A Hospital's Perspective: What They Want from their Anesthesia Group

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DISCLOSURE

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Anesthesia Billing and Practice management Seminar

May 5, 2012

Principal Enhance Healthcare

Consulting fees from investment bankers and numerous hospitals and anesthesia groups

Healthcare Reform

ACHE 2011 TOP CEO CONCERNS

Issue	2011
Financial challenges	2.5
Healthcare reform implementation[4]	4.5
Patient safety and quality	4.6
Governmental mandates	4.6
Care for the uninsured	5.2
Physician-hospital relations	5.3
Patient satisfaction	5.6
Technology	7.2
Personnel shortages	7.4
Creating an accountable care organization	8.4

[1]In 2011 the average rank given to each issue was used to place issues in order of concern to hospital CEOs, with **the lowest numbers indicating the highest concerns.**

Hospital Leadership - Realities 2012

- Uncertainty of Healthcare Reform
- Profit margin pressure, market share pressure
- Planning for bundled payments while living in a fee for service world
- Call pay, employing docs, competing ASC's, imaging centers, urgent care centers etc.
- ACO's and other unclear integration schemes

So….. What do they want from YOU?

#10

Jack Welch

"Simplicity applies to measurement……too often we measure everything and understand nothing"

Top 10 Expectations of Anesthesia Groups

10. Help us meet Hospital Value Based Purchasing targets

Hospital VBP

- Hospital DRG Reductions by CMS (if threshold not achieved)
- Scoring based on both achievement and improvement. First payment Oct 2012, first measurement July 2011-March 2012
- 13 measures in 2 categories
  - Process of Care – 12 measures 70% weight
  - Patient Experience (HCAHPS) 30% weight

YEAR	DRG % IMPACT
2013	1
2014	1.25
2015	1.5
2016	1.75
2017	2

Anesthesia and VBP

- Process Measures we Influence
  - Prophylactic Antibiotics; Cardiac Glycemic Control; Peri-Operative B-blockers; VTE Prophlaxis
- HCAHPS Measures we Influence
  - Communication (MD's and nurses); Responsiveness of hospital staff; Pain Management; Medication Communication; Discharge Information

HOSPITAL COMPARE WEBSITE

	Pain was "always" well controlled	Pain was "usually" well controlled	Pain was "sometimes" or "never" well controlled	Data Collected From	To
National Average	70%	23%	7%	4/1/2010	3/31/2011
Florida Average	67%	24%	9%	4/1/2010	3/31/2011
BOCA RATON REGIONAL HOSPITAL	69%	24%	7%	4/1/2010	3/31/2011
DELRAY MEDICAL CENTER	65%	22%	13%	4/1/2010	3/31/2011
WEST BOCA MEDICAL CENTER	70%	20%	10%	4/1/2010	3/31/2011

#9


I PREDICT SALES TO BE NOTHING FOR TWO YEARS AND THEN TAKE A SUDDEN SURGE.
WHY?
SALES
THE SURGE WAS ADDED SO I COULD GET THE BUSINESS CASE APPROVED. THE TWO-YEAR LAG GIVES ME TIME TO GET PROMOTED.
SALES
WHAT ABOUT ACCOUNT-ABILITY?
THAT'S WHERE YOU COME IN.
S. Adams
E-Mail: SCOTTADAMS@AOL.COM
10-10
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Top 10 Expectations of Anesthesia Groups

