Reducing the Cost per OR of Anesthesia Coverage

Kentucky/Ohio Anesthesia Managers Association

KOAMA

ATLANTIS – NASSAU, THE BAHAMAS

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Why should practices be looking at lowering the cost of operating room coverage?

- Increase income of physician practice owners.
- Reduce the need for hospital support.
- Security – Stay competitive in a competitive environment.
- Remain independent.
- Acquire practices with high operating costs.
- Plan for a future with lower reimbursement and more patients.
Methods to Improve Practice Finances

• Increase Revenue
  – Patient Revenue
  – Hospital Support

• Reduce Costs - This will be the focus of our presentation
Why Focus On Reducing Costs?

• Costs are more controllable by the practice than revenue
  – Difficult to increase contracted payer rates
  – Government rates are flat and declining
  – No control over surgical volume
Why Focus On Reducing Cost per Operating Room?

• Hospital/Surgeons Control Number of Operating Rooms

• Practice can exercise some control over resources used per OR
  – Anesthesia staffing is based largely on the number of ORs covered
Assumptions For This Presentation

- Group Practice with current or potential CRNA staffing
- Group with exclusive anesthesia contract with hospital
- We are not addressing OB, pain management and critical care
- We are not covering multiple anesthesia groups at hospital
### The Problem of the “Gap”

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Patient Revenue</strong></td>
<td>$10,000,000</td>
</tr>
<tr>
<td><strong>Personnel and Overhead Costs</strong></td>
<td>$12,000,000</td>
</tr>
<tr>
<td><strong>Net</strong></td>
<td>($2,000,000)</td>
</tr>
</tbody>
</table>

**Options:**
- Hospital Support
- Decrease Expenses
- Both
What Is an Operating Room?

- Number of simultaneous anesthetics agreed to be covered by group
- OOOR locations can be problematic
- Weekend, night and call coverage are built into main OR weekday coverage
- Definition of the number of anesthetizing locations needs to be clear in group contract with hospital
Operating Room Cost Model

- Number of MDs times MD total compensation
- Plus number of CRNAs times CRNA total compensation
- Plus ancillary Staff Cost (RNs, ARNPs)
- Plus billing and Corporate Overhead
- Divided by Number of ORs covered
- (OB, Pain, Pre-op clinic personnel and other costs excluded.)
## Examples - Per OR Cost Calculations

<table>
<thead>
<tr>
<th>Cost Per ORs vs. CRNA:MD Ratio</th>
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</thead>
<tbody>
<tr>
<td>OR's to Cover</td>
</tr>
<tr>
<td>OR's to Cover</td>
</tr>
<tr>
<td>MD Total Comp.</td>
</tr>
<tr>
<td>CRNA Total Comp.</td>
</tr>
<tr>
<td>MD's</td>
</tr>
<tr>
<td>CRNA's</td>
</tr>
<tr>
<td>MD Cost</td>
</tr>
<tr>
<td>CRNA Cost</td>
</tr>
<tr>
<td>Total Cost</td>
</tr>
<tr>
<td>Personnel Cost</td>
</tr>
</tbody>
</table>
Total Cost per OR Dynamic Calculator

This will be demonstrated live outside of PowerPoint
Reducing Corporate Overhead

• Billing Costs
  – Review in-house operation and personnel cost
  – Outsource if billing cost is lower and collections are guaranteed to be as least equal

• Legal & Accounting

• Management

• Retirement Plan Administration Costs

• Corporate General Liability Insurance

• Corporate Malpractice Insurance
Reducing Corporate Overhead – Cont.

- Difficult to achieve large reduction in this category
- Reductions are divided among all ORs
Reducing Employee Benefit Costs

- Health Insurance
- Medical Reimbursement Plans
- Disability Insurance
- Reimbursement of Professional Expenses
- Vacation and Other Leave Pay
- Company Retirement Plan Contribution
Reducing Employee Benefit Costs– Cont.

• Benefit costs can be nearly 30% of total personnel cost
• Reduce benefits of non-owners
• When reducing, do not limit owners’ tax benefit
The Problem of Daily Variance in ORs Open

• Is the variance predictable?
  – E.g.. Fewer cases on Monday and Friday
  – Surgeons on vacation

• Can variance be determined one or two days in advance?

