Anesthesia Demographics Past, Present and Future?

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Objectives:

• Participants will learn about the changing demographic of anesthesia practice in the US
• Participants will learn to anticipate positioning your practice for the future
• Participants will gain understanding of the cultural history of anesthesia practices and planning for the necessary changes the future will bring
• Participants will learn strategic planning for anesthesia group practice future
• Participants will engage in predictions of what the future might look like, and strategies for confronting

Conflicts of interest:

• I have no disclaimers

Data Sources

• ASA
  – From surveys of graduating residents
• MGMA
  – Surveys of members
• CU Resident Graduates
  – Recently obtained
  – Preliminary study
  – unpublished

Background:

• I spent the first 27 years of my professional career in private practice in South Florida
• I am presently (for the past four and one half years) endeavoring to be an academic anesthesiologist at the University of Colorado School of medicine in Denver Colorado

Traditionally anesthesia groups:

• Owned by MD providers
• Niche Market, i.e. local
  – One or more hospitals
  – Ambulatory centers
  – Physician offices
• Lean overhead
  – Billing expenses
  – Malpractice insurance
• Primary objective
  – Job security
  – Preservation of income and lifestyle
  – Maintenance of status quo
• **Evolution**
  • One person (man) individual practices that coordinated to cover facility sites and call.
  • Encouraged (read coerced) by hospitals to form group practices
    – Facilitates negotiations on behalf of hospitals

• Culturally the tradition of individuality persists

• **Tension:**
  • Individuals make *clinical* decisions
  • Group makes *practice* decisions

**Currently**-

• As of April of 2017 eight entities employed more than 22 percent of all anesthesia providers in the US

*Greenfield, MD and Locke, MA; ABA Communique, Volume 22, Issue 3*
Why Size Matters

- Better contracts with insurance provider
- More leverage in negotiations with facilities
- Cost of billing and compliance
- More health care facilities are part of large networks
- Greater security due to size and scope

Payer mix Comparison Commercial:
MD owned vs. Aggregate

Payer mix Comparison Medicare:
MD owned vs. Aggregate

Payer mix Comparison Medicaid:
MD owned vs. Aggregate

Strategy
The market for anesthesia services in the US has been traditionally bound by regional “cultural” differences

- The anesthesia care team model were more common in the South and East, much less so in the West.
- Anesthesia groups in the Mid-Atlantic region actively pursued opportunities to provide services endoscopic for endoscopy and endoscopic centers. Practices in the west, particularly California, avoided.

Growth

- Challenges the fundamental nature of anesthesia groups-
- Anesthesia practices traditionally were professional associations with limited business and professional management
- Managing a practice of 100+ providers is drastically different from 10-20 (old mom & pop shop)

Professional Management

Size does not guarantee success
Goal no longer income and lifestyle
Security and Predictability (long term goals) prioritized

Strategic Planning

- Anesthesia could, in the past, be synopsized as the service of safely managing patients during surgery
- Quality was defined as safely and comfortably getting the patient through surgery

Strategic Partnership

- Hospitals: “We will provide you with work”
- Anesthesiologists: “We can provide optimized quality experience for your patients and facilitate your opportunities to attract more patients-increase your market share”
What hospitals think of us-

- Over-paid
  - Make a lot of $$
- “Carpetbaggers”
  - We don’t have to go out and solicit business, just comes to us (through them)
- Lazy
  - All we do is sit there, surgeon does all the work

Strategic Partnership

- We must seek to offer Value in our relationships with hospitals and health care institutions
- We must make sure these same hospitals and health care institutions are aware of our contributions

Leverage Anesthesia group brings to hospital:

- Data
  - Manage Data Base
  - Run OR’s and off OR sites efficiently
  - Work 1:1 with surgeons
  - Improve efficiency
- Customer Satisfaction
- Quality
  - No longer anecdotal
  - Must be empirical and measurable

Strategic Partners

- Anesthesia groups should have a thorough understanding and command of data relative to our sites of service
  - Including, but not limited to OR’s, L&D suites, endoscopy, CVCU, Radiology suites and any other non traditional places we provide service
- Anesthesia must share this data with the hospitals and health care systems we partner with to optimally prove our value.

The second law of thermodynamics=US Health Care
Future Prognostications

Anesthesia Apparel of the Future

The Future of Anesthesia Practice?