10. Help us Meet Hospital P4P Items

9. Help us be "accountable"

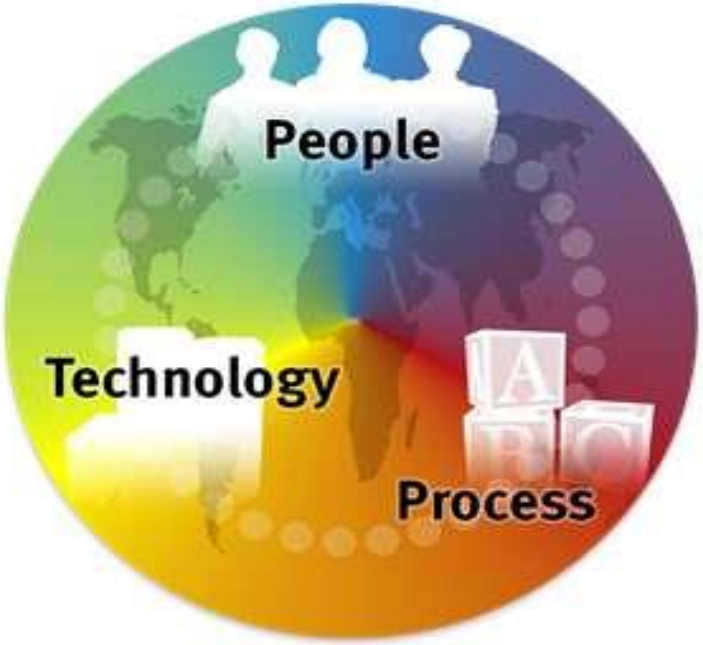
ACO's (i.e. integration) and anesthesia

- ACO's still vaguely defined. Per Donald Berwick:
  - Better care for individuals
  - Better population health
  - Control of costs
- Most CEO's believe that some closer integration will occur in OR services
- Desired role of Anesthesia groups:
  - Coordination of all peri-operative care
  - Increase role in ICU where applicable
  - Post operative pain management
  - Lead efforts for procedure-specific coordinated care protocols

#8

Bill Gates

"Be nice to nerds. Chances are you'll end up working for one"



Top 10 Expectations of Anesthesia Groups

10. Help us Meet Hospital P4P Items
9. Help us be “accountable”
8. Advise on Technology

Technology

You are the expert on:

- AIMS Systems – up to 27% "market penetration" Stonemetz/Schubert *ASA Newsletter* June 2011
- Anesthesia quality tracking tools
- Infusion Pumps
- Ultrasound machines
- Anesthesia machines

You may soon need to be expert at:

- "Automated anesthesia systems" Liu *Anesthesiology* Feb 2012
- Tele-anesthesia – Kapur *Anesthesiology* April 2012

#7

Anesthesiologists add a billion to cost of U.S. screening: Liu et al *JAMA* March 21, 2012

