Somnia
ANESTHESIA

Using Anesthesia to Improve the Effectiveness of Your OR's

© 2010 Somnia Anesthesia, Inc.

Supporting Healthcare Facilities and Anesthesiology Groups Nationwide

Using Anesthesia to Improve the Effectiveness of Your OR's

Presented at:
ASC Communications and the Ambulatory Surgery Foundation –
17th Annual Improving Profitability, and Business and Legal Issues for ASCs

Presented by:
Hugh Morgan, CMPE
Quality Assurance Officer
Somnia Anesthesia, Inc.

Date:
October 22, 2010

Background

- **16+ years experience**:
  - Acute Care & ASC O.R.'s
  - Surgical Groups
  - Anesthesia Physician Practices
    * Group of 30 MDs, 22 CRNAs covering 2 tertiary care hospitals and 2 ASCs (over 20,000 cases annually) in South Jersey
  - Perioperative / Anesthesia Consulting
- **Quality Assurance Officer, Somnia Inc**.
  - Nationwide responsibility for Anesthesia quality at Acute, ASC and Office Based facilities.
  - **Somnia is AAAHC accredited** (since 1996)
  - Drs. Koch & Goldstein (founders); AAAHC Surveyors

Never Underestimate Anesthesia

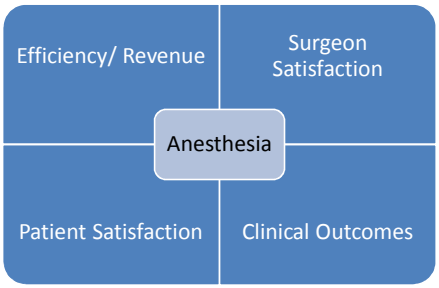
Never Underestimate Anesthesia

- 75% of ASCs experiencing increased surgery wait times*
- 66% of ASCs limiting access to ORs*

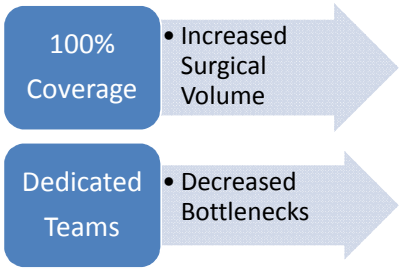
**Source: American Society of Anesthesiologists*

We're an ASC,we don't pay a subsidy…

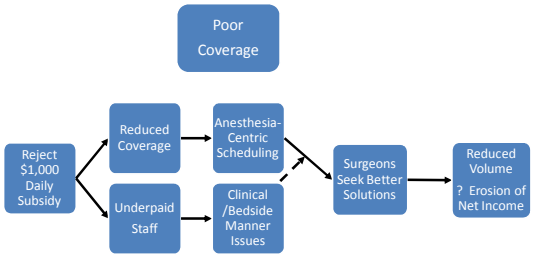
Never Underestimate Anesthesia



Efficiency = Revenue



Poor Coverage=Reduced Volume=Income Erosion



The Anesthesia "Subsidy" Conundrum

- Anesthesia "subsidy" typically seen in acute care facilities where payer mix, numerous coverage locations and "readiness" costs don't cover staff expenses.
- New challenge: Stressed economy = under-utilized ASCs, either by hours of operation and/or volumes, that are not aligned with anesthesia utilization (staffing & revenue) requirements.
- Anesthesia Group covering multiple facilities will typically adjust staff to maximize billable hours of operation & volumes.
- Lack of Anesthesia utilization requirements (transparency) = not making anesthesia group "whole" which leads to reduced anesthesia staffing, closed rooms, less volume, poor patient/surgeon satisfaction.

Subsidy or No Subsidy?

