**Anesthesia Demographics: Past, Present and Future?**

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**Objectives:**

- Understand the changing demographic of anesthesia practice in the US
- Anticipate positioning your practice for the future
- Understanding the cultural history of anesthesia practices and planning for the necessary changes the future will bring
- Strategic planning for anesthesia group practice future

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**Conflicts of interest:**

- I have no disclaimers

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**Data Sources**

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  - unpublished

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**Background:**

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

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**Currently:**

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

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*Greenfield, MD and Locke, MA; ABA Communique, Volume 22, Issue 3*
• 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

Evolution

- Culturally the tradition of individuality persists
- Tension:
  - Individuals make clinical decisions
  - Group makes practice decisions

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

Group Ownership: Physician vs. Hospital

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CU Residents Entering Job Market vs. Pursuing Fellowship, 2011-2017

Of the 90 resident physicians who graduated from 2011-2017:
- 54% chose to enter the job market
- 46% chose to pursue a fellowship

MGMA: Anesthesia groups by size 2010-2016

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Is BIG better?

- 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
- Greater Flexibility

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 summarized as the service of safely managing patients during surgery
- Quality was defined as safely and comfortably getting the patient through surgery

**Strategic Planning**

- Moving into the future we should be engaging ourselves as strategic partners with our hospitals and health systems
- Leveraging our greatest attributes:
  - The ability to keep the patient comfortable and secure throughout the surgical experience
  - Anesthesiology has the greatest potential to positively influence the patients experience

**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-payed
  - 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

**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.

**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

**The second law of thermodynamics=US Health Care**

**Resources:**

- Stein EJ, Mesrobian JR, Abouleish AE. The 2015 job market for graduating anesthesiology residents. ASA Newsletter 2016;80(1)20-24
- Stein EJ, Mesrobian JR, Abouleish AE. The 2014 job market for graduating anesthesiology residents. ASA Newsletter 2015;79(6)54-47
- Stein EJ, Mesrobian JR, Abouleish AE. The 2013 job market for graduating anesthesiology residents. ASA Newsletter 2014;78(4)44-47
- Greenfield, MD and Locke, MA; Strategy and Adaptability in a Competitive Market: Lessons from the nation’s largest anesthesia organizations. ABA Communique, Volume 22, Issue 3
- MGMA (Medical Group Management Association): Databank 2018
- Steven Zeichner, MD Anesthesia Demographics: Past, Present and Future?