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Building a scalable DME operation

Lessons from the ground up

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About your presenter

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Chief Operating Officer, Bonafide & S3 Resupply

20+ years in operations and finance, including C-suite roles across large national and single-market organizations. Significant time as post-acute provider, ambulatory healthcare operations, and technology spaces.

Led two DME companies through major operational, technological, and cultural change. Was a Bonafide and S3 Resupply client prior to joining the Bonafide/S3 leadership team (subsequently acquired by WellSky).

Disclosure: The content provided herein is intended for informational purposes only, and the presenter(s) is not rendering medical, legal, financial, accounting, or other professional advice. If expert assistance is required, please seek the services of an experienced, competent practitioner in the relevant field.

Other Experience

Chief Operating Officer
Home Medical Products, Inc.

Chief Financial Officer & Chief Operating Executive
Med-South, Inc. & Affiliates

Senior Director, Accounting Operations & Acquisition Integration
Surgical Care Affiliates

Business Partner – Leasing, Car/Truck Rental, Car Sales
Enterprise Holdings

Keranikis Management & Consulting – Founder

Certified Public Accountant (CPA)

Learning objectives

01 Identify the operational warning signs that a DME business is outgrowing its current staffing model and evaluate when to restructure roles versus add headcount.

02 Assess technology architecture decisions — including system integration and data visibility across locations — that separate operations built to scale from those built to strain.

03 Apply a framework for redesigning core workflows — order intake, resupply, billing — to hold up under multi-location or post-acquisition complexity.

Part one

Growth doesn't create dysfunction. It reveals it.

What strains first — and in what order

People

Generalists start dropping tasks. The job outgrew the role, not the person.

Information

Simple questions take three phone calls. Answers live in someone's head.

Process

Every location runs the same task a different way. None of it is written down.

Cash

DSO climbs and denials creep. By the time finance sees it, it happened 90 days ago.

> Cash is the metric everyone watches, and the last one to tell you the truth.

Three structural decisions



Staffing

Who does the work

Generalist versus specialist, centralized versus local, restructure versus hire.



Technology

Where the truth lives

One system of record, real integration, and visibility that crosses location lines.



Workflow

How work moves

Order intake, resupply, and billing redesigned to survive volume and complexity.

Most suppliers approach these in this order. The durable order is the reverse: design the workflow, choose architecture that supports it, then staff to it.

Part two – Objective 1

Staffing: When the model, not the people, is the problem

Six warning signs you've outgrown the model

1. Your strongest people work the most hours and are still behind. That is load, not effort.
2. You have heroes. One person knows a payer, a product line, or a queue — and vacation stops it.
3. Escalation has become the normal path. Work moves when someone shouts, not when it's ready.
4. Ramp time for new hires keeps stretching, because the job was never written down.
5. Supervisors are carrying production queues instead of supervising the queue.
6. No one owns the handoff. Intake blames billing, billing blames intake, the order sits.

Three or more? Adding headcount to an undefined job multiplies the problem.

The generalist inflection point

ONE LOCATION

The generalist is the advantage

One person takes the referral, verifies benefits, checks documentation, schedules delivery, and follows the claim. Full context. Nothing falls between the seams — because there are no seams.

MULTI-LOCATION

The same trait becomes the limit

Four times the payer rules, more product lines, more documentation variants. Holding the whole order in your head is exactly what stops working.

The trigger is variety, not volume.

When the variety of payer rules, product lines, and documentation requirements exceeds what one person can hold, split the role along the axis where variety is highest. For most suppliers, that axis is payer.

Restructure or hire? Four questions first

1. Is the backlog even across the team, or pooled in one or two queues? Pooled means bottleneck, not capacity.
2. What share of touches are rework? Above roughly 15%, more people simply produce more rework.
3. Could a new hire be productive in 30 days? If not because the job is undefined, define it first.
4. If your most experienced person left tomorrow, what stops? That is an improvised role, not a designed one.

Add headcount when work is defined, distributed, and simply exceeds available hours.

Restructure when work is pooled, undefined, or dependent on specific individuals.

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FROM THE FIELD

Eleven new hires didn't fix a four-location problem

THE SITUATION

Four-location supplier in the Southeast. Orders grew from roughly 600 to 1,600 a month over two years — organically plus one small acquisition.

Three locations each ran their own prior authorization work with their own payer knowledge. The acquired site ran a fourth process entirely. The same payer was being worked four different ways.

+11
people added

41 → 68
days sales outstanding

WHAT ACTUALLY WORKED

One centralized authorization team. One documented standard per payer. Location staff refocused on patient-facing work.

Six of the eleven roles redeployed rather than cut. DSO back to the mid-40s within two quarters.

Intake turnover fell — because the job finally had edges on it.

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Composite example. Figures are representative of patterns across multiple suppliers, not a single organization.

Part three – Objective 2

Technology: Architecture beats features

Built to strain, built to scale

	BUILT TO STRAIN	BUILT TO SCALE
System of record	One per location, usually inherited with the acquisition	One system; location is an attribute, not an installation
Integration	A nightly file drop that nobody reconciles	Real time, and errors route back to a named owner
Reporting	Export to spreadsheet; every meeting starts by arguing	One definition of each metric, same numbers for everyone
Master data	Patients, items, and payers maintained in each place	Governed centrally, with one owner per domain
Who owns the data	IT — operations submits a ticket and waits	Operations — IT enables, operations is accountable

Almost no one is fully on the right. You don't have to be — but you should know which row breaks first.

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The cost of running in parallel

After an acquisition, keeping their system running feels like the low-risk choice. It is a deferred cost, and it accrues interest.

