Podcast Transcript

Making Sense of Dollars and Cents:

Developing a Return on Investment

Episode 2 – Three Initials with Power: ROI to Prove What You Need, Part 2

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Transcript

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FAITH ROBERTS, HOST: Welcome back. This is Faith Roberts for Elite Learning.

If you've joined us on our last episode and previous episodes of this podcast series, called Making Sense of Dollars and Cents: Finance, Budgeting, and Staffing for Nurse Leaders, then you'll have become familiar with our guest, Pamela Hunt. Pam has a unique ability to share her expertise in healthcare finance in practical, understandable ways that help us master the business skills we need as nurse leaders.

The training we received as nurses focused on our mastery of clinical skills — and rightly so. But when we move into leadership positions, we're often left without a solid foundation in the business side of healthcare. All of a sudden, we have budgets — sometimes multimillion dollar budgets — to manage, staff to manage, and equipment and other needs to fulfill. And we find we have no idea what essential parts of healthcare finance, such as return on investment (or ROI for short), is, let alone how we go about establishing it and using it to justify purchase and other decisions.

Pam is here to help. As I mentioned, she is an expert in healthcare finance; and she has been where you are now as a former nurse leader. Pam is an author of articles and co-author of books, a frequent speaker at state and national conferences and workshops, and a fellow of the American Academy of Nursing. You can learn more about Pam's background in the show notes that accompany this episode.

In our last episode, Pam explained the concept of ROI and its necessity to healthcare decision making. In this second part, she will walk us through an on-point example of how to calculate ROI. If you haven't already downloaded the show notes for this episode to follow along with Pam as she explains the example, you might want to hit pause and do that now. Or you can download your copy of the notes later and, as Pam suggests, relisten with the example in front of you. Downloadable show notes are available on our web page at EliteLearning.com/podcasts.

Let's jump right into Pam's example.

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PAMELA HUNT, GUEST: So, when I talk about that service justification example, in your notes for this session, there is an example of a return on investment for a piece of equipment. I'm going to just walk you through this verbally. And then when you get your hands on the notes, you can relisten to this podcast so that you can have the explanation with the notes.

So, in the example that you will have available to you, the piece of equipment cost $39,000 and some – $758 – or $39,758. In the example, I usually say that maintenance contracts are not part of a return on investment. They should not be counted, if you will, as a fixed cost.

However, in this particular case, in order for us to purchase this piece of equipment, we were told by the vendor that you had to purchase the maintenance contract for 36 months. So, if you have to purchase the maintenance contract for 36 months, that becomes a fixed expense and should be part of the fixed expense for this particular ROI. So, the total for the piece of equipment and the service contract was $45,729.

Then the variable costs are laid out. The variable costs – the leader broke down the cost for an RN and the cost for a CST. So that is a certified surgical tech. Those were the two roles that were going to be used for this procedure.

So that cost is broken down in the ROI that's in your example. The supplies – so there was a supply kit that went with this particular procedure. That was $272 per patient. And then this leader even went to the – there was case supplies necessary, too. So that detail is in your example as well, and that detail is

detailed enough to say we're going to need the prep pack, the unsterile gloves, the sterile gloves, the gown, the towels, the Bovie cautery – really detailed of everything that's going to be needed for this procedure.

So, you may be asking yourself, do I really need to go to that detail? And the answer is yes because some of these procedures have such a small margin that you really need to know what that is. So for this particular procedure, all those little things add up to $53.55 per case. So, if you have a very narrow margin, $53 could make the difference.

So, the total variable cost – this leader isn't done yet. They took the expense for reprocessing the instrumentation for this procedure as well. And they calculated that that was $17.91 per autoclave load to run that load. So, they have a total fixed cost that includes the capital equipment and the maintenance; and they have a variable cost that includes the labor, the supplies, the supply kit, and the reprocessing. So the total cost-per- case of the variable ends up being $269. So, what do you do with that next?

Well, as you will see on the example, then the leader took that total fixed cost and went to the payer mix for this patient population. And we want to look at revenue. So, for this particular procedure – now, this is what I want you to hear – how different this can be.?

For this particular procedure, Medicare reimbursement was $1,560. But Commercial Payer Code 37760 – which I have no idea what that is, but I'm just saying. For the commercial code, that code paid $27,158. So you guys hear that. That's a $5,500 difference in reimbursement according to the private pay code and the Medicare code.

