

VSA Wins ASA Component Society Award

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Assessing Your Practice's "Vital Signs": Analyze, Compare, and Improve

By G. Montgomery "Monty" Baylor, MD

Anesthesiologist and Pain Physician,
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Dr. Baylor

Many physicians think their practices are well run, if not exceptionally run. Over the years I have discussed this with my colleagues and the consensus has been consistent. The majority of issues related to practice management difficulties are external (i.e declining reimbursements, government regulations, unfair hospital competition etc.) Rarely are internal issues considered or explored. How does one know if their practice is optimally run?

I am honored to have been asked to write and coordinate a quarterly column in our newsletter about these very issues and aggregate experiences from our colleagues that are instructive and useful. I thought a good way to start would be to discuss a general framework about how to analyze performance in individual practices, set benchmarks, and assess metrics.

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Consolidation in Healthcare: Implications for Anesthesiologists

By Judith Jurin Semo, PLLC



Judith Semo

Consolidation continues in all sectors of the healthcare industry, with new hospital and healthcare system affiliations, physician practice mergers and acquisitions, and payer combinations.

New alliances also are being created across service lines, as illustrated by the CVS-Aetna merger, the Humana collaboration with Walgreens, and the Cigna acquisition of Express Scripts.

New strategic combinations are occurring that are anticipated to transform the delivery of healthcare, such as the new venture formed by Amazon, Berkshire Hathaway, and JP Morgan aimed at lowering employees' healthcare costs, and the strategic partnership between the Walgreens Boots Alliance and Microsoft, which will test "digital health corners" in some Walgreens stores.

What are the implications of these new combinations? Although it may be too soon to know how these new partnerships will affect the delivery of healthcare services, the anticipated effects of these new combinations include more value-based initiatives, the increased use of data analytics, and different access to healthcare services for patients. Another result of these combinations may be a potential change in the payer mix at existing healthcare facilities.

Anesthesiologists need to consider the implications of the ongoing consolidation

in the healthcare industry for their practices.

Anesthesiologists may think that these new combinations and the consolidation among hospitals really will not change their practice, as patients will continue to need surgery and to come to hospitals, ASCs, and physicians' offices for care. Although the ultimate effect of the many changes in the healthcare industry may not be known, anesthesiologists need to be aware of how these changes may affect the facilities at which they practice and their practice opportunities.

The consolidation among hospitals and hospital systems is particularly pronounced. According to February 2018 testimony before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, "There have been 1,519 hospital mergers in the past twenty years, with 680 since 2010." Consolidation activity continues unabated in 2019, with the Beth Israel Deaconess Medical Center/Lahay Health and the Dignity Health/Catholic Health Initiatives mergers.

Changes in service lines/changes in hospitals. As hospitals affiliate with larger health systems, there is the potential for the system to consolidate services in certain system hospitals, which may result in a shift in service lines at system hospitals. There is also the potential for smaller hospitals or less well-utilized hospitals to be converted into other types of non-acute care facilities.

Increase in uncertainty

With any change in leadership, there is uncertainty regarding the direction the new leadership team may take and the changes it will implement. If a hospital at which an anesthesia group practices affiliates with

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ASA-VSA Dues Discount for Active Members in Their First Year in Practice

The Virginia Society of Anesthesiologists values our Resident members and recognizes the challenges you face as you start your career in anesthesiology.

Resident members receive a discounted renewal rate for the first year after finishing an approved anesthesiology residency program.

This special Transitional Member Fee is \$150, a \$200 discount off the Active member dues and you still receive all member benefits.

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UPDATE

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Practice Management: We All Need to Learn the Language of the Business of Medicine

By Jeffrey A. Green, MD, FASA



Dr. Jeffrey A. Green
VSA President

If you are like me, your premedical and/or medical education consisted of chemistry, biology, anatomy, physiology and mostly science or math-oriented classes.

My education did not include any economics, accounting, or finance. These business world topics are not historically included in the pre-medical or medical curriculum.

Despite changes in the medical education pathway since my college and medical schools days, there is still a paucity of information on business topics for physicians. We are doing our students a huge disservice by not educating them in the business principles they will need to practice medicine successfully in today's environment.

These business principles and their terminology are like a foreign language and unless physicians learn to speak in the language of business, we will be at a disadvantage while practicing in the modern world of healthcare. The pressure to offer value with high quality and low cost in our medical practice despite increased patient complexity is driving practice to the intersection of business and medicine.

The term "practice management" is an all-encompassing term that essentially covers everything about the practice of medicine that is not clinical. Practice Management includes economics, finance, management and accounting. It also includes communication and leadership concepts like strategy, teamwork, collaboration, negotiation, politics/policy, quality and safety as well as human resources, healthcare law, data analytics, information technology, population health and insurance.

As you can see, there is an enormous body of business knowledge that is now necessary for today's physicians to practice effectively.

Even if a physician is not going to become an expert in these areas, understanding basic terminology will help physicians speak the language of administrators, insurers and lawyers whom all physicians will encounter at various times in medical practice.

Earlier in my career, I had no understanding of practice management. By the time I realized how clueless I was about the business of medicine, I was already deep into my career and serving in various leadership roles. I was not taken seriously when sitting across the table from other non-physician leaders in the hospital. Unfortunately, this scenario is common across the spectrum of physician practice in medicine.

