services. The sticker shock can be higher when you're part of a facility. So we're going to talk about staffing classifications, and this is one of those things where I was always kind of surprised that people didn't necessarily know how they were classified within their job. So, you know, the whole thing around exempt

versus non exempt goes back to the Fair Labor Standards act, which goes all the way back to 1938. And really it was a classification of workers primarily around who's eligible for overtime protections and minimum wage rules and so forth.

And, you know, there are these two classifications exempt, you know, which can be all sorts of different jobs. You know, you could be clinical, non clinical, but exempt is really that salary model where you are as an audiologist or for me, as, you know, director of my department, I am paid a salary. I'm paid based on the job that I do, not necessarily how much time it takes me to do it. Whereas on the non exempt side, you know, somebody might need to clock in or clock out, and they are eligible for minimum wage and those overtime regulations. So, for example, within, you know, my department, I'll use as an example, you know, all of the audiologists and the audiology leadership are exempt, paid a salary, and it's a give and take.

So if an oral, for example, you know, runs late, you end up not leaving the hospital until 637 o'clock at night. That's all in a day's work. Even if, you know, your, your schedule or your template had been, you know, that you were supposed to leave at five, for example. And the other side of that, that give and take is, you know, for somebody that's exempt, you know, if you have a doctor's appointment on a given day and you say a staff member comes to me and says, you know, I don't think I'm going to be able to get in until ten on this particular day, get approval to do so. You're not taking vacation time or not being paid for those hours.

It all comes out kind of in the wash. Exempt can be full or part time. It doesn't have to be just full time, which a lot of people don't realize. Now, non exempt, again, more hourly, more clocking in and out and eligible for those overtime regulations. So if somebody, you know, doesn't coming in till ten, they either need to work those hours and flex them within that time period, clock out late on a day, if approved, or they would use PTO for that time or not be paid.

Same thing. If I have one of my patient service specialists, for example, who are non exempt and they were just about to turn off their phones and be done for the night and a phone call came in and it was complicated and they end up clocking out late. We're required to make sure that they're paid for that time. And non exempt can also be full time, part time, or casual. And casual really is a status that is typically less than part time, typically less than, you know, 20 hours a week, for example.

And it might not be regular. So this might be per diem or an individual who you bring in, you know, just at times of high census and that type of thing. There's lots of different kind of nuance to it. But it's important to know, you know, am I an exempt associate or a non exempt associate? If I get stuck at work seeing a patient, what do, what should I expect?

You know, I mentioned those hours, right? So it's important for team members to understand you might have a schedule, right? And that might be the hours of operation for the clinic Monday through Friday, 08:00 to 430, something like that. Or it might be a modified schedule, four tens with off on Wednesday kind of thing. But then there's also your clinical template, which typically, if you're an audiologist, that's the time that you are open for appointments to be scheduled.

That might be exactly the same as your overall work schedule or your template may be, you know, that you start seeing patients 15 minutes after your start time and 15 minutes early at the end of the day, maybe with some time blocked in the afternoon for a food break. But again, it's important to kind of understand, you know, if you are exempt, just like the bonus of, you know, I need to leave early, I have a headache, you're not going to have to use PTO. It all kind of has to come out in the wash. It relates back to another concept, which is important, is full time equivalency, or FTE.

You might have heard this, and sometimes people will say, oh, I'm 40 hours, but as an exempt associate, you're really a 1.0 FTE.

And it's really 1.0 is based off of 40 hours, even if, you know, maybe you're scheduled for five, eight and a halves because you get a half hour at lunch or whatever, but it's based on that 40 hours week. So if you work 40 hours, you're a 1.0 40 divided by 40 is one. If you, for example, if your schedule is modified and, you know, you're still full time, you're still salary, but you're only scheduled to work 30 hours a week, for example, that would be a 0.75 fte, 20 hours would be a 0.5 fte. And sometimes the institution will have things based on your FtE. For example, if you are less than a 0.5 fte, you might not be eligible for benefits or you might be off benefits eligible.

