I spent thirty-six years of my forty-five year healthcare management career managing and operating healthcare facilities. During those years, I found myself—perhaps like you—looking from the outside into the “black box” called anesthesia services, not exactly realizing what I didn’t know about its innermost workings. Not only is anesthesia one of the most critical service components for hospitals, it is also one of the most complex services for a provider group and hospital to efficiently and effectively manage. The operational complexities of the practice require anesthesia groups to invest more of their time, energy, and money into building the supportive infrastructure to effectively manage these practices. But the fact of the matter is that most anesthesia providers are not making the necessary investments in their practices to meet the clinical and operational challenges associated with today’s healthcare reform initiatives.

Over the years I was fortunate to have contracted with several outstanding private practice anesthesia groups. Anesthesia medical directors shared with me the in-depth operations of their practices. I learned a lot from them about their business and clinical models. Following my hospital career, I now have spent nine years working in the anesthesia management services arena, managing a national anesthesia management practice and being involved in more than 200 hospital anesthesia consulting engagements. During this time I have identified some of the most common myths that hospital leadership has about anesthesia services that I would like to share with you and hopefully dispel.

Many C-Suite leadership teams describe anesthesia services as “the black box.” One CEO said: “We don’t know exactly what we don’t know when it comes to how an anesthesia practice should be run efficiently and effectively. We don’t have the clinical and operational metrics and dashboards to tell us how the service is actually performing. Anesthesia services is like a black box, we don’t really know what’s going on inside the box, except for the fact that we’re having to subsidize our anesthesia service.”

Addressing and dispelling these anesthesia myths is essential because they often become decision-limiting factors that restrict hospital leadership teams from selecting the best possible anesthesia solutions for their facilities, surgeons, patients, and perioperative teams.
Are anesthesia services really a mystery black box?

In many cases, anesthesia service is a black box, but it doesn’t have to be that way. Hospitals need to work with their provider groups to establish written rules of operational engagement that align the provider group with the hospital and make that relationship more transparent.

The following rules for engagement between providers and hospitals are “black box” killers:

• Create and agree upon an annual budget and meet monthly with the provider group to review the monthly and year-to-date (YTD) P&Ls. Work together to develop action plans to address monthly variances.

• Create operational, quality, and patient safety dashboards with benchmark metrics to establish expected performance outcomes for the practice. Meet monthly to review the reports and metrics, and create written action plans to address negative variances. Additionally, practice members should have from 10 to 20 percent of their compensation at risk as “skin in the game” to perform and meet established benchmark standards.

• Require the practice to be contractually at financial risk to successfully achieve and maintain benchmark metric standards. Require practices to address negative variances with written action plans that are reviewed monthly.

• The hospital and anesthesia practice should jointly develop a yearly written Strategic Business Development/Alignment Plan, and review the plan quarterly to ensure compliance and success.

These and other simple contractual rules of engagement between a hospital and its anesthesia group will go a long way in eliminating “black box” syndrome for hospitals.
Should you be paying a subsidy? Is it always an exorbitant expense?

The simple truth is more than 95 percent of hospitals pay either a direct or indirect subsidy for their anesthesia services. The subsidy is necessary because of several factors:

- Third-party reimbursement for anesthesia service is insufficient to cover the cost of the service and, in today’s reimbursement climate, it’s unlikely that we will see any movement from third-party payors to address this issue.

- Most anesthesia practices have not built the necessary management infrastructure of tools and processes, nor do they have the business acumen to effectively and efficiently manage a practice that is facing so many internal and external challenges caused by healthcare reform initiatives.

- Low provider productivity is a significant contributor to high subsidies. Anesthesia providers are some of the most highly compensated healthcare providers in the industry today. Yet, it’s not uncommon for providers to be only 45 to 55 percent productive. Many factors affect provider productivity, some the practice can control, some it can’t. Hospital leadership and anesthesia practice leadership should collaborate on a routine basis to identify and address operational barriers and system obstacles that impact provider productivity. At least 70 to 75 percent of a provider’s time should be productive/billable hours.