Scenario: 5 room ASC; staffed by 5 F/T Anesthesiologists

Daily Surgical Capacity: 5 rooms x 8hrs. ea. = 40hrs. Daily

Industry "standard": 1,500 cases per ASC OR; approx. 6-7 cases daily per room

	ASC Utilization	Daily Surgical Capacity	Daily Rooms	Daily Cases per Room	Anes. Revenue per OR Room	Daily Anes. Staffing Costs per OR Room	Daily Profit (Loss)	Annual Profit (Loss)	Avg. Daily "subsidy" to make Anes. "whole"
Example 1	**80%**	30hrs.	5	6	$1,920	$1,800	**$120**	**$132,000**	**$0**
Example 2	**70%**	25hrs.	5	5	$1,600	$1,800	**($200)**	**-$220,000**	**-$1,000**
Example 3	**60%**	20hrs.	5	4	$1,280	$1,800	**($520)**	**-$572,000**	**-$2,600**
Example 4	**50%**	15hrs.	5	3	$960	$1,800	**($840)**	**-$924,000**	**-$4,200**

- Anes. Revenue assumes avg. 8 units per case x $40/unit
- Anes. Staff Costs assume avg. total comp of $400k per MD incl. benefits, insurance, etc.

Keep Surgeons Satisfied

- Surgeon-centric schedule ≠ "efficient" schedule
- On-time starts = abundance of anesthesia staff
- Quick turnover = abundance of anesthesia staff
- Collaborative work environment/trust
- Additional anesthesia services

Keep Patients Satisfied

- Thorough pre-op
- Painless IV administration
- No wait time
- No PONV
- Minimal Post-op pain/discomfort
- Swift recovery
- Prompt discharge
- Limited billing headaches

What Anesthesia Does and Doesn't Do

- Anesthesia does *not* diagnose
- Anesthesia does *not* treat
- Anesthesia facilitates
  - Painless surgery
  - Unconsciousness
  - Quiet surgical field
  - Muscle relaxation

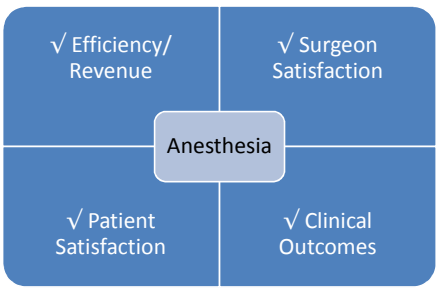
Improved Surgical Outcomes

- More pre-cancerous polyps detected with deep sedation colonoscopies
- Doctors found polyps larger than 9mm or suspected colorectal tumors at a **25%** higher rate in patients under deep sedation

  Katherine Hoda, M.D., Oregon Health and Science University
- Switch from GI doctor performing colonoscopy and delivering sedation to anesthesiologist administering Propofol
  - Up to 43% increase in number and percentage of patients who had polyps detected

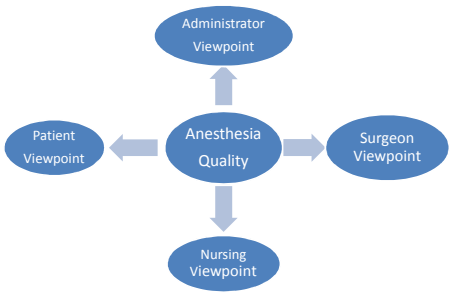
    University of Pennsylvania and State University of New York

Tip 1: Never Underestimate Anesthesia



Define Quality to Achieve Quality

Only Quality Creates Long-Term Success



Patient

- Unrushed/thorough pre-op
- Attentive post-op
- No PONV
- Limited/no pain
  - Physical
  - Financial

Surgeons

- Surgeon-centric schedule ≠ "efficient" schedule
- On-time starts = abundance of anesthesia staff
- Quick turnover = abundance of anesthesia staff
- Collaborative work environment/trust
- Additional anesthesia services

Nursing

- Support, back-up and team mentality
- Surgeon-centric schedule
- Support and assistance with challenging issues
- Solve more headaches than they create
- On-time starts = abundance of anesthesia staff
- Quick turnover = abundance of anesthesia staff
- Collaborative work environment/trust
- Additional anesthesia services