But it's important to kind of understand that and how it's going to play into your decisions when you're looking for positions. And if you're in leadership, you know, you're really thinking about that full FTE complement. I, for example, in my department, I have more people than I have fte because I have some wonderful audiologists who are, you know, maybe a 0.8. They work four days a week, you know, 8 hours a day. That's 32 divided by 40.

That would make them a 0.8. And so when you have people that are less than 1.0, your head count is often greater than your total fte count. And anytime you are trying to, for example, increase fte because you're opening a new site or your access is getting bad and patients aren't able to get appointments as quickly as you want, you often need to justify exactly what that FTE needs to be with volume estimates. And that kind of brings us into scheduling concepts. And there are so many different ways to schedule in hospitals.

You know, most hospital systems do use some sort of electronic medical record. You know, we use epic, but there are others. And, you know, a template or a clinical

schedule can be wide open, meaning, you know, this top window here, this, this image is an example of an open template. We use these, for example, a lot of times at our satellite clinics where, you know, we just want open access for our patients. And so every 15 minutes, there's a note, there's a block, and if somebody calls to schedule a 45 minutes appointment, it's just going to look for 45 minutes out of that total opening.

If there's an ENT clinic patient that needs to be paneled with EnT, it's going to just find it on this open template. Sometimes, though, that doesn't work. Sometimes because of maybe resources, you have more people than booths or you only have one ABR unit. The template needs to be a little bit more specific. And we call that block scheduling, which you can see in this lower picture, which may be, you know, audiologists start today, they might have an 08:00 he, an 845 he, and then maybe switch over into a cochlear at 930 or something like that.

But in that type of example of that block, schedule a patient. If they say, you know, I can't make eight, can I do 815? That wouldn't work in this type of schedule because it's only looking for those specific blocks. And if you don't have them set to release, if you had something like this that I have set up here where there's a cochlear at 930, if no cochlear patient calls and takes that appointment, you would either have to set it to release to something else or that would be unproductive time. So you really, your leadership and you really have to think about what works best for your environment.

You know, when you work in a hospital, there's also multidisciplinary clinics. You know, sometimes those can be scheduled where an audiologist may look like they're not even there that day and it might be blocked and they're just on clinic. And that's, you know, first come, first serve, whatever's happening in Ent or blocked for inpatient consults or orders, you know, it's also an option to just have those things kind of fit into your outpatient open template, which is how we do it. But there are lots of different ways to do it. When you're in a hospital, you're often, your same audiology department is

responsible for inpatient orders as well as anything going on outpatient, which I think in some ways is why that exempt type of model works really well, because, you know, there may be a need, an inpatient need that comes up late in the day and you want to be able to address that without fear of, you know, oh, there's no budget for overtime kind of thing.

Another thing with hospital based services, this is not specific just to pediatrics, but definitely impacts us, is that hospitals anymore, I think, are becoming less and less just a hospital. Often you have these hospital systems that have satellite clinics and a lot of diversity in location, bringing that care closer to home, which is wonderful for our patients and families. So, but you're having to think as, you know, especially as in leadership roles, you know, how are we scheduling that? How many days a week at a certain satellite do we need? What do we do when someone calls out that morning triage?

It's all kind of part of that overall scheduling consideration. So a topic that I know a lot of people dislike, I actually love, is budgeting. And we're going to talk about different budget concepts as they relate to, you know, what we do in hospital audiology now. You know, frontline clinical audiologists might not really think about the budget very often, or you might work in a department where the budget is omnipresent and you're kind of always thinking about it. I always think about it because it's a big part of my job responsibilities as a director, creating the budgets and then making, justifying them, making sure that we're staying on them, explaining variances and that kind of thing.

But I think even if you are on the front line, it's important to understand how this works. It's often a process with multiple revisions before it gets to executive or board approval to be kind of finalized. Often there are cuts. You know, just recently we had a situation where, you know, the board, all the budgets kind of went through, and then the board said, I just want to see, you know, a certain percentage taken off the top. And so all the

different departments need to figure out, you know, what can I trim, what can I do from a leader perspective and then understanding what the budget year is.

