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Facing the Anesthesia Shortage Head-on: Crisis or Opportunity?

There is no doubt that there is a current shortage of anesthesiologists and that shortage will continue for some time. While there is debate about the role that CRNAs may (or may not) play in solving this shortage, there is little doubt that now is the time for both innovation and change. Innovation in the manner in which anesthetic services are delivered is required along with change in the “us against them” mindset that permeates so many hospital settings. Applying some basic business principles to anesthesia practice management is helpful to understand what needs to be done to effectuate change in the short and long term.

Clearly, the demand for anesthesiologists is outstripping the supply. As with so many other specialists, America simply is not “making enough” anesthesiologists. Add to this shortage the increasing number of baby-boomers who will increase the Medicare population – large consumers of anesthesia services. Add the proliferation of the *types* of anesthesia settings: main O.R.s, diagnostic catheterization rooms, labor and delivery suites, MRI sites, ambulatory surgical centers, and office based anesthesia. Not long ago there were only main O.R.s.

Part of the overall shortage of anesthesiologists has to do with the growth in anesthesia locations. More sites, more need for anesthesia trained bodies. Subtract from the supply the anesthesiologists who prefer to sub-specialize in pain management. Also subtract the office-based surgical market which allows those anesthesiologists who might otherwise work part-time in an O.R. to have a far less stressful practice a few hours per week in a surgeon’s office. You see that the market is larger and the supply shrinks even more. Next consider that the main O.R.s are consumed with higher acuity patients requiring greater procedure time than ever before, and placing greater demands on the anesthesiologists. This is evident from the increased number of RVUs per case. Over all, anesthesiologists are spending more time on patient care activity, yet, on average, supervising fewer surgeries per year. So, what is to be done?

Is there anything to ease this situation? The CRNA workforce is on the rise. As some states opt out of physician supervision requirements for CRNAs, this may help abate the imbalance between supply and demand. Clearly, there is substantial controversy over the clinical equivalency between CRNAs and physicians, making the relationship between the nurse anesthetists and the MDs difficult in many situations. The situation is exacerbated by recent years’ growth in the pay scales for CRNAs. When CRNAs are in short demand, salaries rise to near those of the starting physician associates in some locales. So, what is a group to do?

1. Effectively Use What You Do Have.

Clearly improving the perioperative efficiency for anesthesiologists is an absolute mandatory minimum effort for anesthesia delivered in hospitals. To do this, you must effectively deploy the highest paid people to their highest and best use, and work down from there.

Let’s start with the basics of “deployment” in general. How many times have you looked at the schedule and thought: if I could eliminate the “shot-gun start...” and yet, how many times have you heard that it is the way that the O.R.s “must be” run. Why? Deploying all of your most expensive resources (physicians) at the same time is not an efficient use of the most expensive talent that you have, if it means that you deploy them all at once, only to start sending them home half or two-thirds of the way through the day. If you use a shot-gun start and then start closing O.R.s at 2 – 3 in the afternoon (or worse, earlier) then why were you opening so many at the same time? You could have used fewer physicians by opening less O.R.s, and kept them open later. This saves money. Those anesthesiologists and CRNAs you sent home still expect to be paid for a full day, even if you didn’t have enough cases – or, they expect you to send them somewhere productive later.

Of course, hospital executives will claim that not accommodating surgeon demands for early times will lose business. Poppycock! You may lose business (unlikely) but neither you nor the hospital need lose money. Economically credential your block times and surgeons generally. Slow surgeons and Medicaid dental cases get the least desirable times. And pay attention to the case drop off at the noontime hour—often a surgeon induced phenomena.

Now let's consider the way that you deploy your anesthesia coverage. Clearly, the most effective way to increase individual anesthesiology productivity and income potential is by using integrated physician and CRNA teams. This means having the right mix of providers (doctors and CRNAs). Too many of either is less efficient. Fully leveraged teams allow the anesthesiology department (or group) to generate the most anesthesia revenue per hour of coverage, while most effectively deploying the highest levels of talent where it is required. Since the payor mix is also a factor, making those decisions "on the go" is also important. The critical point here is maximizing anesthesia revenue for O.R. coverage.

But don't limit yourself to physicians and CRNAs. Innovative groups are deploying physician assistants, anesthesia technicians and RNs for tasks that don't require anesthesiologist attention. Think about it especially if you have a heavy pre-anesthetic work or a substantial pain management program.

