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WHAT DO HOSPITALS WANT FROM ANESTHESIA GROUPS?

10 EXPECTATIONS FROM FACILITY LEADERS YOU SHOULD KNOW ABOUT

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In today's healthcare environment, anesthesia groups have many issues to deal with, including ACO's, pressure on reimbursement, quality tracking, the surgical home, and pressure on hospital subsidies. Despite these concerns, it is important to remember that for groups which enjoy exclusive arrangements with one or more facilities, their key asset is their hospital contract. Without a contract for services, the patients at that facility would be serviced by another entity, and all other issues would become irrelevant. Since hospital contracts are awarded and retained at the pleasure of facility administration, a fundamental consideration for groups should be to understand the expectations of facility leaders from their anesthesia providers.

This article will address that issue from the perspective of the author, an anesthesiologist who consults for both hospitals and providers, giving a unique perspective on these expectations. As the world of healthcare continues to shift from pay for volume to pay for value, and as patient satisfaction and transparency become our new reality, the expectations of facility leaders shifts as well. We will approach hospital expectations of anesthesia groups at a high level and as a "Top 10 List" in the David Letterman format – counting down to the most important expectation.

ABOUT THE AUTHOR

Dr. Robert Stiefel is a board-certified anesthesiologist and co-founder of Enhance Healthcare Consulting. Dr. Stiefel has over 20 Years of experience as a clinician, consultant and strategist, which allowed him to lead numerous initiatives addressing a wide variety of issues including assisting anesthesia groups re-design of governance, subsidy negotiations, policy/procedures, compensation methodology and implementation.

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10 HELP US BE 'ACCOUNTABLE'

Implementation of the Accountable Care Act ("ACA") has had many impacts, one of which is a focus on Accountable Care Organizations ("ACO's"). While these entities currently impact a minority of anesthesia groups, many facilities are carefully considering creation of or involvement in an ACO. Since ACO's involve closer integration of care throughout the patient experience, anesthesiologists are ideally positioned to take control of the peri-operative experience for patients. While hospital leaders typically do not specifically describe it as such, these expectations are fairly consistent with the Surgical Home initiatives championed by the ASA. (1)

Facility Leaders are looking for anesthesia providers to oversee and manage surgical care from time of booking to time of discharge. These efforts include pre-operative preparation, pain management to facilitate recovery and discharge, participation in procedure specific protocols (such as total joint programs) to optimize patient safety, efficiency and satisfaction, and assistance in the ICU as indicated.

9 ADVISE US ON TECHNOLOGY

Part of the ACA focuses on hospital adaptation of technology. Terms such as "meaningful use" are now part of the daily lexicon for hospital leaders, and technology adaptation across the entirety of patient care continues to advance at a rapid pace. Facility incentive revenue which may be in the millions of dollars is at risk for not meeting meaningful use parameters. Peri-operative and Anesthesia Information Systems ("AIMS") are only a part of that spectrum, but are the areas where anesthesia providers are looked to as value added experts. For peri-operative systems, anesthesiologists are commonly expected to participate as part of a larger team determining the system to either implement or upgrade.

AIMS have increased dramatically in recent years, now with almost 50% of hospitals with a system live, being implemented or under contract (2). When it comes to AIMS, hospital leaders view anesthesia groups as their subject matter experts and expect at least one group member to be well versed in the desirable attributes of a system, the pros and cons of various options, and to actively participate in the choice of a system. During the implementation of a new anesthesia IT platform, it is important that all group members participate willingly in the transition, and are not seen as impediments to the initiative moving forward.

Other areas of technology where anesthesia groups are expected to contribute include the choice of anesthesia quality tracking tools, purchase of anesthesia machines, as well as the purchase of items such as Ultrasound machines and Infusion Pumps.

(1) Schweitzer, M. et. Al, June 2013, The Perioperative Surgical Home Model, ASA Newsletter, v. 77 no. 6, 58-59

(2) Stonemetz, J., November 2013, 2013 AIMS Market Update, ASA Newsletter, v. 77 no. 11, 28-30

8 HELP US MEET HOSPITAL P4P ITEMS

Another component of the ACA which directly impacts hospital revenue is the Value Based Purchasing Initiative ("VBP"). The percentage of CMS payments at risk based on VBP to hospitals gradually increases each year to 2% by 2017. In 2014, this program is based on measurements of quality and is 45% based on process of care, 30% on patient experience, and 25% for mortality rates for certain conditions including heart attacks. Process of care items influenced by anesthesia providers includes antibiotic administration, VTE prophylaxis and proper glycemic management for cardiac surgical patients. Patient experience items which anesthesia providers influence include pain control, patient communication and responsiveness of hospital staff.

