

How much does it cost your facility to perform a surgical case?

Is there a difference between the cost of different surgeons performing the same type of surgical case? Is it cost effective to continue adding cases to a surgical list even though it means staff are paid overtime? Is this surgeon's list making us any money? Should we offer a different specialty? These are some of the questions we ask on a daily basis in the busy day surgery environment.

Although the number of cases being performed as day surgery continues to rise many day surgeries are seeing a decrease in their revenue growth rates. With pressure to keep uninsured rates as low as possible and reduced health insurance contracts we have become price takers and our focus turns to costs.

The traditional way to cost surgical cases was to divide the total costs by the total number of cases giving you an average cost per case. If you are a single specialty day surgery centre this will give you a pretty accurate average over a year. Cost accounting is more of an art than a science. It is based on averages, allocations and "best guesses".

The Problem

This method presents a number of problems:

1. Variances in the procedures performed
2. Variances in the surgical consumables used
3. Variances in the time taken to perform the procedure
4. Variances in the equipment used
5. Variances in the number and type of staff used

Detailed cost information provides you with the tools to reduce costs and improved your bottom line by:

1. Significantly reducing inventory costs with optimal stock levels sourced from the right supplier.
2. Understand where costs are excessive
3. Influence surgeons to consider alternatives using real data regarding their costs and outcomes in comparison to their peers
4. Engage in strategic business planning

Of course, although case costing is important, it must also be kept in perspective. This is a cost : benefit proposition, the cost of getting the data should outweigh the benefits obtained.

Costing Methods

There are various cost accounting methods the two most common are:

1. **Standard Cost Accounting (SCA)** – Where we take the surgeon's preference card and cost the typical quantities used for the procedure along with the typical time taken and a standard overhead charge. At the end of the accounting period – month/quarter/year – the standard costs of the procedures performed are compared with the actual costs associated with the period.
2. **Activity based costing (ABC)** – Where overhead costs are allocated to cases in a more logical manner than the traditional approach of simply allocating costs on the basis of the number of procedures. Activity based costing first assigns costs to the cases that are the real cause of the overhead. In a multispecialty centre the costs of cleaning and maintaining scopes would only be allocated to scope procedures, likewise pain management and orthopaedic procedures requiring the use of the image intensifier would be allocated those costs whilst all other procedures would not.

The most appropriate costing method for a day surgery centre Activity based costing.