2. Let Those Who Have the Most Interest in it Control the Outcome.

This takes us to the turnover time. Let's assume that the hospital can get a handle on the turnover time, for a moment. (This is a big assumption, in some cases.) Who handles the scheduling? Often it is not the anesthesia department; it is the hospital. That is not always an advantage. Consider the advantages of block time, cases to follow, and shared rooms (one quick cataract surgeon assigned two rooms), that have been learned over the years. Consider the lessons that have been learned by teaming the anesthesiologists and/or CRNAs with the surgeons, and work *with* the principles and not against them. Perhaps a team approach to scheduling makes better sense. When the OR schedule is published, the anesthesia coordinator is going to have to make out the anesthesia schedule to coordinate staffing of the rooms in any event, so perhaps it makes sense to coordinate the effort sooner, at the time of booking. Or better yet expand your contract to include overall responsibility for the O/Rs, including scheduling-- for an additional administrative fee, of course.

3. Control the Payor Mix (If You Can).

Then there is the dreaded payor mix. This can be the hardest thing to fix. Anesthesia income is, at the end of the day – after you have made all of the efficient moves stated above – still a function of maximizing the income potential per hour per O.R., so, it comes down to the payor mix of the facility. Since the main O.R.'s compete with hospital ambulatory surgery centers, which compete with out patient surgery centers and even ambulatory settings (such as doctors' offices), the main O.R.s are more often than not the locations of the sicker (and poorer) patients. Consider that while the number of O.R. cases is going down, the relative values per case are going up. Consider also that most anesthesiologists receive no case adjustment for the severity of the patient's condition and it is easy to see why the per-case income is *decreasing*. Taken together, many hospital settings make the profitable (or even break even) delivery of anesthesia impossible, and given the number of competing locations in which anesthesiologists *can* practice, this problem can lead to understaffing and the common need for the hospital to subsidize the department.

While Medicare is a relatively poor payor for all physicians, the variation between commercial and government is most pronounced for anesthesiologists. Medicare pays most doctors about 80% of commercial rates; anesthesiologists get about 40%. As a result, anesthesiologists often rely on commercial inpatient surgeries to subsidize Medicare and Medicaid cases. This is why the case mix matters; it cannot be controlled if the group practices only at the hospital, or the hospital employed group does not also have a surgery center or outpatient department.

Direct care subsidies are unavoidable for hospitals with low commercial or high Medicare/Medicaid payor mixes. For much of the country, the Medicare "unit rate" is around \$19.00. If

one anesthesiologist worked thirty hours of continuous time in cases (remarkable, really, given down time for turnover, pre-operative screening, and other built in non-billable anesthesiology time), with about twenty cases a week of five base units each all for Medicare patients only, then he would earn roughly \$245,000 (assuming six weeks away for CME and vacation). After malpractice and health insurance and pension and put a small amount towards CME, the doctor would earn about \$180,000. Try to hire an established, or even a recently minted, anesthesiologist for that salary!

This is why the case mix is so important to the anesthesiologist, and why it becomes important that the case turnover be maximally effective and that the “good cases” stay at the center or that the anesthesiologists go to the centers where the “good cases” are --to cover the losses that can accrue in the main O.R.s where they may not be able to control the case mix.

Hospitals with Medicare intensive surgery mixes are finding an increasingly widening gap between anesthesia revenue generated by their O.R.s and that generated through pain management or selective other outpatient or ambulatory services. Couple this with anesthesiology income expectations, and you will see the increasing coverage crisis that leads anesthesiologists to defect, or worse, to switch hospitals, favoring those institutions with the better commercial payor mix.

4. What Can Your Group Do Differently?

Because the ability to generate revenue depends upon the efficient delivery of service and the mix of services performed, and because ASCs improve the efficiency of anesthesiology economics, out patient surgery in the ASC (or outpatient department) or in the office presents a very lucrative revenue source for the anesthesia provider. This makes outpatient sites a logical setting choice for many anesthesiologists. Keep in mind also that those serious anesthesiologists deliver are fundamentally different in those settings. Unlike the hospital, where the institution may have started with a non-profit motive and then turned it into a business model, a proceduralist starting to operate in his office and needing an anesthesiologist probably started out with a business plan. The doctor likely considered and understood the economics of case turnover, the costs of doing business, the patient base, the insurance market, and the like; that surgeon likely pre-screens the patients for services to be performed in the office or surgery center based on their insurances. The anesthesiologist does not face the “take all comers” problem in the ASC that are faced in the hospital. It is clear that these settings are fundamentally different on many levels.