I was fortunate to realize my educational shortcomings, and had the opportunity to obtain a master's degree in healthcare administration. It was an enlightening experience and I now feel capable of understanding problems and being a part of solutions to challenges we face in medicine every day. I can now speak the language that sometimes means understanding numbers and figures on budget spreadsheets but more importantly, tells my colleagues in the administration that I can listen and speak to them with an educated understanding of business.

I realize not everyone can take time out of their practice to obtain a master's degree in business or healthcare administration, so what should VSA members do to educate themselves? Fortunately, there are many resources available. One of the professional organizations that has plenty of information and is very physician friendly is the American College of Healthcare Executives (ACHE). They have courses, conferences, webinars, and online educational content that are specifically developed for physicians, and they have just recently developed a partnership with the ASA.

Another place to find quality business educational products is the ASA. In addition to the certificate in business course, ASA has many educational offerings for those who want to learn more. To supplement traditional business courses, the ASA offers a Physician Leadership program. They are also offering a new program on communica-

tion, negotiation and teamwork jointly with ACHE at the start of the Annual Meeting this year.

Another great place to start for practice management is the annual ASA Practice Management meeting. This three-day meeting in Las Vegas in January is where "leaders in anesthesia practice operations will share insights, discuss common challenges and solutions, and help you stay at the forefront of anesthesia practice management." This meeting is the ultimate place to be for anesthesiologists, residents, students, and administrators who are interested in learning more about practice management to help define the future of anesthesia practice.

I also recently learned that Medscape has a Physician Business Academy with on demand business courses for physicians. I have not explored this resource yet, but this is a great example of the multiple educational options out there to meet the demands of any anesthesiologist's busy schedule.

Recognizing the importance of business skills to today's physicians, many medical schools now offer combined MD/MBA or MD/MHA degrees. However, these programs cannot enroll everyone. Therefore, some are proposing a business of medicine curriculum as part of medical education. Although it is never easy to squeeze additional learning into an already packed curriculum, perhaps a "business rotation" in the 4th year is a way to prepare for the rigors of today's medical practice.

More than ever before, anesthesiologists are challenged to meet the needs of complex patients while trying to provide cost effective, high quality and safe care. A basic understanding of business principles would be beneficial for most anesthesiologists who work in this environment.

I would urge you to look for opportunities to improve your business education and contribute to improvements in your practice. Also, if you have suggestions of other business resources for anesthesiologists or ways to improve the business curriculum of undergraduate, graduate and resident physicians, please contact me and I will share with other VSA members.

A New Approach for the VSA Update

With this issue, the *VSA Update* will be taking a new approach by addressing a topic, in the model of the *ASA Monitor*, for each edition. As long as I have been a member of the VSA and editor of the newsletter, we have taken a more “relaxed” approach to the contents. This quarter the newsletter will be on Practice Management.

I finished my residency at VCU in 1982 and went into private practice in June of 1986. How things have changed in the world of private practice since then. I’ll briefly give my opinion as to whether the practice models and climate have improved or need reassessment.

The private practice world back then was overwhelmingly physician-owned practices with virtually no large groups that employed providers in today’s models. Now we have more and more large national companies buying up anesthesia practices, and for some in the group, that amounts to a financial windfall. The other change is healthcare systems creating large multispecialty groups that employ all their physicians.

Are these changes for the betterment of the individual providers? How did we get to this in the medical world, and is this perhaps the leading cause of physician burnout that we hear so much about? This is a complex issue because of the buying up of practices, whether by national companies or the takeover by healthcare systems. Prior to the current practice models, in many specialties we never heard about physician burnout to the extent we do today. Perhaps the loss of control is a factor in burnout.

Many years ago I had the pleasure of being in the first CBA course offered by the ASA under the direction of Asa Lockhart, MD. In that year-long program, we learned a lot about the business of medicine. One thing that stood out was that the vast majority of people who go into medicine major in sciences in undergraduate school, and had virtually no interest in business.

Yet when one entered private practice after completing their training, they were entering a world where business knowledge

I wouldn’t mind being 30 years old, knowing what I know now, BUT - and this is a BIG BUT - I would not want to be entering the world of healthcare now.

did matter. We are naive targets when a slick talking person comes in and gives a sales pitch offering to manage your practice, do the billing, take care of your benefits. All you have to do is worry about being a good physician. Right???

Well, how did that work for us? We have become a specialty that, more and more, has very little to say about anything from the practice model to having a regimented plan for how we provide our care. Many of these decisions are being made by young MBAs who are great with a calculator but have no idea what we do.

When we ran our practices, it simply took a couple of physicians who had a basic understanding and an interest in doing what was necessary to keep physician control.

The simplest way to look at a buyout is that owners of the practice will receive a cash buyout while the lower level players just become employees. Perhaps the most realistic way to look at it is the group income is generally a fixed number.

When you get bought out there is still just one “money pie”. Now that money pie also goes to the company that purchased the group, leaving less for the practitioners. Again, remember that now that you are an employee you have little to do with important decisions. Another reason for burnout.

Another factor that we learned about in the CBA was the difference in thoughts and ideas of the different generations. As a baby

Welcome New Members

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Shayla Gaither, MDDumfries
Cannon Turner, MDRoanoke
Junhua Zhang, MD.....Norfolk

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Dallin Gould, DO.....Richmond
Travis Hayden, MD.....Charlottesville
Hamelma Kassahun, MD.....Charlottesville
Stephanie Keller, MD.....Richmond
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Harrison Plunkett, MD.....Charlottesville
Daniel Ridley, MD.....Charlottesville
Harrison Wade, MD.....Richmond
Amanda Williams, MD.....Richmond

We Need Your Help

All 140 seats of the state legislature will be on the ballot this November, so it’s a crucial time to support VaSAPAC.