So for many institutions, the budget year is the same as a calendar year. So if your budget starts January 1, the people who are doing the budgets are likely working on those in the summertime for the following year. So there's a lot of that planning going on. We're going to talk about two different types of budgets. We're going to talk about capital budget and operating budget.

And I'll set it up in advance to say, you know, we all have, our general life has both of these. You just don't think of it that way. So if you're a homeowner, for example, you know, your operating budget is just your day to day. You know, if you're thinking about, you know, what do I need in order to meet my expenses? You know, that's your car payment, maybe, or your Internet bill, your cell phone, your mortgage or your rent, that kind of thing.

Capital budgets are generally for equipment, new locations, projects. So in the non clinical life, that might be, I have my operating budget all my day to day expenses, but I need to sack some money away for, you know, renovating the kitchen or something along those lines, and you're keeping that in a different pot and figuring out how you're going to pay for that. And that's kind of like a layman's way to think of capital versus operating some institutions. There might be some dollars in operating for, you know, some minor equipment and things, but anything over a certain dollar amount, for example, $5,000 would need to be budgeted through capital, and there may be an additional request process that goes for that. You know, often as a leader, you know, if I have team members, if we really want to do something new, or we have a piece of equipment that is meeting the end of its life, we're kind of always planning ahead and thinking ahead about, you know, what do we need to ask for for capital and how are we going to justify it?

Sometimes it's just this is needed for day to day, and it's at its useful life. It's going to break. And, you know, this would be the loss of revenue if this thing broke. So we need to replace it. Other times, for new things, you have to do.

An ROI, which is a term you might have heard, stands for return on investment. And really it's a performance measure that's, you know, kind of used to evaluate the efficiency or profitability of an investment bought from an institution. You know, often you need to look at several different things. You know, if you want an audiometer, even though you might know in your head, I only want the GSI audio star pro, or I only want this madsen or whatever it is the institution may say, I need to see three quotes with three different companies and, you know, cost benefit analysis of each before a decision can be made. And often ROI could be thought of as a time period, how long until a project or an investment, a brand new site or, you know, vestibular equipment, something like that, would pay for itself.

And sometimes there's negative ROI. Sometimes I, you know, want to do something that is either really cutting edge or will bring maybe a different type of business to the institution, but it's not going to turn a profit. And sometimes that's okay, and sometimes it's not, but that's kind of all that thing. So if you're working somewhere and you're like, why do we not have x? A lot of it has to do with what that process looks like for your department and your institution.

I mentioned your operating budget is really just like, what does it take to fund the regular operations, salary, benefits, supplies, you know, you name it. As far as, like, day to day stuff, paying for continuing education for your staff. Do you pay for, you know, mileage, travel, if somebody has to cover a site that's not where they normally work? All that. All of that goes into your operating budget.

Your operating budget is also where you get your profit and loss. So, you know, how much money based on volume are we projecting that we're going to be able to generate revenue, and then what are our expenses? And then that gives us our, you know, net or our margin. And your margin is really how much money at the end of the day, you know, do you have leftover after your revenue for your operating, and you paid your operating expenses? Right.

So that's how much money do you have at the end of the month after you paid all your bills? Right. And, you know, I work at a nonprofit institution, and a lot of people kind of think of that as like, oh, profit doesn't matter. It's not true. So even if you work in a nonprofit hospital and a lot of pediatric hospitals are, the way that I always try to explain it is no margin, no mission.

So when we do take what we have made and it doesn't go to a bunch of external shareholders, but that does need to be reinvested. So if you want capital, if you want to ultimately hire additional staff or any of those things, or as an institution, all of that margin needs to roll up to fund and building a new surgery center closer to our patients. That's what that margin is used for. And it really, it does matter, you know? So a lot of people think audiology departments and peds institutions can't be revenue generating.

I beg to differ. You know, we can. It's just done in a different way, which we're going to get to in a little bit. Okay. So, you know, it's important that your operating budget also, this is where any salary increases, whether they're merit or cost of living, where all of that kind of plays in.

And so, for example, you have someone who's really great. They come mid year and says, I want to raise. That all has to be looked at as far as what's in the budget and

what can we do? What can't we do? And then the ripple effect of what that would mean for the rest of your team and so forth.

