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Disclosures

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Anesthesiology Consultants of Marin, Inc.

Chamberlin Health Care Consulting Group, Inc.
Why Would Hospitals Want to Change Anesthesia Services?

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Anesthesia Group Replacement

- Reasons hospitals change groups
- Sources of the reasons (problems?)
- How to avoid and fix those “reasons”
  - AVOID is so much easier than FIX...
Anesthesia Group Replacement

By the end I want to leave you with 3 thoughts:

- BE INDISPENSABLE
- WE HAVE NO FRIENDS
- DATA –DATA-DATA
Why on Earth would Hospitals Want to Change Anesthesia Groups??

Why are we even having this session??
WHY ?????

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(among other things...)

$\$
What are the real reasons?

1 -$$$$

2 -Someone told the hospital it has a choice in providers, and asked if they were happy with their current providers?

3 -Someone told the hospital CEO the new group would provide professional management of the most important sector of the hospital – anesthesia and the operating room, and make the change-over easy!

4 -We cause problems. Potentially lots of problems – yet they PAY us above and beyond our billings and they wonder why should they do that?
CEOs are generally good business folks. They generally do not understand the complexity of medicine, and in general do not have to. They understand they need a service, and that service should perform with excellence, or it needs to be changed. Simple business math.

Oh – and for us, quality is assumed. In fact excellence is assumed. Simply being clinically good enough is no longer good enough...
What WE know:

- We are smack in the center of the highest cost and profit center in the hospital (the OR.)
- We are involved in and responsible for every aspect of sedation and anesthesia for all procedures done everywhere in the facility.
- Successful anesthesia (clinical and administrative) is critical to the financial and clinical success of every hospital.
What do CEOs “know”?

- These anesthesia folks are exceptionally expensive, and have **NO CASH VALUE** to the facility.
  - They do NOT bring patients to us (CEOs forget patients may stay away because of anesthesia...)
- They are the focus of complaints, lack of cooperation with case scheduling and professional issues – **HOW CAN I DO WITHOUT THEM??**
- **Frankly, I do not even know their names...**
Over 80% of anesthesia groups in the United States require compensation for the services the facility wants provided. (just say yes to their staffing grid?)

Given decreasing government and private payor reimbursement, groups cannot recruit and retain excellence in anesthesia providers without some assistance from the facility.
How Much $$ \text{ (stipend) }$? 

- First, don’t use the word “stipend.”
- Use “Payment for Requested Services” or Compensation for Services Requested.”
- Get an outside Fair Market Value Consultant – the hospital will certainly have one and you will need an ally.
Fair Market Value

- A good consultant takes the emotion out of it – it becomes a straightforward business transaction all business people understand.
- Present the independent analysis to your facility so they know you are not being unreasonable.
- The MGMA has national and regional data to support what is reasonable – find someone who is in the know and can help you. DO NOT BE OR ACT GREEDY! Be open and honest – you are business partners!! (or should be...)
- The hospital should NEVER pay you for sloppy collections, bad contracts or bad management.
WE CAN REPLACE YOU WITH CRNAS, WHO ARE CHEAPER...
CRNA Replacing MD based on Cost

- Read the article by Drs Abouleish, Stead and Cohen in the ASA Newsletter December, 2010.
  - Absolutely excellent cost accounting analysis – BUSINESS DISCUSSION!

- Read the article by Drs Abouleish, and Clark in the ASA Newsletter January 2012
  - Excellent overall analysis
CRNAs Cost Less Myth

The analysis of actual cost is much more complex than just yearly salary, and depends on a number of factors such as:

1. staffing ratios
2. number of anesthetizing locations
3. amount of after-hours care.