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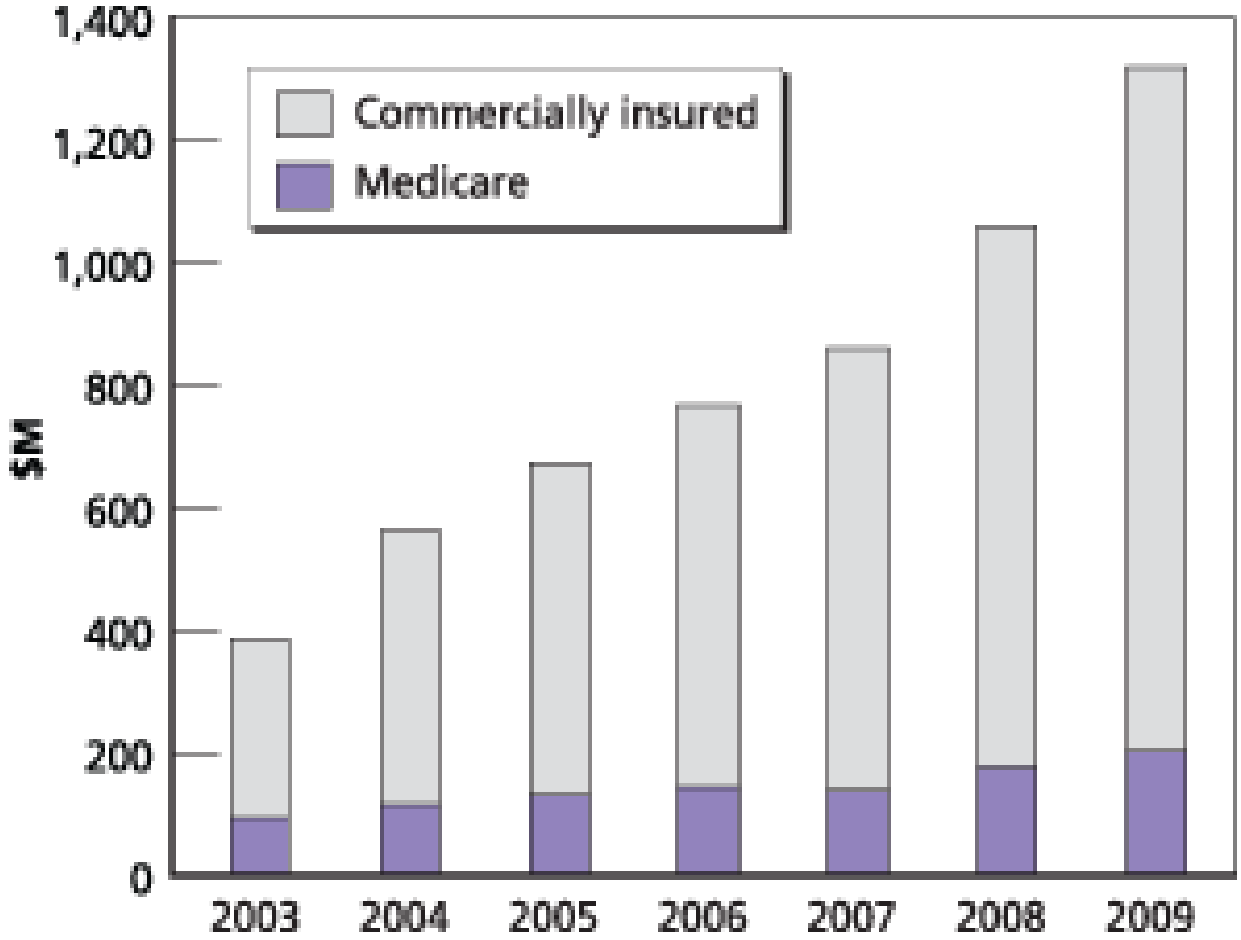
7. Cover “Out of OR” cases

RAND study

Estimated National Spending on the Use of Anesthesia Providers During GI Procedures Has More Than Tripled



Out of OR

- Dramatic increase in out of OR cases. Ever increasing demand
  - Lower overhead than in the OR
  - Desire for deep and safe sedation
  - Convenience
- Anesthesia providers vs conscious sedation?
- Administrators want their out of OR cases covered
- Recommendations:
  - Do a pro-forma on OOR cases
  - Attempt to consolidate scheduling
  - Discuss hospital support if indicated
  - Determine if a conscious sedation program is preferable

#6

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7. Cover “Out of OR” cases
6. Address Post Op Pain

ASA Practice Guidelines – Acute Pain (Anesthesiology Feb 2012)

- Groups offering Pain management services should:
  - Provide acute/post op training for hospital nursing personnel
  - Document pain intensity and side effects of treatment
  - Be available at all times
  - Participate in developing policy/procedures
  - Track outcomes, quality improvement

PAIN MANAGEMENT

- Hospital Perspective
  - Direct link to VBP and HCAHPS scoring
  - Increasingly perceived as an anesthesia differentiator (ortho, general surgeons etc)
- Group Perspective
  - Requires special expertise
  - Significant resource requirements
  - Profitability?
  - Will your group be able to survive “pain free”?

#5

"I'm sending you to a seminar to help you work harder and be more productive."