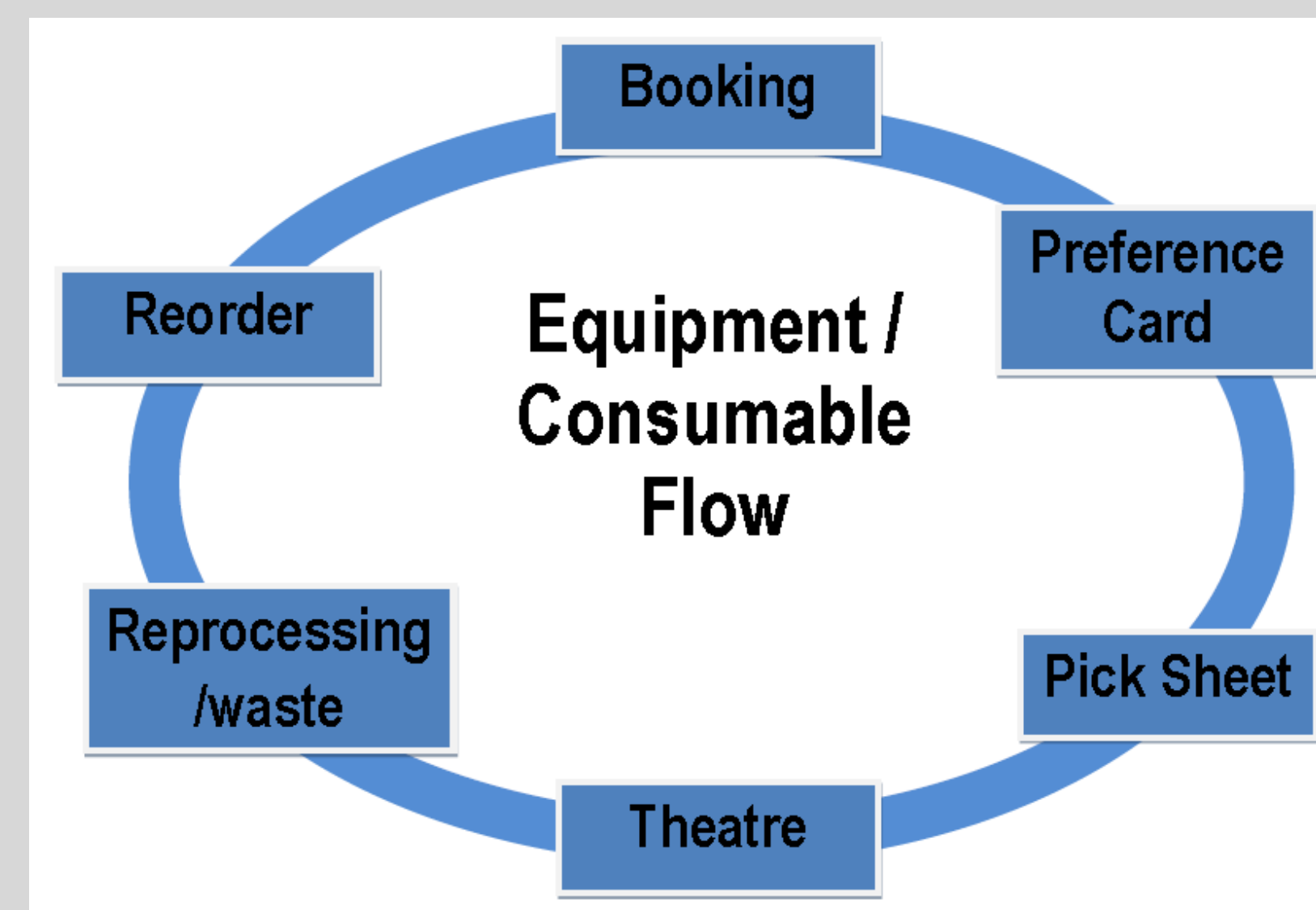
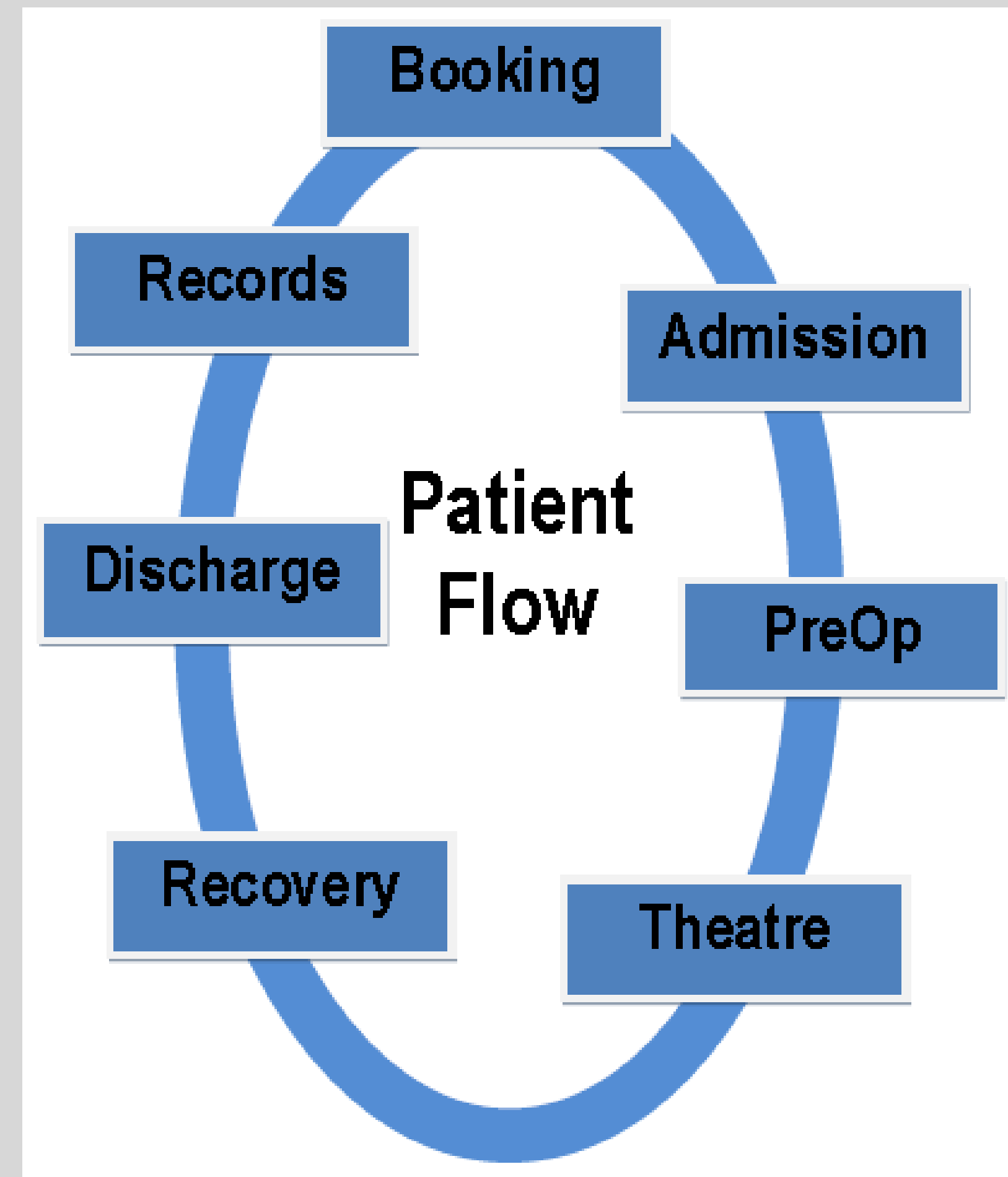
Cost Elements