Depending on local circumstances, introducing nurse anesthetists may actually cost more than a physician-only delivery model.
“THE REPLACEMENTS”

- Scope of Practice \(\leftrightarrow\) Limit of License

- CRNAs Replacing Anesthesiologists.
- APNs replacing Primary Care Physicians.
- LVNs replacing RNs
- Housekeepers replacing LVNs
- Cooks Replacing Housekeepers
- No cooks, only take out...
DANGER…

- Truthfully, as the national healthcare economy changes, we are moving in the direction of the lesser licensed professional doing more and more – practice to limit of their license and expand the scope of practice.

- It is, therefore, in the anesthesiologist's best interest to expand OUR scope of practice, and become *indispensable* to the hospital OUTSIDE the OR.
We have no cash value??

- **Value Based Purchasing (VBP)**
- Starting in 2013, every facility will have $$ withheld from their federal payments, from 1% in 2013 to 2% in 2017.
- They can “re-earn” this money and more (or less) if they meet quality criteria set by CMS.
- “Quality”, as you know, is defined by meeting process criteria, not outcomes
Process Criteria

There are 12 measures in the CMS "Clinical Process of Care"

There are 8 HCAHPS dimensions in the "Patient Experience Domain"

CMS sets threshold and benchmark data for each process of care and patient experience measure, and basically the hospital needs to meet and exceed those benchmarks to get back the money withheld.
How can anesthesiologists help?

- Antibiotic received within one prior to incision
- Cardiac surgery patients with controlled 6AM postop glucose
- Beta-blocker given for patients on beta blockade
- Appropriate VTE prophylaxis within 24 hours
- OB response time (responsiveness of hospital staff)
Find other ways to decrease expenses (=making money…) 

- There are a myriad of things your group can do to save money for the hospital.
- Mix your own Ancef.
- Suggest a less costly anesthetic – sevo versus des, depending on room turnover, etc.
- On time starts – less delays (simple measure – lots of press.)
- MANAGE the OR for efficiency.
GOAL

- You want the CEO to understand you are his/her partner in achieving the maximum amount of returned money, based on the fact you control around a fair percentage of the variables that go into the process checks.

- Your goal is to have them ask “how could we operate without these guys?”
"It is easy to change groups"

- This is a dangerous one – example:
- In Visalia California, Somnia bid for and received the anesthesia contract, over the long term group. Whatever the details, the surgeons, the community, and the hospitalists wrote letters and opposed the change of the groups, in particular opposed the institution of the care team model and use of CRNAs.
The administration said thank you, and proceeded with Somnia and their business plan (1:4 ratio CRNA.)

Data is still being collected, but it appears nothing has changed in terms of case volume etc. **POINT - > we have no friends.**

This monumental change does not occur without at least tacit approval of those around us.

*We have no friends...*
We cause problems
(who knew??)

- Truthfully, even if your group required no compensation – the problems we cause can give CEOs enough headaches to make them want something different, particularly if prodded and pushed...
Predatory Companies ask:

- Does your group exhibit ANY of the warning signs of suboptimal anesthesia management or clinical performance?

- Let me help you identify those areas you may be missing in an underperforming group:
Signs of a Anesthesiology Group In Trouble..

- Clinical Issues
- Professional issues
- Customer Satisfaction
- Operational and Administrative Issues
  - (this is not just me guessing – this adapted from Somnia’s white paper on suboptimal anesthesia management)
Poorly Managed Groups

**Clinical Issues**

- Generally non-compliance with the anesthesia services standards, policies, procedures and best practices
- Length of stay in PACU
- High level of PONV
- High rate of case cancellation
- Re-intubation rate in ICU
- Constant complications at review committees
- ANY CLINICAL PERFORMANCE LESS THAN EXCELLENT!
Poorly Managed Groups

- **Clinical Issues**
  - No Evidenced based medicine
  - No Quality benchmarks
    - Poor SCIP initiative percentages
    - Medication errors – this is a big one
    - Levels of adverse outcomes
Poorly Managed Groups

Professional Issues

• Performance quality
  • All about measureable metrics for standards, problems and documented evidence of improvement (data data data!!)