With many hospitals operating on thin profit margins, the escalating VBP revenue at risk becomes increasingly important each year. Furthermore, in the new age of transparency, much of the data gathered in the VBP program is publically available at www.hospitalcompare.hhs.gov. For these two reasons, hospital leaders are understandably focused on excellent VBP performance. Since anesthesia providers are involved in all surgical care, we can expect administrators to increasingly look to us to "take ownership" of all pert-operative related areas of VBP.

7 COVER 'OUT OF OR' CASES

Over the past decade, we have seen rapid growth in requests for anesthesia services outside of the operating room and obstetrical floor. Endoscopy, MRI, Cath lab, and invasive Radiology are some common, and often far flung, locations anesthesia groups are asked to cover. As an example of the growth in out of OR services, one study showed that the anesthesia payments for endoscopy services more than doubled from 2003 to 2009 (3).

Hospitals of course want to facilitate volume growth of these cases which contribute nicely to revenue and profits. To do so, availability of safe and immediate anesthesia services helps to support the satisfaction of the proceduralists, and to continue caseload growth. Unfortunately, these cases are often scheduled on the day of the procedure, not coordinated with the OR schedule, and cases in various locations are not efficiently coordinated among themselves.

This leads anesthesia groups to the risk of inefficient use of expensive providers, or of alienating the proceduralists and therefore facility leadership. We recommend that groups take a proactive approach to out of OR cases. Gather data on caseload and revenue opportunities as well as manpower costs for coverage. Develop a pro-forma to assess the profitability or expense for coverage of these cases. Then work with resources in the hospital and medical staff to develop a coordinated approach to scheduling these procedures. In our experience, properly managed out of OR anesthesia coverage can be profitable, while refusal to provide coverage can cause significant friction with hospital leadership.

(3) Liu, H; Waxman, D; Main, R; Mattke, S, 2012, Utilization of Anesthesia Services During Outpatient Endoscopies and Colonoscopies and Associated Spending in 2003-2009. JAMA, v.7 no. 11, 1178-1184

6 ADDRESS POST OP PAIN

As described above, pain control is part of the patient satisfaction component of VBP scoring. In addition, proper attention to pain control has the potential to improve post-operative ambulation, reduce length of stay and reduce complications. From the perspective of hospital administration, in addition to the above items, excellence in post-operative pain control can be a significant driver of surgeon satisfaction which can have a positive influence on surgical market share.

In 2014, the ability of anesthesia providers to place blocks for many orthopedic procedures is a core expectation. We now often see the use of continuous catheters, home infusions and orthopedic block services. Both Surgeons and Administrators often expect these capabilities, and the ability or lack thereof can significantly move local market share.

Beyond orthopedics, expectations are escalating for anesthesiologists to be aggressively involved in addressing post-operative pain for all surgical patients. As the focus continues on patient satisfaction and reduced length of stay, the ability to provide these services will be seen as a differentiator between anesthesia groups. The challenge from the group perspective is to secure the expertise and resources to provide these services profitably. This is a challenge we believe must be met, as it appears likely that the ability to provide advanced pain management services will be a fundamental requirement to maintain surgeon and hospital support in the age of transparency.

5 DRIVE OR EFFICIENCY

As reimbursement for healthcare continues to get squeezed, facilities recognize the imperative to maximize efficiency. In a fee for service model the operating room typically accounts for the majority of hospital profits and revenues, while in an ACO or flat payment model it becomes an area of expense. In either model the focus on OR efficiency is high on the list of many hospital leaders. Despite this recognition many leaders are not experts in the details of OR efficiency improvement. They naturally look to their anesthesia providers as experts to lead ongoing OR performance improvement in conjunction with nursing leadership.

From the hospital perspective it is no longer acceptable for anesthesia providers to simply provide quality intraoperative care. The expectation is for groups to take an active role in managing the OR board, to create flexibility in scheduling to meet the OR's needs, to help drive OR efficiency improvement efforts, and to be the "eyes and ears" of administration on the OR. In 2014, groups which choose not to provide these value added services are frequently viewed as not meeting the requirements of their facilities.

4 'OWN' PRE-OP PREPARATION

As an important driver of on time starts and reducing day of surgery cancellations, pre-operative preparation is recognized as an important anesthesia deliverable by hospital administrators. As with OR Efficiency, CEO understanding of the details of preadmission testing is often limited. They look to their provider group to prepare patients for a seamless start to the day of surgery. As a rule, administrators are flexible in the route taken to achieve this goal. They are typically comfortable with triage mechanisms where only a subset of patients are be seen by anesthesia prior to the day of surgery. A common theme is the desire for all providers within groups to develop consistent parameters defining an acceptable pre-operative workup. A great dis-satisfier is where a patient is deemed cleared prior to the day of surgery by one anesthesia provider, and then further testing is requested by a different provider on the day of surgery.