Contributions to the PAC will help to raise the visibility and profile of anesthesiologists, connect you to new and returning legislators, and continue to build productive relationships with key General Assembly members.

**Please make a contribution at
vsahq.org**



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VSA Receives ASA Component Society Recognition Award at August Board of Directors Meeting

By Jeffrey A. Green, MD, FASA

VSA President

Acting ASA Director

VSA received the ASA Component Society Recognition Award (in the large-size component category) for its submission on an “Advocacy Accomplishment – defeat of harmful balance billing legislation and budget language”, in the Advocacy Initiative area.

This is the first year the awards were offered. The award carries a \$1500 prize that can be used for new or ongoing member engagement initiatives or programs.

Dr. Jeffrey Green, VSA President, accepted the award at the Board of Directors meeting in Chicago on August 18. Lauren Schmitt, VSA lobbyist, gave a presentation about the advocacy accomplishment at the ASA Component Society Summit on Aug 18.

This award is recognition of the multi-specialty effort by physicians, patients and hospitals in Virginia to defeat the harmful balance billing legislation that was offered in the last General Assembly session.

Although we were not successful in passage of the language that VSA and other medical specialties supported, this outcome was viewed as a success for the House of Medicine.



ASA CEO Paul Pomerantz; VSA President Jeffrey Green, MD, FASA; ASA President Linda Mason, MD

There is a balance billing workgroup that was created with language in the Governor’s budget that will convene this summer in a further attempt to resolve this issue. There is currently balance billing legislation being debated at the Federal level, and you are

encouraged to contact your legislators.

Special thanks for work on the award application to James Pickral and Lauren Schmitt at Commonwealth Strategy Group and Stewart Hinckley and Andrew Mann at Ruggles Service Corporation.

Encourage Your Practice Administrators to Join VSA

The VSA encourages your practice administrators to join! We have two options:

1

If 90% or more of a group’s physician anesthesiologists are VSA Active members in good standing and all members will be on a single group bill, the annual dues are FREE.

2

If less than 90% of a group’s physician anesthesiologists are ASA Active members in good standing, or the group does not participate in group dues billing, the annual dues are \$75.00

To have your practice administrator join, go to: <https://www.asahq.org/member-center/join-asa/educational>

- On this page, click on the category you’re interested in – in this case, its: Anesthesia Practice Administrators and Executives – Educational Member
- Click on the + sign next to the title
- The box that opens, will contain full details and the membership rate(s)

How Your Anesthesia Practice Can Add Value to Your Hospital and Avoid Cuts

By Martha Kelley, MS, CMPE

Administrator

Virginia Anesthesia and Perioperative Care Specialists, LLC



Martha Kelley

Every anesthesia group would rather not have to depend on money from their hospital to make ends meet, and there are a lucky few who don't. Government payors account for anywhere between 35 – 50% of a

group's payor mix, and we all know those payors do not even cover the hourly expense of a nurse anesthetist.

What happens when the hospital says, oh by the way, we are reducing your stipend by \$XXX and you will just have to live with it?

This scenario is happening more and more frequently due to hospitals' tightening their budgets and viewing hospital-based anesthesiologists as vendors rather than true partners. We all have seen hospitals bend over backwards for referring physicians; more blocks, less call, office space, etc. But which physician group is in the hospital caring for their patients 100% of the time – anesthesia.

Anesthesia groups have implemented the Perioperative Surgical Home and Enhanced Recovery After Surgery protocols (to name

a few programs), which both dramatically improve patient outcomes and reduce lengths of stay, bringing value and cost savings to the hospital. But it doesn't seem to be enough.

So, what's next?

There are several avenues to explore to make sure you are bringing value and controlling your costs. Are you staffing efficiently to meet the coverage requirements laid out in your contract? I would bet most groups are but OR utilization is probably running below what is needed for revenue to exceed expenses. This is where sound data comes into play.

We all know utilization data from our billing systems is always lower than the hospital's data, as they do not account for turnover time, late surgeons, equipment failures, local anesthetics, etc. Hit the hospital with the facts through data. Show utilization by the day of week and time of day to accurately reflect the number of OR cases.

Most hospital administrators will be shocked to see they aren't running eleven concurrent rooms every Monday at noon, more like seven or eight. Based on that data, work with the hospital to reduce the amount of downtime in the OR's, saving time and money for both entities.

Our first reaction to any request for stipend reduction is to say, "we can't". Before you get to that point, take a hard look at what you may be able to do to reduce expenses. It may be cutting some services to the hospital.

Is anesthesia taking on critical care duties with no compensation? Available 24/7 for codes while there are highly qualified ER staff that can handle those? Staffing three OR's well into the night when only two are needed? Negotiate, negotiate, negotiate!

Develop a relationship with administration that enables any anesthesiologist or administrator to stop by the C-Suite to chat about what's going on in the ORs, outside of a formal meeting.

The norm was for anesthesia to keep their heads low and plow through, don't make waves and go with the flow. Less seen, less heard was the best way. That is not the case any longer. Be active in as many hospital programs as possible, put anesthesia in the forefront as a highly valued and needed partner in the OR's and beyond. Be the best so the surgeons and nurses can't fathom not having your group take care of their patients.

