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Modern Pediatric Audiology

The business and changes in modern pediatric hospital-based audiology practice

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Introduction

- My background…
- Getting to know you…
- Why this topic is important…

Learning Outcomes

After this course, participants will be able to:

- list three key differences in the hospital-based business model for pediatric vs adult patients.
- identify a way in which working with the parent as the customer differs than the patient themselves.
- explain one way in which pediatric audiology is practiced differently in a hospital.

Pediatric Audiology basics

- What is a Pediatric Audiologist?
  - A 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)
  - A sounding board, a miracle worker, a social worker, an under-qualified behavioral therapist, and more often then in past…a productive member of the business.
- Where do we work?
  - Private practice, ENT, schools, districts, Hospitals

Hospital based Audiology

- Generally (both ped and adult) 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 that are different than other settings

Pediatric/Hospital based Audiology

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

Business of Pediatrics

- What does a Director in a Pediatric Hospital do?
- What needs to be done?
- Offsite locations, how do you staff?
- Coordination of services
- Multidisciplinary teams
  - Craniofacial (often called “cleft”)
  - Ear Anomaly
  - Down Syndrome
  - Cochlear Implant
  - Auditory Processing

Staffing

- Determining need for new Full Time Equivalent (FTE)
  - 1.0 FTE means full time 40 hours
  - To calculate your FTE # hours scheduled/40
    - 30/40=.75 FTE
  - Need to prove, usually with volume estimates that a new Audiologist is needed.
- Determine Schedule including how will change current staffing balance
- Recruitment
- Interviewing (in hospital setting, isn’t just the “boss” decision, usually involves a team interview)
- Determine offer based on approved salary range
- Hire
- Training, which often will involve specific hospital approved competencies which must be completed (and often re-completed annually)

Staffing/Scheduling

- Building templates (schedules)
  - Overall and then physically in an EMR
- Ensuring ENT clinic coverage
  - Many different models
  - What works for us=use of "resource"
- Ensuring response to orders and STATs
- Approving time off requests and ensuring coverage for multiple sites/locations
- Morning triage for last minute call-outs
- Giving instructions regarding patient rescheduling
- Communicating plan/changes

Budget

- Create capital budget plan for following year
- Make volume projections for all locations
- Determine revenue per unit of service based on previous year reimbursement data
- Balance FTEs
- Make FTE projections
- Request budgeted FTE increases
- Estimate for all other expense lines (minor equipment, supplies, office materials, travel, CE etc.)
- Defend end of year projections and budget for next year
- Make cuts/changes when asked

Manage Hospital Relationships

- Work collaboratively with ENT on plans and also problem solving
  - Many pediatric departments are part of ENT, so this relationship varies
- Other departments often working with include (for scheduling, begging for time, directly providing care, etc.):
  - NICU
  - HEMONC
  - Therapy Services/Speech
  - Sedation Services
  - Surgical Services (OR)
  - Research

- Performance Evaluation and Rounding
  - Regular check-ins with staff
  - Setting annual goals for performance management
  - Monthly or quarterly “Rounding” meetings
  - Creation of Development Plans or Performance Plans (what we call them- may go by other names) when improvement is needed
    - Meet with staff member regularly during duration of these plans
  - Keep records in employee files
  - Complete annual performance review for HR
  - Determine merit increase and complete paperwork
  - Hold facilitated meetings if staff conflicts arise
  - Respond to human resource concerns/questions

Data, Data, Data

- Responsible for running many reports and completing calculations:
  - Access (time to get appointments)
  - Slot Utilization
  - Productivity
  - Billed unit volume per FTE
  - Reimbursement
  - Budget compliance reports such as Expense per unit and FTE
  - Unsolicited feedback reports
  - Patient satisfaction
  - Documentation compliance
  - Late notes and charges tracking, etc

Clinical Productivity

- Factors for consideration:
  - Staffing
  - Complexity
  - Hours
  - Equipment 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.

Workload Based Productivity

- Very simplistic
- Number of visits, procedures, encounters, or patients.
- Provides an easily understood indication of the volume of work.
- Primary disadvantage: they usually do not take into account the complexity of services – all services are counted equally.

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.
- Pitfall?
  - Doesn't take complexity of work into consideration, gives "credit" even if nothing is billed, can be inefficient and doesn't account for no-shows.

Time-Based Relative Value Units or Workload Units

- Method that gives a time-value to each procedure (CPT) which then allows for a calculation of productivity based on hours worked.
- This can be estimated (general assumptions lead to a work hour assumption per FTE)
- This 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 or the department on the whole

Calculation Example

- CPT codes given a value based on 15 minute units of service.
- The total available/possible units 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 RVU Method

- Another option is the Resource-Based Relative Value System (RBRVS) of the Centers for Medicare and Medicaid Services
- 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).

- Two advantages:
  - Account 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.

Relationships to schools

- Often referred to in pediatrics as the "clinical audiologist" or "Managing Audiologist" when patients have more than one audiologist in their life (school or Intermediate Unit based).
  - Often a negotiation of who does what. Earmolds, programming, annual testing etc.
- Navigating FERPA in addition to HIPPA.
  - Can test results, programming information etc be shared freely between two audiologists seeing the same child?

Family Educational Rights and Privacy Act (FERPA)

- Protects the privacy of students' "education records."
  - Includes any school nurse records, or any testing data, progress notes etc completed by providers within the school (school completed audiograms, slp progress notes, etc)
- Both HIPPA and FERPA do have allowances for "continuity of care" meaning that if the sharing of PHI is for treatment purposes, two professionals can communicate without the signed release from the patient or guardian.
- Parents rights under FERPA include
  - Right to inspect and review education records.
  - Right to seek to amend education records.
  - Right to consent to the disclosure of information from education records, except as provided by law.

HIPPA

- The Health ***Insurance*** Portability and Accountability Act of 1996 (HIPAA) has two primary purposes:
  - to reduce the costs and administrative burdens of healthcare by standardizing the electronic transmission of many administrative transactions that are currently carried out on paper, and
  - to ensure that healthcare providers (including audiologists) protect the security and privacy of their patients' records (their Protected Health Information-PHI).

Obstacles unique to the business of pediatrics

- Hearing Aid units dispensed is NOT a metric that is regularly used in the pediatric hospital community.
  - Very small self-pay market
  - Insurance concerns and capitations
  - High Medicaid rate in many areas as some states, HL is a qualifying diagnosis
  - Reimbursement arrangements make it difficult to break even
- Margin is created by volume of diagnostic billing.
  - Ideally being part of a system which allows for facility billing which offers higher reimbursement per code as compared to practice billing model.
- Medical model leads to higher acuity patients which can be time consuming, and hospital compliance often dictates detailed reporting requirements.

How has pediatric audiology changed in recent years?

- VRA challenges due to children having constant screen time and entertainment.
  - Few companies are making puppet systems, and the video systems do not always work well.
- Every generation of children and parents pose different challenges
- Expectation for care in community and outside of large hospital
- Telehealth in pediatrics is slightly different than in adults. Higher reliance on real-ear which makes remote fitting and check ups more difficult.
- Telehealth remote diagnostics are possible and are a great way to improve access and improve satisfaction especially with millennial parents.
- If locations in multiple states, Medicaid practices are different and they are primary payer

Thank you!

- I find nothing to be more rewarding than working a pediatric hospital and I love being a Director.
- There are challenges, but hopefully there will always be interest in these positions.
- Questions?