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5. Drive OR Efficiency

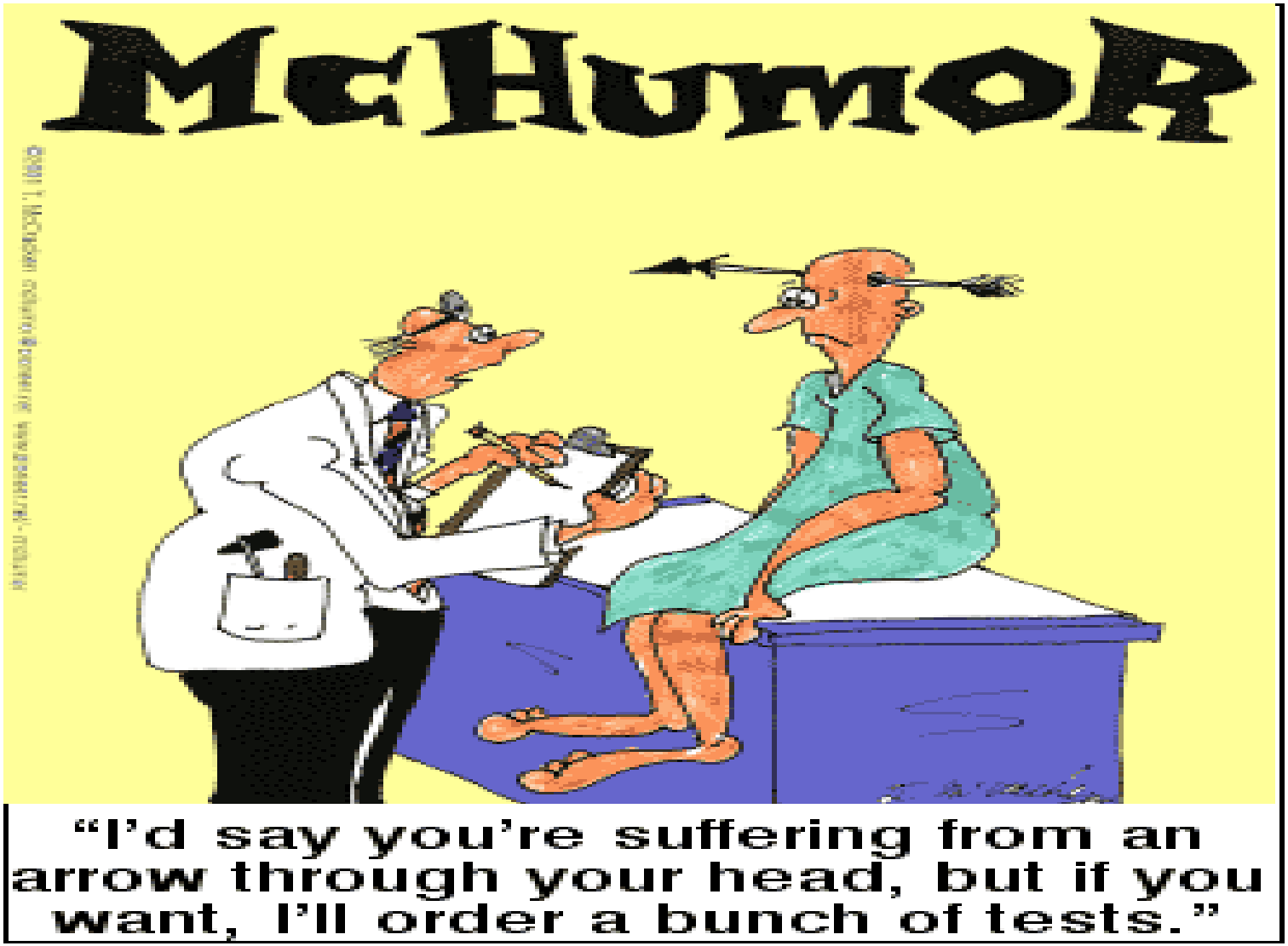
OR EFFICIENCY

- A black hole to many CEO's – anesthesia should:
  - Run the board
  - Adjust to daily/hourly requirements
  - Continuously drive OR process improvement (on time starts, DOS cancels, DOS delays, scheduling efficiency etc) along with
    - Surgeons
    - Nursing
    - OR managers
  - Advise on and interpret data
  - Be the "eyes and ears" in the OR

OR EFFICIENCY

- Recommendations:
  - Coordinate with nursing to run the board
  - Get involved in block scheduling
  - Help track appropriate efficiency metrics
    - First case start delays (with root cause)
    - Turnover time
    - OR Utilization
    - Scheduling efficiency
    - Block utilization
  - Communicate with administration
  - Active role in OR committee/process improvement

#4


McHUMOR
"I'd say you're suffering from an arrow through your head, but if you want, I'll order a bunch of tests."