Unfortunately, even after all that the hospital may decide to put out a Request for Proposal (RFP). If you have truly analyzed your costs along with OR utilization, developed trusted relationships, and made yourself invaluable to the hospital, it is highly doubtful another group could come in and take your business for the same quality with less cost.

Stick your neck out and be sure you know how anesthesia is viewed in your hospital and/or Ambulatory Surgery Center (ASC); it may save your job.

ASA August Interim Board Meeting Summary

By Jeffrey A. Green, MD, FASA

VSA President

Acting ASA Director for the August Meeting

The ASA held its summer Board of Directors meeting in Chicago on August 17 and 18. Each state, as well as some of the organizations within ASA, are represented. This session is a chance for the Board members to learn about the latest issues of importance to the ASA, obtain education on the activities of the ASA administrative council and executive officers, vote on items of business and network with colleagues. This is one of the three meetings held annually.

Highlights included the unveiling of a new ASA communication strategy emphasizing the role of anesthesiologists to various

stakeholder groups. This campaign is aimed at employers, the public and others in health-care. The ASA is allocating money from strategic reserves to promote this effort.

The ASA added scientific discovery as a new pillar in the strategic plan and made it a priority for 2020.

The ASA finances are strong, led by investment gains, but expenses continue to grow along with the size of the organization. The Board authorized the treasurer to have discretion to use some of the gains from investments to pay off some of the mortgage on the ASA headquarters building in Schaumburg, IL when market conditions are favorable.

Finally, the board received an advocacy update from the Washington office on issues

such as balance billing, Medicare-for-all, payment reform and scope of practice.

There were various issues debated by the Board in the reference committee hearings including reforming the ASA committee selection process and committee composition, changes to membership categories, the merits of an incremental vs. sustained dues increase, and the expansion of education for residents on advocacy.

There was substantial debate about the revised statement on the anesthesia care team and the new guidelines for surgical attire. Both will be hot topics for the House for Delegates meeting in October. The Board of Directors will meet again at the ASA Annual meeting in Orlando in October.

Leadership Philosophy: What makes a great leader?

"The people who are crazy enough to think they can change the world, are the ones who do." - Steve Jobs

By Brooke Trainer, MD
Associate Editor

What makes a great leader? Taking a leadership course? Experience? Natural Instinct? The key to being an effective leader lies in mastering a wide range of skills from effective communication, listening skills, strong work ethic, to the ability to organize, encourage, and motivate others.

These skills are not innate in all of us. Even those with plenty of experience or professional leadership training may fail. Leadership is such an important aspect of any project or business's success that books upon books have been dedicated to the topic.

Jim Collins, author of *Good to Great*, notes "Humility plus will—that is where the essence of leadership begins". An experienced leader knows they can't do it all—they learn how to play to their own strengths and find others to fill in for their weaknesses.

In this issue on practice management, I wanted to take the opportunity to touch upon one aspect of business necessary in every successful practice: effective leadership. The fact is, whether you work in a hectic office or a busy hospital environment, you need to know how to effectively lead and manage other people to be successful.

Here is a summary of four common characteristics found in effective leaders.

Experience



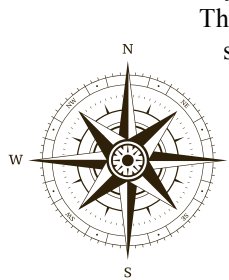
Experience allows leaders to be more comfortable in taking chances and more confident in making a decision. Inexperienced leaders may hesitate or become indecisive and ultimately never act on a decision.

General George S. Patton may have said it best, "A good plan executed now is better than a perfect plan executed too late". Experience can allow a leader to become more confident that they are moving the

organization in the right direction. Experienced leaders learn how to stack the deck with advocates who support their mission, yet are able to accept constructive criticism along the way.

In contrast, an ego or overconfidence can lead to disastrous consequences. Overly confident leaders fail to recognize warning signs or read social cues. They are usually too preoccupied with their own needs and wants to see the turning of the tides.

Communication Style



Though communication styles may differ, most important is the ability of the leader to deliver compelling messages, which motivate others to participate and perform.

Communication is the compass of leadership. Clearly articulated goals help keep groups on track and organized. It allows people to know what is expected, valued, and appreciated. These clear directions allow the organization to be more productive. Effective communication also helps people remain organized, track progress, and discuss openly.

When new ideas are being developed, it is important to clearly define mission objectives and review them at every step along the way with involved essential personnel, especially when these other personnel are of equal or greater power and authority. This monitoring of progress with regular checks and balances avoids potential miscommunication errors and assures compliance with intended goals and model structure.

When one person in a team disagrees with the direction of the project, it is best to have a direct discussion over the issues with other team members, rather than utilize your power and position to make decisions alone, especially if they are in contrast to what the group decides. It is best to never assume you know more than others, or worst, to use this

as an excuse to deviate from a plan.

Instead, it is wise to listen to the reasoning of others, even if you disagree initially, always conducting yourself with humility and humbleness, and maintain integrity by communicating your thoughts and intentions directly. Effective communication is such an important aspect of management that a multitude of workshops have been established to help leaders hone and refine these skills.

Values

A person's own set of values, beliefs, and principles are the fundamental elements influencing how they interpret reality, and guiding their understanding of others.



Capable leaders have a vision of where they are leading and are able to instill a larger sense of purpose within the organization. Without a vision, there is no purpose. Effective leaders value strong work ethics, lead by example, and demonstrate a commitment to the mission or institution beyond that of self-preservation. They are willing to put in the extra hours needed to accomplish goals.