• Performance Efficiency
  • Processes surrounding the operating room
    • OR Turnover
    • PACU length of stay
    • On time starts for first case of the day
    • On time chart review and audit
Poorly Managed Groups

- **Dissatisfied Customers**
  - Patients
  - Surgeons
  - Consulting Physicians
  - Nurses (OR staff)
  - Administration

- **ASK!!**
  - Survey your customers
  - We assume clinical outcome excellence, now we prove customer satisfaction excellence, or how we are taking steps to improve it
Poorly Managed Groups

- **Dissatisfied Customers**
  - **Patients**
    - make preop phone calls, make pre and post op visits
      - listen, understand they are scared and often under informed by the system – you be the solution to that
        - the missing link.
  - **Surgeons**
    - Quiet, motionless patients, no memory, awake intact.
    - On time cases, no delays, help with medical preparation (surgical home coming...)
  - **Consulting Physicians**
    - Respect them
    - Inform them about the status of their patients
      - A simple phone call to the PCP goes a long way postop
Poorly Managed Groups

- **Dissatisfied Customers**
  - **Nurses**
    - Respectful, considerate of their problems
    - Help with turnover
    - Understand what they have to do and find a way to help them do it.
    - Treat them as colleagues, not underlings
    - Can be your best ally or worst enemy
  - **Administration**
    - Tell them and show them (data-data-data) you have “aligned incentives”
    - You want the hospital to do well, therefore you are studying processes to improve turnover, first case starts, avoiding overtime late cases, etc.
    - AND ACTUALLY DO THE ABOVE!
Poorly Managed Groups

- **Operational and Administrative Problems**
  - Staffing, recruiting, revenue management and attempts at subsidy reduction
  - (we discussed fair market and being honest about your business – this alone takes away much of the predator group arguments)
  - Clean up your side of the street
Poorly Managed Groups

- **Operational/Administrative**
  - Apparent lack of concern about collaboration with the hospital’s business concerns
  - Little committee participation
  - Poor communication between the anesthesia dept and administration
  - Isolationist thinking – “locker slammers”
Checklist

GET INVOLVED

- Really involved – become **INDISPENSABLE**
- Be on *all* the committees (internal compensation)
  - OR management
  - Pharmacy and Therapeutics
  - Finance (find someone with an interest or degree)
  - Professional Practice (with RNs)
  - Any and all committees that will have you (and there are a lot of committees out there)
  - ICU
  - Surgery and Trauma
  - Hospital board committees
Checklist

Show the hospital what you do to help them:

- Peripheral Nerve blocks to get patients out of the hospital earlier with minimal pain
- Pain management for total joint patients – we market virtually pain free total joint surgery!
- Give grand rounds on preop preparation
- Take the lead in problems: infection issue? Anesthesiology will head that committee...
Dashboard

PERCENTILE
TOTAL SURVEYS TAKEN: 3287

Facility: 54
Overall: 57
Provider: 67
Reception: 71
Scheduling: 47
Staff: 61
Checklist

- Demonstrate your interest in managing the anesthesia and operative resources to their maximum cost effectiveness and efficiency – how?

- Send a group member to ASA Certificate in Business Administration Course (CBA.)
  - Somnia and NAPA use this exact phrase: “We have business trained anesthesiologists that can lead your entire operating room for business and financial efficiency, at no additional cost to you!”
Checklist

- Truly, you need to become indispensable to the hospital.
- Your goal, again, is to have them ask “how could we operate without these guys?"
- They need to know not only your chief, but all your names, and what you do
Checklist

- Outside The Hospital for Inside The Hospital
- Outside – In: The Surgical Home
- As PPACA evolves, and ACOs evolve, the ASA has created the concept of the “surgical home” to align with the “medical home”
- Be the leader of the surgical home...
Checklist

- Stop in at least weekly to your CMO and ask:
  - “what have you heard about anesthesia”

- Listen for ANY hint of negativity – mostly you want to hear “frankly, nothing...”
INDISPENSABLE

NO FRIENDS

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