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4. “Own” Pre-op Preparation

STONY BROOK

PREOPERATIVE TESTING GUIDELINE

AGE	Hb/Hct	Bleeding Tests	Lytes	Bun Creat	Gluc	LFT's	EKG	CXR
0 - 50								
51 - 74	■						■	
75 - 99	■		■	■	■		■	
DISEASES								
Hypertension			■				■	
Moderate Cardiac	■		■	■			■	
Severe Cardiac	■		■	■			■	■
Pulm. - Mild								
Pulm. - Severe	■						■	■
Smoker > 20 yrs.	■							?
Malignancy	■							?
Lymphoma								■
Hepatic	■	■	■			■		
Renal	■	■	■	■				
Bleeding	■	■						
Diabetes			■	■	■		■	
MEDICATIONS								
Diuretic			■	■				
BP Medications			■	■			■	
Cardiac Medications			■	■			■	
Steroids			■		■			
Anticoagulants	■	■						

* Please note that the above preoperative testing is a guideline for our surgeons and may be waived at the physician's discretion.

The survey study observed that 59% of patients had at least 1 unnecessary test (95% confidence limit = 52%).

Katz, et. Al. Survey study of anesthesiologists and surgeons ordering of unnecessary pre-operative laboratory tests. Anesth Analg 2011; 112:207-12

Variation in PAT

- Difference in rates of pre-op consults in Canada from 10 to 897 per 1,000 Wijeysundera et al Anesthesiology Jan 2012
- Not one of the possible tests for 4 different clinical scenarios was universally agreed upon by PAT directors Katz et al Anesth Analg Jan 2011
- No difference in intra and post op events in ambulatory patients randomized to “standard” testing vs. no testing Chung et al Anesth Analg Feb 2009

PAT – the CEO perspective

- PAT should prepare patients for seamless start on day of surgery
- Triage mechanisms are fine
- Only test where indicated (PAT testing costs $20B/year in US)
  - To predict risk
  - Alter anesthesia management
  - Improve outcomes
- Give me consistency among group members
- Allocate resources to see appropriate patients in PAT prior to the day of surgery

#3

"I have no objection to alternative medicine so long as traditional medical fees are scrupulously maintained."

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4. “Own” Pre-op Preparation
3. **Reduce Our Subsidy**

Anesthesia Subsidies

- 80% of hospitals pay to support anesthesia
- Key subsidy drivers: Fair Market Value compensation, anesthetizing locations, staffing model. Revenue cycle management
- Recommendations:
  - Identify drivers above
  - Proactive communication with facilities
  - Open dialogue about subsidy components which may be maximized, and how to work together to achieve

#2


FIRST
ASSEMBLY OF GOD
www.churchsigngenerator.com
IT'S
MANAGEMENT &
LEADERSHIP

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4. “Own” Pre-op Preparation
3. Reduce our Subsidy
2. Leadership, Leadership, Leadership

Anesthesia Leadership

- Most consistent identified shortcoming by hospital administrators
- They are seeking leaders who can align anesthesia services with hospital goals
- Recommendations: Focus on the 5 C's
  - Culture
  - Consistency
  - Communication
  - Customer Service
  - Collaboration

#1

THE PAIN STARTS IN MY HUSBAND'S LOWER BACK, THEN IT TRAVELS UP HIS SPINE TO HIS NECK, THEN IT COMES OUT HIS MOUTH AND INTO MY EARS. AND THAT'S WHY I GET THESE HEADACHES.

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4. “Own” Pre-op Preparation
3. Reduce our Subsidy
2. Leadership, Leadership, Leadership
1. **Please, please, please keep the surgeons out of my office!!**

What can you do with this information?

SWOT ANALYSIS EXAMPLE

Strengths	Weaknesses
Clinical Cardiac Surgeon relationships	Timeliness Pain management Pre-op testing OR management Neuro
Opportunities	**Threats**
GI Coverage Pain Clinic Managed care renegotiation Merger with local group	RFP – less expensive alternatives Big national groups Competitor across town

QUESTIONS?

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