Okay, this ties into budget, ties into template. We're kind of building as we go, but we're going to shift and talk a little bit more about clinical productivity. So clinical productivity can be measured in a lot of different ways. And a lot of what we talked about as far as staffing, complexity of the services offered, hours of operation, equipment, resources, how many booths are there, AVR units, all of that. How much space do we have?

And then also how do we do non billable activities, you know, checking in hearing aids or, you know, processing paperwork, who does insurance, who does scheduling, all of those types of things can impact our clinical productivity. There are different methods. Some work better than others, for my opinion, in a pediatric environment. And then another piece is we're going to talk about a few different models for clinical productivity. It's important to understand that how much data you have access to as a leader and the ways in which an institution is looking at success are going to really play into which model might work best for you.

And if you are working at a hospital and you're not sure how clinical productivity is calculated, it might be a good thing to ask. A lot of times, this is one of, and what we call stewardship metrics, or metrics that you might be looked at each year to determine merit increase and to determine, you know, how financially successful the department is. So the first one we're going to talk about is the most simplistic. It's just patient volume based productivity can be very simple. This could be just number of visits, expected number of visits.

It could be number of procedures, but again, just the number encounters. So, like appointments, patient touch bases, or just numbers of patients, it, you know, provides

a pretty easily understood indication of, you know, the amount of work that's being done based on volume. But one of the disadvantages is that it usually does not take into consideration the complexity of the services that are being offered. Often, if you're just doing patients, for example, you know, all services are kind of counted equally. So if you have a patient that you did a TMP on versus a patient that you did a cortical evoked potential on, that might not be taken into consideration.

And so somebody who's doing longer, more complex appointments might have lower productivity than someone who's doing audios all day. And so thinking about that and how that would weigh in for you as a leader or you as a provider in a department is important. Asha defines productivity purely as the percentage of a clinician's day that they're involved in patient care. Which kind of brings us to more of a slot utilization, capacity based way to measure productivity. This calculates a percentage of total booked or unbooked time, right?

So as a function of what was available. If a provider, for example, has an open template, like I showed you a few slides ago, where, you know, from the time they get in until maybe noon, and then from one until they leave, their template is just open in these 15 minutes increments. It's very easy to calculate how much of that is used, and, you know, that can be very easily understood. Some of the pitfalls it might, it takes complexity into consideration if the appointment is longer, so more of those slots are used. But it might not take complexity into consideration.

If you have a non billable appointment and a billable appointment that are the same period of time. And then often you get as an associate, you might like this, but as a leader, you get credit, for example, for no shows. So if an appointment is on the schedule and that time is blocked, whether that patient came or not, this metric would show utilization. But from the how does this really impact the budget and profit and

loss? If that time was booked and not used and nothing was billed, then this can skew things in the wrong direction.

And so your productivity metric might not match your actual profitability, which can be an issue. There are, though also different kind of time based or workload unit ways to pull a lot of what we do together in order to give a little bit more detail as to productivity. Often, you know, referred to as either us or units of service, workload units or build unit volumes. Productivity. So this is a method really that just gives a typically a time value, but a unit to each CPT code that we do.

So if we have, we call it a CDM, but if we have kind of a list of all the different procedure codes and CPT codes and HCPCS codes, everything we do, and then it's looked. Each one is evaluated and determined on, you know, based on, let's say 15 minutes units of service. Then any time that that CPT code is billed, it can generate a unit or two units, four units, six units, whatever it is. And then that information can then be extracted to see how many units an individual audiologist is billing or the department is billing within a given period of time. You know, it could be exact if you have the data, or it can be a little bit more estimated if need be.

And typically, you know, in a perfect world, you can take that information and also merge it with worked hours or productive time to get a percentage of productivity. And generally, you know, if this is the system that your institution is using or would like to use, there is a target, a stated target for productivity, either for each person or the audiologist in general or department and so forth. So I'm just going to walk through a quick calculation example. Right? So let's say CPT codes are given value based on 15 minutes units of service.