• Can staff be adjusted to meet daily variance

• Can staff cost be cut when ORs are not open?
Deliberate Understaffing

• Example: 22 ORs but 2 frequently unused
• Staff for 20 ORs and when 22 are needed . . .
  – Increase normal CRNA:MD ratio
  – Move cases around / delay a case
  – Bring in post-call MD
  – Poll personnel on vacation
  – Local locum pool
The Problem of ORs Running Late

• Is the variance predictable?
• What is the least costly method to cover late hours?
  – CRNA OT, 10-12 hr. shifts, staggered shifts
• Who covers late? CRNAs, MDs?
• Less costly to have MDs cover late hours
Reducing Non-Owner Clinical Personnel

- Employed Physicians
- CRNAs
- RNs / ARNPs
Reducing CRNA Overtime

• OT only after 40 hours
• Closely manage schedule and CRNA time
• Put CRNAs on salary with a target of 40 hours
• Shift cases to earlier hours
• Managing weekend overtime
Reducing CRNA Hours

• Send CRNAs home early
• Cancel overtime days
• Don’t guarantee full days, including Saturdays
Change CRNA: MD Ratio

- Will need to employ more CRNAs
- Number of MDs reduced over time
- Determine if employed MDs are economical
- Easier to implement when adding ORs and hiring CRNAs instead of MDs
Change MD Compensation Model

- Change from “equal pay for equal work”
- Incentivize doing cases instead of going home
- “Eat what you kill” system
- Sell or auction call & weekends
- Multi-tier system (junior partners)
- Long step into full equity partner
- Costly buy-in
- Eliminate pay for administrative tasks
Change Practice Ownership Model

- Reduce number of owners, usually by attrition
- Convert to ownership by few, paying employed MDs a lower salary
- Merge with another anesthesiology group – economy of scale
- Sell or give practice to practice management company
Implement “Collaborative” Model

- Some ORs are covered by independent CRNAs
- CRNAs billed as independent will reduce reimbursement slightly
CRNA Scheduling

• 10- and 12- hour shifts
• Late start
• Second shift
• Flex staffing
• CRNAs from “pool”
Flexing doctors

• Who should be sent home w/o pay first?
  – MDs
  – CRNAs

• Non-guaranteed vacation – MDs may be called to work when on vacation for extra pay

• Pool of occasional doctors
# Use of Day Docs

<table>
<thead>
<tr>
<th>Total Comp</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>$300,000</td>
<td>Day Doc</td>
</tr>
<tr>
<td>$500,000</td>
<td>MD</td>
</tr>
<tr>
<td>$200,000</td>
<td>CRNA</td>
</tr>
<tr>
<td>$450,000</td>
<td>(MD + 2*CRNA)/2</td>
</tr>
<tr>
<td>$366,667</td>
<td>(MD + 3*CRNA)/3</td>
</tr>
<tr>
<td>$325,000</td>
<td>(MD + 4*CRNA)/4</td>
</tr>
</tbody>
</table>
Eliminate RNs, ARNPs, Administrative CRNAs, Administrative MDs

- Will probably slow down cases
- Hospital could employ or pay directly for these workers
- MDs owners will need to donate administrative services
Locum CRNAs and MDs

• Don’t use
  – Drawbacks

• Do use
  – Benefits

• May depend on the current cost of locums
Sharing Benefits of Lower Costs

– With owners
– With hospital
– Divide between both
How Difficult Are These Measures to Implement? (cont.)

Less Difficult

• Fewer Partners
• Partners retiring soon
• Current low CRNA:MD Ratio or all MDs
• Partners motivated to work hard for more pay
• Hospital threatening group
How Difficult Are These Measures to Implement?

More Difficult

• Many Partners
• Current high CRNA:MD Ratio
• Partners prefer “life style”
• Difficult CRNA market
• MD don’t want to work with CRNAs
• MDs unwilling to accept higher medical direction ratio
What If?
Hospital Employs Group

- Personnel benefit costs would decrease
- More personnel would probably be needed
- The CRNA:MD ratio would be increased
- Independent CRNAs may be used in some locations
- Hospital may eventually reduce number of ORs covered to cover increased costs
Group Taken Over by Practice Management Company

Goals would be to stabilize hospital stipend and ... Squeeze out 10-15% profit by implementing above techniques ... with all MDs as employees
Conclusion

• How dire is your current situation?
• What is your time frame for lowering costs?
• Are you prepared for employee pushback?
• The employment market has changed
• Brace yourself for the new paradigm in healthcare delivery and reimbursement