

Changing Anesthesia Providers: A Hospital's Dilemma

Define the Problem

"I can't deal with this anesthesia group anymore!"

As a national anesthesia practice management company, we've heard this and similar statements from hundreds of hospital executives. Many administrators will go as far as putting the anesthesia contracts out to bid, without weighing the potential consequences of this decision. Their medical staff may oppose it, finances might not allow for operating room disruption, or they discover their issues are resolvable. Faced with these concerns, a hospital may decide *against* outsourcing and end up paying their group a subsidy or a higher subsidy. Either way, having to make the decision to outsource puts the hospital in a tough position. Outsourcing anesthesia services can effectively alleviate surgical and administrative pressures if the hospital administrator is educated about the process and understands how to improve the probabilities of a successful outcome. Let's begin by discussing some of the contributing factors that lead to problems with a hospital and its current anesthesia group.

The shortage of anesthesiologists and CRNAs is among several market trends effecting hospitals and ambulatory surgical centers nationwide. In the 1990's, it was projected that there would be a surplus of anesthesia providers, thus resulting in the closure of many residency programs and CRNA schools.^{1,2,3} Simultaneously, the predicted reduction in demand for surgical procedures did not occur. Due to advances in surgical techniques and procedures, more patients have surgery on an outpatient basis. In addition, hospitals have a greater demand for anesthesia to cover OB, trauma centers, Cath. and GI labs. The number of procedures, and more importantly, the number of sites (ASCs and office based) requiring anesthesia services has steadily increased. In this complicated environment, many anesthesia groups experience difficulties in recruitment and retention. This imbalance in supply and demand has led to chronic personnel shortages, prompting anesthesia providers to demand higher compensation levels and increased benefits from hospitals.

The relative decrease in provider productivity has also had an effect in the marketplace. Many graduating residents expect to be guaranteed the day off after call and 8 weeks vacation. This has led to further limitations on the number of anesthesia providers available on a daily basis. Nationwide, nearly 70% of anesthesia groups are receiving some form of stipend or subsidy from the hospitals they service.⁴

Identify the Need

In the majority of cases, hospitals become frustrated because they provide financial support, but their anesthesia group fails to meet their service expectations. Second only to their "subsidy" concern, is the belief that the group does not possess the management and leadership qualities necessary to provide a sufficient level of customer satisfaction to

the medical staff, particularly surgeons and obstetricians. Surgeons and obstetricians, represent most of the revenue for the hospital, so administrators want to meet their needs. This puts the anesthesia group in the middle and ultimately causes coverage problems. The hospitals and surgical specialties want continuous, 24hr operating room access and anesthesia availability. Providing this level of coverage not only means recruiting more personnel in a tight market, it means that anesthesia groups have to provide coverage at a fixed cost, with little or no revenue to cover these costs. These issues can lead to a deteriorating situation that accelerates over time. Documented by the Advisory Board in its publication *Navigating the Anesthesia Shortage*, a well-known anesthesia practice consultant diagrammed this scenario below: ^{5,6}

{ SHAPE * MERGEFORMAT }

What has become apparent in our 50+ years of providing anesthesia services and management solutions is that the quality of clinical service is almost never the concern. It is the need for an anesthesia team that possesses the leadership and structure to work effectively with the hospital. The most successful environment is one where anesthesia leadership works collaboratively with surgical nursing and the department of surgery. Hospitals are looking for anesthesia providers who mesh with the culture of their facility. A knowledgeable anesthesia chief must lead his/her team on a daily basis, navigating difficult situations between administration, OR nursing and surgeons. They must understand that hospitals view the surgeons and OBs as the ultimate customer.

Make the Right Selection

When a hospital determines that an alternative to their group is unavoidable, they begin by researching information from their colleagues, competing local groups and national anesthesia practice management companies. A consultant may be hired to analyze their issues and arbitrate if both the current anesthesia providers and facility are willing.⁷ With or without an intervening consultant, the hospital may still search for an alternative to its current situation. Hopefully, they will have openly discussed their concerns and intentions with the current anesthesia group leadership. Regardless, they may give formal notice to the group and initiate a request for proposal (RFP) from prospective vendors. The RFP should provide specific information about the hospital and explicit expectations about the level of service required. Key points that are addressed in the RFP include:

- Defining scope of work and standards
- Service provisions
- Staffing considerations (e.g. physician/CRNA ratios)
- Liability risk
- Insurance and indemnity
- Term limitations

Once specific hospital statistics and concerns are identified, information is exchanged until both parties agree to the terms and scope of work presented in the RFP. Whether the hospital issues a RFP or conducts its search in an informal manner, the following steps will be initiated:

Step I - Information is requested by the potential alternative (vendor):

- Current arrangements: number of providers, MD/CRNA ratio
- Adequate/optimal coverage requirements: OR's, OB, Out of OR coverage. Hours per day/week to be covered
- Surgical case type and volume
- The hospital payer mix, broken out by surgical inpatient/outpatient and OB
- Monthly OR schedule indicating cancellations, after hours, weekends and "add-ons".
- What has prompted the hospital to consider an alternative to its current group?