Recognize that most ASC ventures grew out of frustration with hospital-delivered operating facilities. Physician owned sites are very savvy about turnover time, efficient use of O.R.s, and the like having suffered through inefficiency at the hospital and the need to correct what was not working for them at that time. Since the most important fundamental for anesthesia income is revenue generation per O.R. bill time, you can see the attraction to non-hospital models hold for surgeons and anesthesiologists in general.

5. Provide a Last Resort (If All Else Fails).

In the most recently published “Supplemental Compliance Program Guidance for Hospitals,” the Office of the Investigator General (OIG) of CMS, the OIG recognizes the push-pull between hospitals and traditional hospital-based physicians (e.g. anesthesiologists, radiologists, emergency physicians and pathologists). Clearly the OIG is opening the door for discussion between the group and the hospitals(s) regarding payment for 24/7 coverage, extended hours, and the like so a group is not economically required to close operating rooms.

Factors Influencing the Supply and Demand for Anesthesiologists	
Demand	Supply
<ul style="list-style-type: none"> • Increase and Diversity in Anesthetizing Locations • Increase in Pain Management • Sub-specialization within the field • Aging population • Increasing high acuity procedures • Increasing number of procedures 	<ul style="list-style-type: none"> • Reduction in Medicare and corresponding commercial payor payments • Increasing costs to practice anesthesiology • Increasing attractiveness of non-hospital anesthesia locations

6. What Else?

So, what else can be done? For one thing, groups can be larger and serve multiple hospital and other locations. Only if your group becomes larger can it diversify itself and protect itself from changes in the payor mix at any one facility. Only then can it protect itself from the changes in hospital administration and the policies at any one facility.

Similarly as your group becomes larger, it inherits a better ability to schedule and use its *own team* time more efficiently. Evaluating your self as a team of providers of mixed sub-specialists allows you to look at yourself as an entire team of providers – physicians, CRNA, PAs and RNs.

If the group is able to do this and work with the hospital administration to consider total functionality within the setting, it may be able to consider the effective use of your own time. For example, if a group can capitalize on its O.R. downtime, and look at itself as a care team, it might be better able to redeploy its members in different ways, possibly using Physicians Assistants and patient care protocols to leverage the anesthesiologists with CRNAs, AAs, PAs, nurses, and the like.

Maximizing anesthesia income means being sure that all of the available work that is scheduled to be done is actually performed. Preventing cancellations is critical. This may mean rethinking how you handle the pre-anesthetic work up in the main OR and who handles it.

Likewise, you might be able to better “work” the schedule -- particularly where the anesthesiologists are in charge of the O.R. scheduling and able to effectively run the O.R. schedule, so you can minimize downtime by scheduling pain clinics or using ambulatory anesthesia opportunities when the O.R.s slow down.

All of these strategies, however, require having enough critical mass that you can change the way that you deploy yourselves. If you only have the number of anesthesiologists that you need to staff your current situation, then you cannot change what you have or how you offer it, and so you likely cannot change very much. Certainly if your payor mix changes unfavorably, you will be at the mercy of the hospital. So, if you are to seek a change, you need to think about your situation differently. Think about the tools that you would need to make a change, and the size of the critical mass that you would need to be able to change the way that you deliver the care. Think about whom (what other groups in your area) might be in a situation similar to yours, and how together you might be able to do things differently. Only then will you be able to make an effective change.

Clearly, this is a time for strong leaders. This is a time to stand back and assess your market. Consider what your practice brings to the table and look for groups similarly situated to yours within your own market. Consider how you might work *with* administration, not against it. This is a difficult time for anesthesiologists, and simply capitulating to the times is **not** the right answer. It is not the right answer for you personally. It is not the right answer for your group or for your hospital.

There is much to be said about what is occurring in the market for anesthesia. One place to find more information is in an excellent report available through The Advisory Board Company entitled "Navigating the Anesthesia Shortage - *Ensuring Sufficient Coverage to Enable Procedure Growth.*" Additional information is available at their website at www.advisory.com.

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