The real question hospital C-Suite leadership should be asking is: “Is the hospital paying the right subsidy amount?” The answer to this question in most cases is No! In consulting with hospitals, we’ve discovered the typical hospital can reduce its subsidy cost by 10 to 25 percent without negatively impacting patient care outcomes, while still providing surgeons with room access and availability to meet their surgical case volume on a timely and efficient basis.
Is there a shortage of anesthesia providers?

If you read the literature on this topic, it would lead you to the conclusion that there is a national provider shortage. Overall in the marketplace there are sufficient numbers of anesthesia providers to meet staffing requirements, with the exception of scattered pockets around the country. Those areas tend to be in rural, medically underserviced markets, which have traditionally been difficult to recruit to in the first place.

The following factors have had a favorable impact on the supply and availability of providers:

- **TEAM ANESTHESIA:** The introduction of team anesthesia has leveraged the supply of anesthesiologists by moving them off the stool and into a direct supervision role, monitoring CRNAs who provide the hands-on administration of anesthetics. While there are still some anesthesiologist-only practices around, they are a very small minority, because they are just too costly to operate with today’s reimbursement schemes. The good news is that in most regional markets there are sufficient numbers of qualified anesthesiologists and CRNAs to meet demand.

- **NURSES ARE FOLLOWING THE MONEY:** Many nurses have migrated from traditional nursing roles to become CRNAs. In the early ‘80s, acute shortages of CRNAs occurred, as the demand for CRNAs exploded with the clinical acceptance of team anesthesia. Compensation for CRNAs soared, attracting more and more nurses to obtain their CRNA registrations to meet the ever-growing demand. In the late 1990s and early 2000s, many university nursing programs scrambled to start or expand CRNA programs. The proliferation of programs has, in most regions, kept the CRNA supply and demand in balance. For example, in the state of Alabama three CRNA programs graduate more CRNAs than the state hospitals can possibly absorb. Alabama has become a net exporter of CRNA talent to other states.

- **ANESTHESIA ASSISTANTS (AA):** The introduction and acceptance of AAs in many states has added an additional source of providers to the team anesthesia model.

The bottom line is that there are sufficient numbers of anesthesia providers in the current provider pool to meet the needs of almost all hospitals for the foreseeable future.
Do provider groups have to pay premium compensation rates to recruit and maintain quality providers?

First, all healthcare providers should be paid a fair and equitable compensation rate for the markets where they are working. Provider compensation rates vary from region to region. You should know your regional rate structure. A good reality check is the MGMA provider compensation annual report. The benchmark recruitable compensation rate for a well-qualified, experienced anesthesiologist is typically around the 60th to 75th percentile of the MGMA compensation scale. It is not uncommon to find anesthesiologist practices compensating providers at 100 to 120 percent of the MGMA pay scale and passing this cost on to the hospital in higher subsidy.

- Compensation rates for both anesthesiologists and CRNAs have been declining for the last three to four years. As further clarification on this point, a provider seeking employment with a new private practice group or anesthesia management group will probably be hired in at the 60th to 75th percentile of the MGMA pay scale. This does not necessarily mean the end user – the hospital – will have the savings passed on to them by the provider group.

- The supply and demand equation has shifted over the last few years. While the supply of providers currently is sufficient to meet the demand for services in the broader marketplace, there are still spot shortages in some areas. Generally speaking, we are seeing increasing numbers of providers becoming more mobile, moving within and out of markets where they are currently employed. We believe this is partly because of general improvement in the economy.

- Anesthesia providers are continuing to work longer and are not retiring at the rate originally forecasted, thus elevating, in the short term, some of the supply and demand issues.