Step II - Operational and financial analysis is performed by vendor:

- Professional billing revenue projections
- Proposed staffing scenarios; List options
- Local market survey and cost analysis; vendor determines direct compensation, billing, overhead and margin to be used as assumptions
- Site visit to meet with:
 - OR director, Chief of Surgery, CFO, CNO and CEO
 - Current anesthesia chief and providers

Step III – Vendor prepares results of analysis

- Create a proforma: revenue vs. costs, amount of subsidy detailed
 - Full disclosure to hospital and any assumptions explained and documented
 - Cost items including profit margin should be separately identified
 - The proforma may be shared and discussed with hospital administration prior to the group submitting a response.
- Proposal or RFP response would include:
 - Financial terms, if necessary how will financial support be provided?
 - Income guarantees
 - Fixed stipends
 - Volume or reimbursement adjustments
 - How will issues of leadership and management be addressed?
 - Chief
 - Providers: employees or independent contractors

The reputation and the clinical and administrative expertise of a group are critical when reviewing the responses to the RFP. There should be evidence of strong leadership and clinical excellence, with the ability to maintain staffing levels. It is essential that hospitals evaluate the turnover rate of their providers to determine their ability to recruit and maintain staff during the course of an agreement. Hospitals should request

references, testimonials and case studies, making sure to find out how many clients a potential group currently has and the length of time they've provided services for them.

The financial stability of a group often determines how much structural support can be gained by a hospital. Functions such as billing, credentialing, recruiting, finance and legal are performed in-house and are rarely outsourced when dealing with a financially secure provider. A larger anesthesia group, that has the infrastructure to build a solid foundation, tends to present less risk to the hospital and encourages future growth.

So what types of organizations should be considered? One possible alternative is to bring in a management-only organization. Under this type of arrangement a company would provide management services such as billing, payroll and third party negotiations, but the group would remain and maintain its legal identity. This works well if the issue is the lack of management functions as opposed to leadership. If leadership is the problem, options may include another local provider, a large regional group or an anesthesia practice management company (APMC). APMCs are typically owned by investors, and possess the capital resources to effectively expand hospital services.

Some hospitals are apprehensive when presented with the option of an APMC. They fear these groups may come into their facilities without being sensitive to their culture and traditions, thus causing disruption and controversy. It is important to understand that the primary goal of a reputable APMC is to bring talent into the framework of the existing organization to meet the expectations of the hospital. Understanding the process of how an APMC integrates its services into a hospital or medical facility may allay concerns related to the transition.

Proceed with Integration

When an alternative provider has been selected, the detailed contract negotiations begin. Legal issues involving malpractice requirements, indemnity, non-competition and termination clauses are frequently the subject of negotiation.

How the transition will be handled needs to be decided and clearly understood by both parties. Most new groups or APMCs will eagerly sign up the existing, qualified providers if they are not contractually precluded from joining the new group. The start date begins when there is a written contract that allows the new group to "sign up" new providers. For most situations, it will take somewhere between three and nine months to fully staff. The hospital must be aware that using extended locum coverage can be costly.

The ability to recruit and construct a new anesthesia care team is ultimately the test. The group should have access to national recruitment resources. Several APMCs have subsidiary companies that specialize in permanent and locum recruitment and thus have a continuous pipeline of candidates in front of them.

Any change in an organization is difficult, and a lack of information creates greater uncertainty about the outcome. The surgical staff will be the most apprehensive, and wonder, who will be at the head of the table? What are their qualifications? The new

group should be comfortable and adept at meeting this challenge. They should speak with all surgeons and staff to explain what will happen and why the new group will be a welcome change. Everyone must be aware that there will be some transition period with new faces, but the new providers will be highly qualified and motivated to meet the demands of the surgeons and hospital.

The most important decision by the new group and hospital administration will be the identification and recruitment of a new chief. The chief may be a physician from the hospital's present anesthesia staff or someone brought in from the outside. The recruitment of a chief may not occur until after the commencement of services. Some groups or APMCs, like Sheridan Healthcare, have a pool of veteran leaders who step into start-up situations and provide reassurance and effective leadership in the interim.

When a hospital makes the decision to change its anesthesia provider there are several factors to consider. They need to educate themselves, understand their consequences and define their expectations to get ahead of the game. Market forces will continue to influence provider availability and coverage, but selecting a group that is financially stable, professionally managed with a solid infrastructure and effective recruitment will ensure less risk and bring about the operational stability and productive relationship hospitals seek.

For more information, or for a request for proposal, please contact Sheridan Healthcare, Corporate Development department: 877.707.4545 { [HYPERLINK "mailto:corporatedevelopment@shcr.com" }](mailto:corporatedevelopment@shcr.com) }.

“Sheridan Healthcare” includes Sheridan Healthcare, Inc. and its subsidiaries and affiliates.

References:

1. Wall Street Journal, “*Once a Hot Specialty, Anesthesiology...Fewer Jobs, Lower Pay*”, March, 1995.
2. Reves & Greene, 2001 *Anesthesiology and the Academic Medical Center*, Spring 2000.
3. Mayo Clinic proc. Schubert, Eckhout et al., 2001
4. MGMA, *Cost Survey for Anesthesia Practices, 2006 Report on 2005 Data*
5. Clinical Advisory Board, “*Navigating the Anesthesia Shortage*”, 2005
6. Jody Locke, *When does an administrator typically look to outsource anesthesia?* Presentation, ASA Practice Management, 2005.
7. Lockhart, Asa, Presentation, ASA Practice Management, 2005