Col DeMarco, Vice Commandant of the US Air Force Office Training School teaches future commanders, "A great commander works for the squadron, for the group, for the wing... not the other way around." Leaders need to learn how to bring all their talents, passions, intellect, energy, time, and resources to the table.ⁱⁱ

These things become the tools in which leaders are able to build their organization. These tools can help a leader ensure their subordinates have the vision, guidance, and support they need to accomplish the mission.

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or is acquired by another hospital system, there may be concern about the direction the new system will take. Will the system look to consolidate the anesthesia contracts in a single group? Will the system look to consolidate all hospital-based physician services and contract with a large provider of hospital-based physician services (e.g., anesthesiology, radiology, hospitalist, and emergency medicine services)? Will the new system look to employ the anesthesiologists? Note that the uncertainty and unease about possible changes in direction may occur even if the planned deal ultimately is not implemented.

Changes in hospital contracting

The author has observed changes in hospital contracting stemming from consolidation. Some present opportunities for anesthesiologists. Others present challenges. And many are a mix of both opportunities and challenges.

First, a hospital system may want to have a single anesthesia practice provide services across multiple system hospitals. As a consequence, the system may push separate practices to combine. Alternatively, the system may pressure a long-standing anesthesia practice to cover one or more outlying hospitals that have low volume, a poor payer mix, and/or inefficiently run operating rooms, with unrealistic coverage expectations and insufficient financial support.

The hospital system may want to consolidate separate anesthesia agreements covering services at individual hospitals into a single “master services agreement” that covers multiple hospitals. Typically, the hospital system insists upon use of the system “template” agreement and is resistant to changes in the template. In some instances, the system anticipates greater efficiency in the delivery of anesthesia services and therefore expects financial concessions from the anesthesia practice in exchange for the master services agreement.

Second, consolidation can, and often does, result in far less autonomy at the local hospital level. Just because the CEO at the local hospital at which an anesthesia group practices appreciates the value that the group provides, it does not mean it will provide protection for the group against changes the system may want to implement. Increasingly, the local CEO no longer controls the decision regarding which anesthesia group

Although the ultimate effect of the many changes in the healthcare industry may not be known, anesthesiologists need to be aware of how these changes may affect the facilities at which they practice and their practice opportunities.

will provide anesthesia services or which changes in the system “template” will be approved. Nor does a good relationship with the local hospital leadership assure that the hospital will agree to the level of compensation the anesthesia group believes is needed.

Consolidation can result in the loss of hospital contracts, especially if an anesthesia group is the smaller one in the system, or if the group has had any performance issues. With Medicare payment now being based in part on patient satisfaction (via the scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS” survey), hospital systems are focused on having “service-oriented” anesthesia groups.

An indirect effect of consolidation is the possibly increased strength of a health system’s clinically integrated network (CIN), which can result in a shift in an anesthesia group’s payer mix, with more cases being subject to a possibly lower CIN rate.

In some cases, consolidation results in hospital employment. In some instances, the hospital system wants to move all physicians to an employment model. In other settings, the hospital system is unwilling to continue (or to begin) to compensate an anesthesia practice for services that are not self-supporting, without regard to the opinion of an independent valuator as to the fair market value of the group’s services. More than one health system has taken the position that, if it has to pay for anesthesia services, it wants complete control over the delivery of such services.

Strategies to navigate the evolving healthcare market.

The changes in where healthcare services are being delivered, how they are being delivered (e.g., telemedicine), who is providing them, and who is paying for them require rethinking of a group’s operations and its facility agreements. Although this article focuses on hospital contracts, many of the same points apply to agreements with ASCs.

Termination without cause

Termination without cause can be risky, as it can result in termination of a favorable agreement if the hospital elects to terminate the agreement. Yet, if there is a marked decline in volume at the hospital (with no change in the group’s coverage obligations), or changes in the service lines at the hospital (e.g., the move of a profitable obstetric practice to another system hospital, or commencement of Level I trauma services), the group may want to be able to terminate the contract, if coverage no longer is sustainable and the hospital is unwilling to agree to changes in the agreement. Be aware of the risks of a “no-cut” contract in an evolving healthcare market.

“No poaching”

Is there a limitation on the hospital – or a hospital affiliate or the healthcare system – trying to contract with or employ all or a subset of your group’s personnel during the term of the agreement and for some time period following termination? A “no-poaching” provision can provide protection, at least for the designated time period, against a health system moving to employ the group’s anesthesiologists and anesthesiologists or to contract with a subset of them. Such a provision may even provide protection against indirect efforts to contract with the group’s personnel through the hospital’s contract with a new group that then tries to contract with the former group’s personnel. (The group should consult with counsel regarding antitrust considerations and the permissibility of such a provision in the context of the group’s relationship with the hospital.)

Changes to coverage and triggers to review coverage

It is important for changes to coverage to be negotiated and mutually agreed upon by the anesthesia group and the hospital (or

ASC), and not simply dictated by the facility. It is in an anesthesia group's interest to identify certain occurrences as "triggers" (e.g., a drop in volume above a designated level) that will require renegotiation of coverage.

Triggers for review of fair market value and compensation

An anesthesia group may want to include a contractual provision that identifies certain occurrences that will require a reassessment of the fair market value of the group's services by a mutually agreed-upon independent consultant. If the parties are unable to agree on compensation to account for the changed circumstances, then the anesthesia group will want the ability to terminate the agreement.