Two sets of master data to maintain and keep in agreement

Two reporting definitions, so no number is ever settled

Two support relationships and two training curricula

A manual reconciliation someone inherits and never escapes

Workarounds compounding in both systems every month

The migration gets harder each month, not easier

Decide the target system **before you close** and set a consolidation date you're willing to defend. Twelve months is reasonable. Eighteen is the outside edge. Indefinite means never.

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Integration: three questions vendors don't volunteer

What moves, and which way?

A one-way integration means someone is rekeying on the return trip.

What happens when it fails?

No error queue and no named owner? That's not an integration, it's an assumption.

How fast does it fail?

Silent failure teaches staff to distrust the system — and to start a spreadsheet you can't see.

The four connections that carry a DME operation

- Referral source → intake
- Eligibility & authorization
- Inventory & purchasing
- Claims & remittance

Only have attention for two? Do intake and claims — that's where money enters and leaves.

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Visibility is not reporting

Reporting tells you what happened last month. Visibility tells you what is happening now, at a level of detail you can act on.

Can you answer these right now — for every location — without asking anyone?

- How many orders are stuck, and exactly where?
- What is cash collection by location and by payer?
- Which denials are repeating, by reason code?
- How old is the oldest unworked item in every queue?

One metric, one definition, every location.

If one location counts an order as received at referral and another counts it at documentation complete, the dashboard isn't just wrong — it's teaching you the wrong lesson. Define it once, publish the definition, make it boring.

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THE OBJECTION YOU WILL HEAR

“My team can't handle learning another system right now.”

That's not resistance. It's usually an accurate read of available capacity.

Stop waiting for a calm quarter

There isn't one in DME. Waiting is a decision to stay where you are.

Make the change smaller

One workflow, moved fully. Let the team feel a win. Then the next one.

Budget for the dip

Plan four to six weeks of reduced throughput and staff for it. Don't blame the team for physics.

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Part four – Objective 3

Workflow: Designing for complexity you don’t have yet

A five-step redesign framework

01	Map the actual path	Not the policy manual. Sit with the person doing the work and watch.
02	Name both sides of every handoff	Most delay is wait time at a handoff nobody owns — not work time.
03	**Push decisions upstream**	Every requirement verified at intake is a denial you don't appeal 90 days later.
04	Standardize 80%, route the rest	Don't design the standard process around your hardest payer. Build a named exception path.
05	Instrument before you scale	Cycle time and touch count. Without them you can't tell improvement from luck.

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CORE WORKFLOW 01

Order intake

WATCH THIS Percentage of orders complete on first pass. It predicts your denial rate, your cycle time, and your turnover.

Everything downstream inherits whatever intake produces.

The failure mode at scale

Intake becomes transcription. Someone types what the referral sent; the completeness check happens later, somewhere else, by someone who has to make three calls to fix it.

What good looks like

One intake standard across every location

Payer requirements built into the intake step — not a binder, not a memory

A completeness gate: the order cannot advance without required documentation

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One queue with routing rules, not one pile per lo

CORE WORKFLOW 02

Resupply

WATCH THIS Percentage of eligible patients contacted on time — not orders shipped. Shipping is the lagging number.

High volume, highly repetitive, almost entirely rules-based — and the one a manual process silently caps.

The failure mode at scale

Resupply outreach competes with new-order work for the same people. New orders always win — someone is on the phone. Recurring revenue softens without anyone deciding to let it.

If resupply depends on outbound calls, revenue is capped at calls per day.

What good looks like

Eligibility-driven outreach, not calendar-driven — contact patients when they're actually due

Adaptive, multi-modality outreach based on patient responsiveness

Patient-initiated channels carry routine volume; staff handle exceptions

Separate staffing or separate hours, so resupply never competes with new orders

Adherence data feeding the outreach list, so the conversation is clinical, not clerical

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CORE WORKFLOW 03

Billing and revenue cycle

WATCH THIS First-pass yield — claims paid without human intervention. Everything else is downstream of it.

Billing is not where you fix revenue cycle problems. It's where you find out about them.

The failure mode at scale

You staff the appeals team instead of fixing the source. Appeals feel productive — you can measure them, you can watch the queue shrink. It is treating the symptom well.

What good looks like

Denials categorized by root cause and by the step that caused them

A scheduled feedback loop returning the top three causes to the team that created them

Payer rules maintained once, for the whole organization

Exceptions separated from production, so expensive people aren't doing data entry

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Post-acquisition: The first 100 days

Days 1 - 30

Change nothing. Document everything.

You don't yet know which local practices are workarounds and which are genuinely better than yours. Standardize now and you'll standardize the wrong things.

DAYS 30–60

Pick the differences that matter.

Compare their process to yours on the three core workflows and decide which standard wins. Sometimes theirs does — say so publicly when it does.

DAYS 60–100

Sequence the consolidation.

Announce the target system and the date. Move one workflow completely. Name one person on the acquired side who owns the transition.

What kills post-acquisition integration isn't technical difficulty. It's ambiguity about whose decision it is.

Plan for it before you need it

Six things that cost far less at 600 orders a month than at 1,600.

1. Write down how the work is actually done for all three core workflows.
2. Define your metrics once, publish the definitions , enforce them everywhere.
3. Decide your target system now — before a deal forces the question in a hurry.
4. Build the exception path deliberately, so the standard process doesn't carry everything.
5. Identify your heroes and document what's in their heads. That's your largest unfunded liability.
6. Instrument the three workflows now, so you have a baseline to measure against.

Four things to take with you

01 Growth reveals dysfunction; it doesn't create it. The shortcut you live with today costs you triple at triple the volume.

02 When work is pooled, undefined, or dependent on one person — restructure. Don't hire into it.

03 Architecture beats features: one system of record, two-way integration, one definition per metric.

04 Every requirement verified at intake is a denial you don't appeal ninety days later.

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Thank You

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