And, you know, that might be, you know, a comprehensive audio might be two units of service. Expectation it's done within 30 minutes. Maybe, you know, comprehensive

OAE's might be 15 minutes. That's one unit of service. The total kind of available or possible units of service are calculated by those kind of productive hours, if you're using 15 minutes by four, because there's 415 minutes units, theoretically, each hour.

So once compiled, if an audiologist were to bill, let's say, 360 units and they worked 37 productive hours, you got that information from a payroll system. The available potential units for 37 hours would have been 555. This individual billed 360. So 360 divided by 555 gives you 64.8% productive. Now, maybe that's acceptable to your institution, maybe it's not, but that's kind of a way that then goals and targets can be set for productivity.

Okay? So another common way to calculate productivity based on units is to use Medicare rvus, or relative value units. So if you've heard that term RVU, if you're currently working somewhere that calculates your rvus, this is where that comes from. So they're based on what's called a relative value scale that weighs all CPT procedure codes. Okay?

They're determined. The AMA, the American Medical association, with input from specialty societies and other experts, assign a relative value to each CPT code. And rvus have three components. So typically there's professional work, which sometimes audiologists are not eligible for. That's the time, technical skill, physical effort, stress, and professional judgment.

There's practice expense, overhead costs, and non physician labor, and then professional liability or malpractice costs associated with that particular CPT. Because, again, these are also used for all sorts of procedures, obviously well outside of our scope of practice as well. So there's advantages to this, to using rvus as your metric versus something like another unit of service calculation that is time based. One is that it accounts for complexity on a relative scale, which can be helpful. And I think, in my

opinion, the more prominent of the advantage would be that it can be benchmarked to the productivity of other facilities.

So, for example, you know, this is. This is something that can, you know, many institutions use rvus, and so you can kind of look at that across, you know, institutions. There are disadvantages, though, and, you know, one of the major ones is that not all audiology services and CPT codes actually receive any value. So there are things that we do and we bill and that the institution is generating revenue off of that might have a zero value RVU. And so, you know, that has to be taken into consideration.

Another thing is that our, you know, HCPCS codes, which are typically, you know, what gets billed for hearing aids and other devices, and sometimes the procedures that go with those do not have RVU associated with them, in most, in many cases in the system, the whole Medicare system. And so it's another example of how, you know, as a department, it might be difficult to explain your volume if somebody is looking purely at these numbers, especially if they're looking at those numbers compared to other specialties that maybe don't have some of this nuance. You know, I, I'm going to, you know, I gush and go kind of on and on about all the reasons that I love being in a hospital. But I'm going to talk a little bit about, you know, some of the things that make hospital based service and thinking about profitability and the business of audiology that are a little different in a hospital environment, especially a pediatric one. I always kind of chuckle a little when I get contacted a lot of times by manufacturers or larger buying support type groups that want to help us essentially dispense more hearing aids.

Or if you think about the traditional kind of profitability of dispensing higher end hearing aids, more expensive hearing aids, hearing aids and units dispensed, it's generally not a success metric that can be used for pediatric hospital community. And there's a lot of reasons why. One is we're working with children who, you want to make sure you're

getting them the most appropriate technology, but you're not necessarily going to be in a situation where you're trying to, you know, get them maybe the fanciest hearing aid device that has the largest profit margin, you know, especially because likely you're going to get what insurance gives you. And that's a big piece of this. Right.

So, you know, I don't necessarily like, need somebody to help me make sure that my patients are getting new hearing aids every couple of years because one, insurance may not pay for it in the same clip, but also, is that really what's most appropriate for the child? So a couple of things that play into this one in pediatrics, there's actually quite, in the United States at least, a pretty small self pay market, it does exist. But true self pay, where you're doing, for example, bundled services, is much less of a thing in the pediatric hospital based world.

They're because of the fact that every state is a little different as far as how they cover hearing aids and treat hearing loss for children. But the coverage for children under 21, for example, does tend to exceed as far as how often you come across it more for children as compared to adults. And there are certain capitation things where, you know, there are patients that we see that, for example, we can't dispense to them because their insurance, for example, might capitate that they can only get their devices from a certain location or a certain type of place. And, you know, we're going to continue to see them, but we're not going to generate revenue off of the device. So just some different pieces.