Importance of not being subject to a "noncompete"

It is not uncommon for hospitals to try to limit other locations where an anesthesia group can provide services, even in non-exclusive arrangements. As the market evolves, it is critically important for an anesthesia group not to be limited in where it can provide services. It may be that the group needs the flexibility to follow cases. In other instances, a group may need to be able to find additional non-hospital sites where it can provide services to supplement its income from services at a hospital. Equally importantly, the group needs to be able to deploy staff to other locations if OR utilization at the hospital is variable from one day to the next.

Assignment and binding on successors

If a hospital can assign an anesthesia con-

It is not uncommon for hospitals to try to limit other locations where an anesthesia group can provide services, even in non-exclusive arrangements. As the market evolves, it is critically important for an anesthesia group not to be limited in where it can provide services.

tract to a new owner, and if ownership of the hospital changes, an anesthesia group needs to ensure that the hospital contract is binding on the new owner. It is important to confirm that the hospital contract contains language providing that it is binding on any assignee of, or successor in interest to, the hospital.

Right of first refusal

It is in an anesthesia group's interest to have the right to bid on other opportunities that become available within the hospital system, such as the hospital opening or acquiring an ASC, the hospital acquiring another hospital, or the decision to replace the anesthesia group at another health system facility. Ideally, the anesthesia group will want the right to provide services at that other facility and to avoid issuance of a request for proposal (RFP). There are many details to be negotiated as part of a "right

of first refusal" that are beyond the scope of this article. They include: the scope of the facilities covered, how to deal with an existing anesthesia group, compensation issues, and timing.

The only certainty in this evolving health-care market is that more change will occur. A time of enormous change creates both challenges and, for the well-positioned and highly functioning anesthesia group, opportunities. Anesthesia groups need to position themselves to minimize their susceptibility to undue risk and to enhance their ability to pursue new opportunities.

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Judith Semo is engaged in the private practice of law in Washington, D.C. As counsel to anesthesiology practices nationwide, Ms. Semo has had extensive experience in legal issues relating to the practice of anesthesiology, including contracting with hospitals and ambulatory surgical centers, negotiating compensation arrangements with hospitals, developing pay-for-performance programs, complying with Medicare and other billing requirements, drafting employment agreements, and addressing other practice management issues facing anesthesiology practices.

Letter to the Editor

Hello Dr. Rein,

I am an anesthesiologist practicing in Northern Virginia. For many years I was part of the local group that was eventually taken over by NAPA. For the last two years I have joined Kaiser Permanente. I am a regular reader of your editorials in the VSA newsletter UPDATE. I love them because you exactly express my views on several topics, especially on the role of CRNAs in current anesthesia practice.

Again, I agree 100% with your views in

the latest issue of UPDATE, titled "Political Correctness and Confronting Common Problems." Whenever I take an opportunity to speak with obese patients, I have an advantage with my (excellent, I have been told) bedside skills. I nicely and gently tell them quick basics of what they can do to help themselves. I have my own spiel.

1. Eat only whole grains-your slice of bread should have at least 2 gm of fiber, ideally more. If you eat rice, eat only brown rice.

2. No fried food.

3. No added sugar. Whole fruits are great but NO fruit juices.

4. Start eating a little less.

I am amazed by the lack of education about choosing healthy foods in many patients. That tells me there is lot of opportunity. My goal is to do whatever I can do at my individual level.

- Name withheld by request

Winchester Anesthesiologists, Incorporated (WAI)

By Casey Dowling, DO, FASA



Dr. Dowling

My name is Casey Dowling, DO, FASA and I have the great privilege of writing a spotlight on my practice, Winchester Anesthesiologists, Inc. (WAI).

Frankly, I'm thrilled to do so.

I have been with WAI 18 years, after seven years in a previous practice. This gives me the insight to recognize the superior nature of WAI, and why I have not thought of leaving since I joined in 2001.

WAI is an independent, physician-owned group delivering anesthetic services in both the physician-only, and physician-led care team models. We are headquartered in Winchester, Virginia but our practice covers the upper Shenandoah Valley and the Eastern Panhandle of West Virginia.

When I first joined WAI, we covered eight ORs in the main 300-bed hospital,



Winchester Medical Center. Currently, we have 17 ORs at the now 500-bed Winchester Medical Center, and deliver anesthesia at the remaining EIGHT Valley Health entities.

Besides general, OBGYN, urologic, bariatric, ENT, ortho, and two ambulatory surgery centers, we have Level 2 Trauma, major neuro, major vascular, robotics, and open heart (TAVRS, MitraClip, Apollo, LVADs). And then there's the NORA: Cath lab, endo and radiology to name a few.

For 18 years I've been a part of WAI, and as you can see the practice has been ever evolving. So why have I stayed? Because the mechanisms and the values of the group have always been the same.

We are all EQUAL partners. Yes, there are 32 physicians now. At one point I was the solitary female in this group and now we are almost half! Everyone has a vote, and everyone has skin in the game.

We are QUALITY driven. We use evidence-based multimodal therapies to give our patients the best care possible. When the evidence changes, so do we.

We are CITIZENS in our facilities. We show up at committees, we chair committees, and we communicate frequently with surgeons and administrators. Let's face it, we are a facility-based specialty. It is always in our best interest to be involved and to be embedded.