There's a couple other codes in the example as well, depending on the patient diagnosis. Each of those both pay better than Medicare. Each of those pay less than the $7,000 reimbursement. But then what the leader needs to do – so what that tells you is, by this payer, you know what you're going to get reimbursed.

You immediately subtract the variable cost because you got to cover that cost. That's the variable cost. And the result of that equation is the amount you have left over to start chipping away at that initial investment.

So, let's take the Medicare as an example, just the Medicare payer if 100% of the patient population for this procedure was Medicare. The reimbursement was $1,500. The cost-per-case for the variable expense was $369.

So that means I have $1,190 left to start chipping away at that initial investment, which was $45,000. So now I'm going to take that $1,190 that I want to start contributing to reducing my cost for that initial equipment. I'm going to divide that into the $45,729. And that tells me that I would need to do 39.42 cases before I've made enough, minus my variable supplies, to pay for that initial expense of the equipment and the maintenance cost.

I've asked the surgeon that's going to do this procedure how many of these do you think you'll do a month? And he said he thinks that we'll do three a month. So, if we do three a month – remember, I said it's going to take 39 to break even.

If I do three a month, I divide 3 into 39. And that means that it's going to take me 12.8 months to break even on this procedure if 100% of the cases were Medicare cases.

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HUNT: Before I go further and talk about the next table that you'll see when you go to your handouts, when you go to your notes, let me see if Faith has any questions.

ROBERTS: Well, of course, you knew I would. This process, you did a great job of saying all the different departments that would be places that the leader could go to get this information. If you are asked to do an ROI, what in your mind is a reasonable timeline for you to get that information and put it together and be able to present it?

HUNT: Well, that's a difficult question because it varies so much, actually. It varies according to what else those other departments have going on. It varies according to the urgency of the need for the equipment.

So for example, replacements; everybody on the podcast today can relate to this. Replacements used to be what I would call no-brainers. You didn't have to do an ROI if you already had the equipment and it quit working.

Obviously, you had to replace it. But now, because of organizations being so frugal and needing to be so frugal, I've been in organizations that require an ROI even on existing replacement equipment. So in that case, if we had something, and we had patients scheduled in the queue, we already had patients scheduled, and the equipment failed, then that urgency would be much greater than if it was something that was brought to us, and we were really examining this is a new procedure and should we move forward with the piece of equipment.

ROBERTS: OK, all right.

HUNT: Does that make sense?

ROBERTS: Yes, it does.

(SOUNDBITE OF MUSIC)

HUNT: All right, thank you. So now that we know each line item – let me just tell you about that commercial payer code that paid the most. If 100% of our patients were that commercial payer, it would only take us 2.2 months to break even. So big difference, and you'll see that in the table that's available for you in the example.

Now, what this leader did is they took it a step further. And they went to the physician that was requesting this equipment and said, OK, I know some of the patients are going to be Medicare. I know some are going to be this procedural code, some are going to be procedural code number 2, some are going to be procedural code number 3. Can you give me an estimate, based on the patient population that you're seeing in your office that would access this procedure, what the percentage of those would be?

So, this surgeon said, you know, I think 50% are going to be Medicare. I think 10% are going to be the highest payer, unfortunately. Ten percent were going to be the highest payer. I think only 30% are going to be the next private code, and 10% are going to be the next private code. So in that case, this leader, in the second table that you'll see, has taken that information from the surgeon and weighted those percentages into the reimbursement pro forma, so that now based on what that surgeon actually

predicts the payer mix will be, they can say that I believe that it would takes 17 procedures to break even. And that will take us 5.7 months.

Now, for those of you who have never done return on investments, you might ask yourself, is that a long time, is that a short time? Five-point-seven months is a very short time to recoup the initial investment and start making revenue after that point. So this would be very definite. If the organization had the resources for this capital, it would be a very definite yes, let's move forward and do this. Because after only 5.7 months, we're going to start making revenue that's going to contribute to the bottom line.

(SOUNBITE OF MUSIC)

HUNT: Let's talk about a couple of things in this pro forma that are just fun. I'm going to ask you some questions.

So, suppose $5,000 has been spent last year to improve the space for new diagnostic equipment.

So, the space, let's say it's a corner. You know how we find corners in hallways. The space was improved last year. Maybe new lighting, etc. was put – new paint on the walls last year because we thought it was going to be used for new diagnostic equipment.

But instead, you want that same space for your new procedure. Would that $5,000 that was spent last year be part of the cost of your analysis? And I know you can't respond, but I'm asking you to think about that in your head right now.

And the answer is no. It would not. We consider that $5,000 a sunk cost. That's what we call it in finance.