You also have to think about your payer mix. So if you've heard that term payer mix in your hospital, it really is your total pie. What percentage of what's coming in is going to be, you know, Medicaid or Medicare, traditional versus managed, and then commercial versus self pay. For example, in pediatrics, the payer mix does tend even in, you know, areas where maybe your adult payer mix is more commercial. Your pediatric payer mix may still be much higher on Medicaid.

And part of that is that for many states, hearing loss is a qualifying diagnosis or disability. So, you know, I'll use Pennsylvania as the example. In Pennsylvania, their hearing loss is a qualifying disability. There does not need to have a certain level of severity. Some states do.

It has to be greater than moderate. Pennsylvania, if you have hearing loss documented, you can get Medicaid regardless of financial needs. So I've had patients who, you know, both parents have commercial and excellent commercial insurance, but they have a secondary Medicaid, you know, to help with what insurance doesn't cover. And in those situations when someone has Medicaid, whether it's their primary or their secondary, we are unable to balance bill. So, you know, if a family trying to get somebody to spend more money for a device, if their insurance says, you know, we're going to pay $1,000 per year every three years, that's what you are going to take.

And so it's all about making sure that you have good devices that you can offer children based on their hearing loss, but not necessarily, you know, trying to have those be more expensive because you're not going to recoup that in dollars, you know, sometimes the reimbursement arrangements that are negotiated, again, small fish might, you know, that's happening in a total other area of the hospital, for example, or maybe in another state from corporate or whatever. And a lot of times, you know, how much durable medical equipment or hearing aids or reimbursed is not top of mind. And so you might be in situations where the reimbursement arrangement makes it difficult to break even for devices. And then there's often a lack of transparency, sometimes from hospital on payer contracts and exactly how they work for what we do. I think of this as a good thing.

But margin is really typically created by volume of more diagnostic service billing and then follow up service billing. You have to determine if your system allows for facility

billing, like I mentioned, which offers higher reimbursement per code as compared to more of a practice billing model, you know, and while treatment using hearing aids is obviously a huge part of what we do to serve our patients less of the business model piece, that medical model really can lead to higher acuity. Patients. Patients you're testing more regularly for follow up, you know, and doing more time consuming procedures. You know, another thing that is not specific to peds, but in the hospital world, that's important to think about is because of regulatory and policy and so forth, there's often really specific, detailed reporting, reporting requirements as far as, you know, documentation and so forth.

And so that can also be time consuming, you know, where the old kind of like soap note is often typically not going to meet an institution's reporting requirements. So, you know, there are. There's a lot to the business. I could literally do an entire talk just on block templating versus open templating, and how to maximize efficiency in your electronic medical record. But, you know, with all of that, there is a reason why so many individuals, so many audiologists choose to kind of spend their careers in this environment.

One is related to what we just talked about, which is there's often less of a sales model. So for individuals who really did not focus, that's not where their heart sings and they want to spend more of their time doing diagnostics or, you know, not really thinking as much about how much something is going to cost, you know, that tends to be a driver for individuals into pediatric hospital audiology, you know, working with the whole family, working with someone for many years. I mean, you know, I have a patient I'm going to see later on today. I've been with him since he's two, and he's driving now. I mean, it's amazing the relationships that you can form and sustain for a long time.

Hospital practice can be very stable and really allow for a wide variety of professional growth opportunities. It allows you to really work as a team in a very collaborative environment.

Getting to work with otolaryngology and plastic surgery and the craniofacial team and psychology and have all of these amazing resources is at your fingertips. And coming together to treat patients is something that is wonderful.

This picture, I always laugh. So this was my daughter participating in her first, not her last, but her very first research study here at Nomours. When she was only, I think she was maybe eight months old in this picture. And there's so much opportunity for that type of growth. And I feel like our families are part of our work life a lot, and kids will always kind of keep you on your toes and so will business.