WAI are also CITIZENS of our community. Despite the volume and acuity of our work, WAI has always valued and cherished our time with family and friends. Therefore, we allot ourselves the time to participate in our local festivals, schools and charities.

So, there we are. WAI in a snapshot. It's funny, someone asked me "What's wrong with your practice that you always have an ad up that you're hiring? Are you churning through people?"

I was shocked. I had never thought of how the ever-present ad would look to an outsider! Well, now you know. There is nothing wrong with my practice! We're growing. We're hiring. Are you looking for a job?

Anesthesiology Past and Present

Introducing a New History Feature

By Christa L. Riley, MD

Assistant Professor of Anesthesiology
Virginia Commonwealth University Health System

Welcome to the newest column in the VSA quarterly newsletter: Anesthesiology Past & Present.

The column will focus mostly on the history of anesthesia in the Commonwealth, but there is no way to tell the story of our profession in Virginia without exploring the history of our profession generally.

You may wonder, "What value is there in learning the history of our profession? Who cares whether the first ether anesthetic was performed by William T.G. Morton in Massachusetts in 1846 or Crawford Long in Georgia in 1842?"

The story of our profession's American origins is a story of creativity, discipline, a dash of showmanship and a bit of old-fashioned greed and egotism. It is well documented that Crawford Long anesthetized a patient with ether for removal of a neck tumor on March 30, 1842 in his rural Jefferson, Georgia medical practice.

He went on to perform several other surgeries with ether and expanded ether use to his obstetric patients. However, he did not publish his work until 1849 after collecting data on complications and patient outcomes. William T.G. Morton very publicly demonstrated the use of ether for painless neck tumor resection at the packed operating theatre of the Massachusetts General Hospital on October 16, 1846.

Long petitioned Congress for recognition

of performing the first use of ether, but he never received credit during his lifetime. Morton engaged in a lifelong obsession to be considered the discoverer of ether and sought to patent and monetize the use of ether, actions considered distasteful by the medical community at the time.

Again, why does this matter? Long contributed observations and data on the use of ether in multiple patient populations and surgical applications, enhancing the science of anesthesia. However crass he might have seemed to his colleagues, Morton contributed attention and focus on anesthesia, creating excitement and "buzz" that led to capital being made available to develop this new field of medicine. Both

Continued on page 12

Resident Reflections in Anesthesiology: Relationships Build a Practice

By Daniel H. Gouger, MD

Anesthesia Resident, VCU Health

and Joseph Farmer, DO

Recent Anesthesiology Graduate, VCU Health

Hunter Holmes McGuire Veterans Affairs Medical Center, Richmond, VA

The stereotype that anesthesiology as a specialty doesn't emphasize human relationships has always baffled me. I remember even writing about it in my personal statement while applying to residency. The special point about anesthesiology is our relationships with patients and the intimacy in breathing for someone. But relationships matter with more than just patients. They're essential in learning how we fit in the operating room and what kind of practice setting suits us after residency.

So, in a newsletter issue dedicated to practice management, it's worth being reminded of just how much of our practice is relationship driven—and that it starts early.

When reflecting about his endeavors getting into practice and talking about his initial job search, Dr. Joseph Farmer said, "As a non-traditional resident, my method for finding a good fit post-residency may not apply to all, but hopefully there are some things that can be useful as you begin your search. The best steps for me were identifying target groups, making a personal connection to the group, and visiting the site. And I don't recommend waiting on a position to be advertised before starting the process." Dr. Farmer accepted an attending general anesthesiologist position to start this year at Hunter Holmes McGuire Veterans Affairs Medical Center in Richmond.

As an early-minded CA1, my focus tends to center on simple workflow competency and efficiency: putting the tube in the right place, programming pumps, priming tubing, checking machines, and remembering to adjust agent flows. But the salience of Dr. Farmer's point is not to lose sight of the forest for the trees. We should be deliberate about career planning, and that is something that can start early in residency, even if it's something as simple as updating a CV every six months.

"Early on, I determined my target groups by talking to anesthesia staff that had worked

Mastering foundations of clinical anesthesia is important as a junior resident. It's also paramount to cultivate relationships with career advisers, faculty mentors, and everyone else with whom we interact, and to do so with purpose.

at other places in the area. Through these conversations, I was able to get an idea of practices that were a match with my personal preferences and professional goals," Dr. Farmer said. He also advised that, "Spending time on a recruiting site like www.gaswork.com can give you an idea of the groups in a target area and the salary potential. It can also give you an indication of hard-to-fill spots that may [not] be desirable. I tended to question jobs that were posted for long periods of time by multiple sources."

For me and my level of training, that translates to understanding available resources and building professional relationships with perioperative services staff. And I should do that intentionally. Mastering foundations of clinical anesthesia is important as a junior resident. It's also paramount to cultivate relationships with career advisers, faculty mentors, and everyone else with whom we interact, and to do so with purpose.

Dr. Farmer continued to describe how he laid the initial groundwork during his job-hunt experience, saying, "I started reaching out to my top target practices during the second half of CA2 year. The early contacts were to have casual conversations and to make sure the group knew of my interest in case they had an opening in the next year and a half.

"At places where I had no prior contacts, I worked to find people with personal friends that worked in the target groups. Most people can count on their friends to weed out bad personality issues and, for hiring managers, that is a valuable tool in the hiring process."

He continued, recalling, "My first site visit came from an anesthesia tech that I worked with that had worked for the target group and introduced me to a CRNA at the group. After spending some time talking with the CRNA, they introduced me to the group's anesthesiologist that handled hiring. With these personal introductions, it was a very smooth transition to get a site visit."