Administrative Leadership

- Efficient Schedule ≠ Surgeon-Centric Schedule
- Exploration of cost-efficient staffing models (All MD v. "Care Team")
- Prudent use of equipment, medications and supplies
- No subsidy or subsidy supports:
  - Fair Market Value (driven) compensation
  - Fair Market Value (driven) benefits
- Savvy contracting with payers…to a point
- Stellar revenue management
- Pro-growth mindset = flexible staffing and hours

Manage Anesthesia Supply/Demand Gap

The Supply/Demand Gap

Surgical Facilities

Anesthetists/ CRNAs

Be prepared.

Boy Scouts of America

"The future depends on what we do in the present."

Gandhi

The Supply/Demand Gap

Procedures Requiring Anesthesia

Anesthetists/ CRNAs

Supply Stats

- Residents entering anesthesiology practice
  - ↓15% between 1990 and 2002 **(AMA)**
- AMA study of 30,000 practicing anesthesiologists
  - Approx. 60% 45 or older
  - 25%+ 55 or older
  - 12% residents
- Practicing CRNA
  - Shortage of more than 5000 **(U.S. Dept. of Health)**

Supply/Demand Gap Solutions

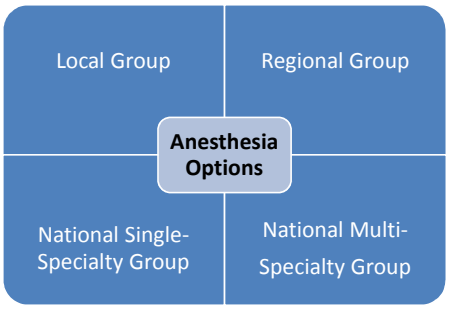
- Scenario I
  - Pay more for same coverage
  - Pay doctors more
  - Provide more robust perquisites
- Scenario II
  - Reduce coverage
  - Sacrifice efficiency and stakeholder satisfaction
  - Nearly half of ASC administrators reducing or re-directing OR procedures due to anesthesia staffing issue
- Scenario III
  - Make your problem someone else's problem
  - Anesthesia is #1 outsourced service – Waller Landsen
  - Increased staffing resources and flexibility; ramp up & down

Ask The Right Questions

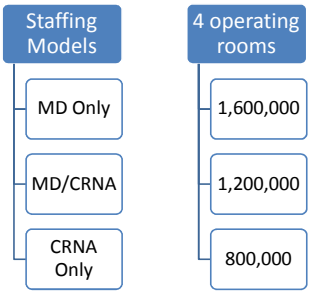
- Do you have the right staffing model?
- Are your anesthesia costs in line with the market?
- Is your contract too long? Too short?
- Do you have enough coverage to meet your goals?
- What is your anesthesia "value proposition"???

Know (*and Understand*) Your Options

Knowledge is Power…



A Perfect Pair



Continuous Measurement and Improvement

Measure to Manage

- Coverage
- Quality Metrics
- Performance Improvement
- Patient Satisfaction
- Surgeon Satisfaction
- Surgeon Retention
- Contracting
- Collections

You can't manage what you can't measure.

Set Clear Goals

- Coverage at or near 100%
- Customer satisfaction EXCELLENCE
- Considerate view of OBSF
- Metric-driven quality data
- No bottlenecks
  - Pre-op
  - Efficient induction and rapid wake-up
  - Post-op

Using Anesthesia to Improve the Effectiveness of Your OR's

- Never Underestimate Anesthesia
- Define Anesthesia Quality
- Plan for Shortages…Simple Economics (Supply v. Demand)
- Know Your Anesthesia Options
- Continuous Measurement and Improvement

Hugh Morgan, CMPE
Somnia Anesthesia
201-400-9795
hmorgan@sominiainc.com

Supporting Healthcare Facilities and Anesthesiology Groups Nationwide

www.somniainc.com