So I always kind of end, to a certain extent, kind of saying that while AUD programs, for example, have tried sometimes to add little pieces around business, a lot of times it's focused on private practice. But if you, if private practice isn't something that you love, but you do are interested in the business, you know, audiology departments and hospitals need great leaders and people who, you know, have kind of an interest in both sides, which is what I love and enjoy and hopefully have imparted some of today. Most institutions are going to, like I said, use some sort of scheduling system. Another piece that is important to think about as a leader or as somebody that works at an institution and you're looking for efficiency is who's scheduling appointments. You know, being part of a large institution, it may be that appointments are being scheduled through a large access center, for example, where, you know, you don't even know the people per se that are scheduling the appointments.

And the people scheduling your audiology visits are the same people that are maybe scheduling primary care or urology or, you know, x ray and all of that. And so, you

know, it can be really important to make sure that you are being mindful of not only your clinical template, but what resources you have. So we do that through each audiologist is a provider, and then our audiologist as well. And then our visit types that are being searched are being searched through the scheduler asking questions of the individual as to what the they're coming in for their kind of chief complaint. And it takes them through different questions to lead to the correct visit type.

If they've had a previous visit and another visit was recommended for follow up, then we can also use that information to kind of drive to the visit type. Our visit types are then complex in that it polls the person for the amount of time, the audiologist, for example. And then let's say it is a, you know, annual hearing aid check. We'll use that one. It's going to look for the time for the audiologist, and then it's maybe going to look for the first 40 minutes of the appointment, a booth, because if it's an annual check, we need to recheck hearing, and then it's going to look for a lab that has the programming equipment versus if it's an ABR.

It's looking for the audiologist, maybe the electrodiagnostic room, and then also, you know, a specific piece of equipment, and that helps to make sure that you're not overbooking. I remember when I first came to Newmore's, we didn't do that. And I remember being in my office and hearing audiologists. Like, I don't have a booth. Like, they had a patient, but they didn't have a booth to use.

And so using the resources that you have can be really, really helpful as far as being efficient. There was also a question around, you know, the use of audiology assistance in pediatrics. You know, I think there's so many amazing ways that we can work with aids or assistance technicians to help to have our department gain and efficiency. So, for example, you know, our assistants check in all the devices. They enter the information onto, into our flow sheets so that we have serial numbers and expiration

dates and warranty information and, you know, receiver lengths and tube the sizes and, you know, all that information kind of going into a fitting.

Other ways are to, you know, have walk in hours to have, you know, assistants be able to do things like tubing changes on ear molds, ear mold fittings where, you know, kids go through ear molds really, really fast, right. And so often they're getting ear molds between appointments. And so how having assistants that are trained and able to do that type of work so that audiologists can be in appointments that are more revenue generating without not having the service for your patients and families can be really good. We also have our audiology assistants do all of the newborn hearing screenings in the NICU and in the inpatient world. And that allows for the audiologist to be more available for diagnostic ABR and other types of visits.

So, you know, there are so many different ways to make a department, you know, high quality with wonderful outcomes, but also, you know, contribute to the overall, you know, margin of the institution. And, you know, the reason that's important, like I said, is not only just, you know, for the greater mission of the institution, but also, you know, as audiologists work extremely reliant on equipment. Right. And so, you know, by making sure that those business concepts are sound and that you're set up for success from a profit standpoint helps, you know, because if you're, if you're a department that is in the red or not necessarily generating revenue, but you're a department that needs new equipment regularly, you know, that those two things might not go together. So the more you can understand and try to contribute the better, as far as, you know, ultimately being able to have what you need to serve your patients in the best, you know, and most efficient possible way.

So are there other questions? All right, well, thank you so much for your attention and, you know, your time. And if anybody has any follow up questions, you can find me. So

I'm going to, this is kind of that, that last slide. So I'm going to turn it back over to Christy.

Thank you so much, doctor Inverso. And thank you for your time and your expertise. I just wanted to remind you all, for all those took the class, just complete the multiple choice exam once this course has concluded, and that will ensure that you earn the ce credit if you pass. Thank you so much, everyone. Have a great day.