Finally, it is generally recognized that there is a great deal of variability in pre-operative tests ordered. Hospital leaders expect standardization of testing, and to limit testing to that which is medically indicated. Once again, they look to their anesthesia group to coordinate and implement consistent, efficient rules to maximally prepare pre-operative patients.

3 REDUCE OUR SUBSIDY

It is estimated that 80% of hospitals pay some financial support to ensure anesthesia services. Many of these subsidies are over $1 Million. Consistent with the theme of pressured hospital profit margins, anesthesia subsidies are receiving increased scrutiny with each passing year. In order to understand opportunities for reduction, hospital leaders should understand the factors which drive subsidies. In evaluating a subsidy, we identify 4 key drivers:

- Fair Market Value Compensation
- Required Anesthetizing locations
- Staffing Model
- Anesthesia Revenue Cycle Performance

When analyzing subsidies we attempt to isolate each of these factors and identify opportunities for cost savings. One of the most important expense drivers is the required number of anesthetizing locations. OR leaders, especially in competitive markets, tend to err on the side of excess capacity in order to attract surgeons with available first case starts. This is a business decision for the facility, but it must be understood that poor utilization of expensive anesthesia resources adds to anesthesia subsidy costs.

Our advice to anesthesia groups regarding facility support is to be proactive in communicating with hospital leadership about subsidy spending. Offer solutions as a partner, rather than be seen as wanting to passively sit back and collect a large ongoing payment. In your discussions stay fact based, attempt to isolate the impact of the drivers on the subsidy at your facility, and to develop recommendations to mitigate subsidy.

2 LEADERSHIP, LEADERSHIP, LEADERSHIP.

Over the past decade we have been involved in hundreds of anesthesia-hospital negotiations. While subsidy spend rates are almost always near the top of the agenda on the part of both parties, behind closed doors it is extremely common to hear concerns about anesthesia group leadership from the facility C-suite executives.

As a contracted service, facility leaders look to the anesthesia department for an aligned direction, continually improving operating room performance and services. The culture of anesthesia groups varies greatly from facility to facility. Some groups have a mindset of customer service, responsiveness and play an active role in advancing operating room performance. Other groups are perceived as the opposite. In fact, when asked who anesthesia groups feel is their main customer, surgeons and administrators often say that the group perceives itself as the customer. In other words, the groups' goal is to minimize their own work, maximize time off, and to maintain the status quo wherever possible. Needless to say this is not a great strategy for long term contract retention!

In the current environment, with many large national and regional entities seeking to earn hospital contracts, being perceived as self-serving and non-customer friendly is a dangerous strategy. We believe that group leaders should recognize that they are in a service business and that they should understand and service their customers – surgeons, administrators, patients and OR nursing leadership. We recommend a focus on the "5 C's of leadership"

CULTURE
Of Customer Service

CONSISTENCY
In Delivery Services

COMMUNICATION
With all Other Members of the Peri-operative Team

CUSTOMER SERVICE
For Administration, Surgeons & Patients

COLLABORATION
On Initiatives to Improve Safety & Efficiency

1 PLEASE, PLEASE, PLEASE KEEP THE SURGEONS OUT OF MY OFFICE!

After all, the bottom line is the bottom line! Hospital C-Suite executives are constantly inundated with issues from all areas of their facilities. To a meaningful degree their perception of hospital based service providers comes from the feedback of the medical staff. In the case of anesthesia groups that is of course focused on surgeons. Surgeons don't tend to be shy about voicing their opinions, which form the basis for the view of the anesthesia group from the C-Suite.

In order to maintain a positive rapport with surgical colleagues, focus on many of the items in #2 above. In our experience, communication is the cornerstone of maintaining good relationships. Patient care is fraught with many variables which can derail the daily schedule and negatively impact surgical colleagues. If anesthesia providers focus on physician to physician communication, many problems may be "nipped in the bud" and the surgeons will (hopefully) stay out of the C-Suite.

For anesthesia groups the current environment includes our primary hospital customers feeling extreme cost sensitivity and intense local quality and service competition. By always keeping in mind what the needs of our surgeons (and their patients) are, we can keep the support of our hospital customers who control our most vital assets – our contracts.

OUR EXPERIENCE. IS YOUR ADVANTAGE

Enhance Healthcare was founded in 2011 by experienced anesthesiologists and business leaders with nationwide experience in anesthesia management, operating room improvement and expertise in OR and Anesthesia business practices.

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We are interested in helping you address your anesthesia and operating room needs and challenges. Whether you are an anesthesia group or healthcare facility, we look forward to understanding your unique requirements and working with you to create a sustainable, long-term solution.

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