And the reason why we call it a sunk cost is because that $5,000 has already been spent. It is not dependent upon your piece of equipment. Now, if that room had not been spruced up, and it didn't need new light lighting, and it didn't need new paint on the walls, and it had not already been done, then yes, that cost would have to be charged to your project.

A second question: Suppose the space that you want to provide this new procedure in is currently being leased, and the lease revenue that your organization is receiving is $12,000 a year. Would that impact your return on investment for this project's cash flow? The space that you want is currently being leased for $12,000 a year.

The answer's yes. You would have to show the loss of that leased $12,000 a year because that income to the organization would no longer be available if you were going to lease that space. So those are some ticklers, if you will, to get you thinking.

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HUNT: One of the questions that I'm often asked, Faith, and I don't know if you've experienced this as well. One of the questions I'm often asked is, should I lease or purchase? What's your organization's experience with leasing or purchasing? Does that cross your mind when you're looking at a large capital purchase?

ROBERTS: Definitely, for those kinds of services that we're not sure yet how many of our providers – our experience has been that sometimes, providers think a certain service is going to be everything, and they tell us they're going to use it. And then they don't, and then we're stuck. So I would say we lean

more toward a lease for a year, and then to see if we're actually going to have the usage to make this work for us.

And as far as leasing, we have found vendors being very open to that, because of course, their mindset is, this will prove itself. But for us it comes down to whether or not the person actually billing for the procedure, the provider, is this going to be something? Or will the next flavor of the month come down the pike and they'll walk away?

That has always been – I think it's every hospital's nightmare. You've got a cupboard someplace with something that everybody had to have, and nobody uses it now. So I'd say we tend to go to lease first.

HUNT: You were really spot-on why you would select lease instead of purchasing. And you are right. We all have a cupboard somewhere with a piece of equipment, or a storeroom with an expensive piece of equipment, pushed back in the corner that was used very infrequently; and now nobody knows what to do with it. My recommendation on making the decision, whether to lease or purchase, is you still have to do a return on investment. You need to do the return on investment to know what the break-even point is, even if you really suspect that you're going to lease instead.

I liken this to when you go to purchase a new car, and maybe that dealership is directing you towards leasing. You want to know what your outright price of that car would be before you make the decision to lease. So you want to know what your outright price would be and your break-even point for that purchase before you go to the lease. Then you want to compare that with what your lease options are, and you want to understand the cost of the disposables.

Oftentimes with a lease, the vendor is less likely to get a discount on the disposables. So what does that mean compared to your outright purchase? You want to understand the quantity that you need to purchase of those disposables for the lease agreement or the lease commitment.

Oftentimes, a lease commitment comes with you have to buy x number of cases. Well, I need to know, am I going to use that number of cases because of the disposable item that goes with the equipment? Because if I'm not, that's wasted money. You want to know what your volume potential is, and you want to know what the life of the equipment is. It's really critical. So those are things to consider when you're weighing the value of leasing versus purchasing.

ROBERTS: And absolutely spot-on, Faith, is if it's something that maybe is new technology, maybe that hospital down the road is doing it. You don't know if there's enough patient population in the entire community to support both, but you still want to be in the game. Then you want to perhaps lease until you know what that volume looks like. So really good discussion here.

(SOUNBITE OF MUSIC)

HUNT: I've talked about who else do we include in this discussion of all this information that we need to gather. And in your notes for this particular session, there is a checklist that actually goes over, I think, four slides of checklist of people that need to be included. I've talked about billing.

So, are there special billing requirements? Are there computer changes that are going to be required? So computer charges that are going to be required to be changed before we're ready to do this procedure.

Are there special payment requirements? What are the codes for this? Whether it's a CPT code or whether it's an HCPCS code, what are the codes that we would need for this procedure?

Is there charge entry responsibility? Is there a new revenue necessary for this department? Because some of these procedures or practices that you may bring up may need a whole new revenue department necessary. And that, to your question earlier, Faith, bringing up a whole new revenue department does not happen overnight, and nor should we expect or get frustrated with our billing partners that that doesn't happen overnight.

What about the electronic medical record? Is it something that we are going to need to put a scan in for it? Does it require a scanning procedure that's going to have to be programmed into our electronic medical record? What about order entry? Is it on the notes, is it on the order forms, etc.?

Health information systems have special documentation requirements, so is there something that the coders need to know in order for them to pick this up in our documentation? Nothing worse than doing a great procedure and a great new service for the patients but not getting paid for it because we didn't code it correctly. Are there transcription requirements around it?