- More CRNAs are graduating each year from an increasing number of programs around the country. A proliferation of new programs and expansion of existing programs meets the growing need for CRNAs. The market for anesthesiologists and CRNAs for the foreseeable future is fluid and can meet the needs of most healthcare organizations.

The good news related to this myth is that hospitals that are requiring full financial transparency from their subsidized provider groups are paying less (subsidy) for their anesthesia service, because the cost of providers is decreasing, and in a financially transparent relationship, hospitals should be the recipients of these savings.
Is changing an existing provider too disruptive and risky for management to undertake?

What we have learned about the change process over the years....

• Whether or not a change in contract providers goes smoothly or becomes disruptive depends upon the competencies, capabilities, resources, and track record of the new provider group.

• Typically, in a provider group transition, a majority of the existing providers choose to stay on. It has been our experience between 80 to 90 percent of those providers the surgeons and hospital leadership want to keep will sign on with the new group. This reduces the hospital risk factor substantially.

• Provider groups that are operationally focused and are routinely involved in transitions will have the expertise and transition processes down to a science. The actual transition in most cases will go smoothly. Within six to eight weeks, if managed properly, the key OR stakeholders (surgeons, patients, perioperative staff) will be happy with their new service.

• Not every anesthesia provider group has the experience, resources, and transition process down to a science. Properly vetting a provider group’s success rate for transitioning a contract is absolutely essential prior to committing to a change in contract services. Remember Franklin D. Roosevelt’s famous quote, “The only thing we have to fear is fear itself.” This is true when it comes to transitioning to a new provider group. There is actually little to fear except the raw emotional effects of fear itself.
Does the acquisition of the group by an anesthesia practice management company automatically mean improved service?

The trend across the nation is for physicians to sell their practices to a hospital system or a practice management company. Practice consolidation is picking up momentum in the anesthesia practice sector. Does this mean if a hospital’s anesthesia service is acquired there will necessarily be new economies of scale, resulting in a reduction in cost along with improved patient care outcomes and a better patient experience? An acquisition does not necessarily mean there will be a positive or negative outcome for the host hospital. It depends upon the acquiring organization’s capabilities.

The hospital, as the sponsor of the anesthesia service to its surgeons, patients/family, perioperative staff, should conduct a thorough due diligence study on the acquiring company, checking on the following issues before assigning the hospital contract:

• How will the acquisition of the practice impact the hospital subsidy cost over a three to four year period? Will the subsidy go up or be reduced?

• Since most anesthesia practices receive a subsidy because operating expenses exceed net collections, how does the acquirer plan to achieve a return on its investment, which is the fully loaded acquisition cost?

• Will the acquirer’s restructuring of the practice’s operating cost include provider compensation and benefits cost to achieve their targeted ROI, and will this ultimately impact the stability of the practice, which could have a direct impact on the future quality of care, as well as the subsidy cost, by undermining the group’s stability?

• What has been the acquirer’s track record in enhancing and improving the anesthesia service operations, improving the quality of care, while providing the service in a more cost effective manner?

These are just a few questions that should be answered before a hospital assigns its existing contract to an outside practice management company. You can enhance the hospital’s odds of having a good outcome by conducting a thorough study of the acquiring management company.
It’s important to dispel anesthesia “black box” myths. Putting these and other “black box” myths in the proper perspective will allow hospital leadership teams to make the right anesthesia service decisions, based on facts, without clouding the process with bias caused by these and other myths.

After reading this white paper, you may have other questions that you would like answered to improve your anesthesia service’s clinical and financial performance. For answers, call me at 678-690-7943, or email your questions to me at kteel@premieranesthesia.com.

Kerry Teel is the president of Premier Anesthesia, a national anesthesia management and consulting company that focuses on maximizing hospitals’ anesthesia service. Kerry is a healthcare industry veteran with over 40 years of healthcare and hospital experience. Prior to serving as the President for Premier Anesthesia, he served as President and CEO of a 526-bed medical center in Texas.