There are a number of basic cost elements which must be considered:

1. Staff – clinical and non clinical
2. Consumables – single use items and reusable items which are reprocessed
3. Equipment – used to perform the procedure
4. Overhead – costs not directly associated with the procedure

Clinical Pathway

It helps to clearly identify the activities of the day surgery when allocating costs:



Staff Costs

The clinical vs. nonclinical split is not necessary, but it helps to allocate an average cost to each.

Clinical:

- Direct patient care (PreOp, Theatre, Recovery, Discharge)
- Clinical support (set-ups, stocking, environmental cleaning)
- Indirect staff costs (training, meetings)
- On costs (annual leave, sick leave, superannuation)

Nonclinical:

- Direct patient related (bookings, admissions, medical records, coding)
- Indirect staff costs(billing, banking, posting, meetings, training, mail, accounts payable, payroll, reporting)
- On costs (annual leave, sick leave, superannuation)

Consumables

These are items which are consumed during the case:

- Surgical consumables
- Anaesthetic consumables
- Pharmacy
- Recovery
- Linen
- Instruments

Overhead

It is useful to group all of the overhead cost elements:

- Premises (rent, electricity, telephone, internet)
- Insurances (general insurance, medical mal practice insurance)
- Maintenance (cleaning, preventative maintenance, security)
- Depreciation/Amortisation (plant and equipment)
- Compliance (accreditation/certification, licences)

Chart of Accounts

If your general ledger chart of accounts matches your costing model, cost is readily available. Each cost element should have its own account.

Where to from here?

Now that we have identified all of the cost elements its decision time. Time to determine the basis for allocation and allocate the costs. This can be as simple or as complex as you want to make it – remembering the underlying premise cost : benefit.

Here is an example of a simple costing system:

- Patient booking – 15 mins per patient @ nonclinical rate
- Patient admission – 15 mins per patient @ nonclinical rate
- PreOp – 20 mins per patient @ clinical rate
- Theatre – actual time x 3 (scrub, scout, anaes RN) @ clinical rate
- Recovery – actual time x 0.5 (1:1 in 1st stage, 1:4 in 2nd stage) @ clinical rate
- Discharge – 15 mins per patient @ clinical rate
- Records - 30 mins per patient @ nonclinical rate
- Surgical Consumables – actual cost
- Anaesthetic consumables – actual/STD cost
- Pharmacy – actual costs
- Recovery – STD cost unless incident then actual costs
- Linen – STD costs
- Instruments – CSSD Reprocessing STD charge plus depreciation amount
- Equipment - depreciation amount plus maintenance amount
- Overheads – STD cost based on minimum of 12 months operation

What can I do with this data?

Collecting this data -

- for a single case will allow you to compare the revenue to the cost
- for a whole list will allow for comparison for the list revenue to the list cost and rostered staff for the day to the list cost
- for a whole fortnight will allow for comparison of total staff costs to cost allocation and help identify areas of under utilisation
- for a whole month will allow for consumables used to be compared to the opening stock and closing stock balances
- identifies areas where costs have not been allocated,
- allows for comparisons between different surgeons performing the same procedures,
- allows for identification of hidden costs not allocated above.

... and after that?

If you find that useful – then you can move along the continuum and implement a costing system like Dox TMS which integrates with the patient administration system, the general ledger and the inventory control system, preference cards and the electronic medical records system to automate this whole process. Ask me about our Theatre Management System

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