Has the medical staff been informed? Are there any wiring – we talked about this a little bit, wiring requirements, equipment needs, etc.? What about materials management?

How many of you – you don't have to raise your hands because I couldn't see you anyway. But how many of you have put bundles into place, really good intentions? And you forgot to tell materials management that all of a sudden, everybody was going to be using this particular supply because it's part of the bundle? And you didn't have enough supplies to for the nursing staff or the caregiver staff to comply with the bundle.

I say that because I had that experience. Not because I'm perfect, but because I did it myself. Had a great bundle rolled out.

All the nursing staff was oriented to it. We were ready to go. Yeah, we ran out of supplies the second day. So make sure that, if there's ordering, you've had that setup as well, and that you've cross-referenced your purchase agreements. They're your group purchasing agreements.

And materials management helps you with that. You're not alone in this. But I want you, as a nurse leader, to know these items need to be checked and to have that conversation with materials management so they know that you're a partner with them.

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HUNT: Who else do we need? Is there any approval needed from [the] med exec committee? Some new procedures need to be run through med exec.

So is there something there that we need to pay attention to? Are there any off-campus considerations – courier services needed, etc.? What about plant engineering? Here's one: How about signage?

If it's a whole new service, and you're in that new room that you took over from somebody that was going to use it for somebody else, how's your patients going to get there? Do you need signage? Are there service contract issues? We've talked about that as well.

Here's one that is oftentimes forgotten, but I think it's really important for patient experience; and that is registration. Does the person who's going to register that patient, before they come to you for the procedure, know that this is something new that you're doing?

How confident would the patient be if the chatty registration person says, oh, I'm not familiar with this procedure. I've never seen us do this before, versus the registration person saying, our department has an in-service on this procedure, and this is really great of what this is going to do for you. And we're one of the first facilities to provide this. How cool is that? So remembering registration in this as well, and that they need to be aware of any new procedures that you're doing.

We can't forget regulatory bodies, everyone. Are there any accreditation issues with this, any state board of health licensing issues with it? Are there any Medicare compliance issues with it?

And communication, what have we told the department, what have we told other departments? Do our pre- and post-departments know how to care for this patient if it's a procedural issue? So those are all on a planning checklist. I think it's great for you to go over and make sure that you understand who should know about this new procedure as well.

(SOUNDBITE OF MUSIC)

HUNT: So, as we come to a close in this subject, again, the notes available for this will really help you, as well as the example that's available. And you know that developing a return on investment is about at what point am I making enough revenue, or have I made enough revenue, that I've covered my initial cost of investment? And from this point on, I'm going to be contributing to the bottom line of the organization.

Faith, thanks for inviting me. And thanks for allowing me the opportunity to talk about this subject. Are there any closing remarks that you might have?

ROBERTS: I would say the level of detail for an ROI is overwhelming at first when you think about it. But the excellent point you make about those notes is the four slides of the checklists, and I think the devil's in the details. And if you're able to keep up and have that as a double check, or maybe even a triple check, with the amount of money that we're talking about on some of these items or services, I think that those notes, together with what you talked about today, will keep us grounded.

And certainly, this is not the purview exclusively of a nurse leader. This is a group project, a team together. Just one question, just for people who have different setups and everything, who is a med exec and who is on that?

HUNT: Yeah, sure. Your med executive committee is made up of the officers of your medical staff. And that is determined again by your organization.

But it is usually, for instance, your chief of surgery, your chief of medicine, your chief of anesthesia, your chief of radiology. It is a governing committee of your organization. And I would direct our participants to have that conversation with their leader. And maybe they even call it differently, but most organizations still call it the med exec committee.

ROBERTS: So then by speaking to their own leader, they can figure out with them the next steps with med exec.

HUNT: Yes.

ROBERTS: And again, it just shows that throughout the whole process in the system, a lot of people are going to have a hand in this. And the clearer we can be with our information, the less questions we will get in return. So just excellent today. Really enjoyed it. Thank you very much, Pam.

HUNT: You're welcome, and thanks for your input as well, Faith. I think it makes it a more rich discussion. So, thank you.

(SOUNBITE OF MUSIC)

ROBERTS: I hope you've enjoyed our episodes covering return on investment and have found value in the show notes and examples Pam has provided us. Please keep your learning going by listening to the next episode in this series. We'll be talking about an especially important topic for nurse leaders: workforce and patient safety.

Until then, this is Faith Roberts for Elite Learning.

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