Dr. William Barrett, Regional Anesthesia and Acute Pain Fellow at VCU Health, further supported Dr. Farmer's points about the utility of leaning on your colleagues and network of professional relationships as an important part of learning to craft a practice. "Whether it's to continue growing as a successful resident or to secure a contract," he said, "Not having that relationship footing to start on can be challenging."

He went on to describe that he's done some job searching through recruiters, too. And while they have their value, it's not quite the same because it's a relationship that feels forced and isn't as reliable. Dr. Farmer added that, "Applying and interviewing for a position after you have spent time getting to know as many people at the group as you can is much easier than blind applications. It also puts you in a strong position to not only successfully get a contract, but also to know enough about the group environment so that you make a choice that works for you long term."

As Dr. Barrett, Dr. Farmer, and I all reflect about what we could do better and how to get started, regardless of training stage, there are still some knowledge gaps left unanswered, though. We all appreciate the importance of clinical competency and building relationships as foundations for success.

Nonetheless, as residents and new graduates we gain(ed) much less insight and exposure during our training years into practice management topics like understanding productivity, reimbursement, and revenue streams, or how to break down compensation models and important components of contract negotiation, or differences and similarities between academic and private practices.

Maybe that's something for which we can look to VSA programs for more guidance.

History, from page 10

contributions were necessary to advance the field of anesthesiology.

Do you remember what you were taught about the Boston Tea Party? Most of us learned some form of a story about idealistic and principled American patriots (who drank tea the way we now drink coffee) angered by British taxation on staple goods. In response, they threw 342 chests of tea into Boston Harbor on December 16, 1773 to protest having no representation in the government levying the tax.

What a heroic story! Too bad it is not true.

It is true that the British government taxed tea and stamps to help pay for British military protection from raids by natives and the French in outpost settlements, just as we currently pay taxes to fund U.S. Armed Forces' protection of American interests. It is also true that American colonists did not have representation in British Parliament, but only 3% of British subjects (20% of men) living in England at that time had representation in Parliament.

Representative government had not really caught on yet. American colonists (75% of men) actually enjoyed more self-governance than their British counterparts in England because most American colonies had established a representative government under their charters. Tea-drinking colonists were actually not paying much tea tax when they drank their tea. American colonists were largely obtaining tea that had bypassed British ports on its trip to the colonies from China.

Colonial merchants, including a man named John Hancock, were smugglers evading import taxes levied by the Crown

and selling tea at a cheaper price. When the British government decided to remove the tax and lower the price of its legally imported tea to combat the rampant smuggling, it was those same merchants that dressed up as Mohawk natives and dumped the legally imported tea into Boston Harbor.

I love this actual history so much more than the spun version we tell the next generation. The former version is only noble and pure, like an ancient myth. Are any of us only noble and pure? There is considerable humanity in the actual account and a glimpse at the kind of hubris that might be needed to create a new country from scratch.

Yes, the greed and tax evasion may taint the moral authority of the revolutionaries, but does it diminish the American experiment of self-government?

You probably know where I am going with this argument. History is not about dates or events but relationships and motivations that shape the culture and ethos of a group and its potential to influence and change society at large. History can be uncomfortable and ignoble, but it is our origin.

The discovery of chloroform and ether followed by the rigorous pursuit of the specialization of anesthesiology by surgeons more interested in their patients' physiology during surgery created the environment where surgical innovation has flourished. Scientific research is imperative to advance and improve the practice of anesthesia.

An understanding of relationships and motivations in our society benefits advocacy of the profession of anesthesiology. Procedures performed today on ever increasingly morbid patients would never be possible if

surgeons were still dividing their attention between operating and directing an assistant to drop a little more ether. The history of our profession tells the story of our valuable contributions to medicine.

To quote Jill Lepore in *These Truths*, "The past is an inheritance, a gift and a burden. It can't be shirked. You carry it everywhere. There's nothing for it but to get to know it."

Please submit comments or questions to vsa@vsahq.org

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Editorial, from page 4

boomer, my generation has a philosophy of working your way up the ladder. We didn't enter the working world after training and think we should be a full partner right away or expecting 10 weeks of vacation and more. The different generations have different values and those need to be recognized.

There is so much more, but this makes me realize that I am lucky to be doing what I am doing now. I wouldn't mind being 30 years old, knowing what I know now - BUT and

this is a BIG BUT - I would not want to be entering the world of healthcare now.

This has also made me realize it is time to turn over the reigns of the newsletter to someone more involved and not turned off by the current environment.

This opinion piece will be my last as editor of the *VSA Update*. It is time for someone more involved in the modern world of anesthesiology to assume this role. I don't even know how many years I've been the editor. I

will miss the chance to express my opinions in this manner.

The new editor will be Brooke Trainer, MD. Brooke has been co-editing for 2019 and it was her idea to go to a theme-based approach. I've been impressed by her passion and desire to do a great job as *VSA Update* editor. Please give her all your support.

THANK YOU, VSA!

It's That Easy Being Green

VSA Member Helps Henrico Doctors' Hospital With Recycling Efforts

By Will Wagnon

CEO, Henrico Doctors' Hospitals

Reprinted from *The Pulse* with permission

The small ways of doing our part are what make the larger differences possible. This coming Monday is Earth Day. The global celebration first began in 1970 when 22 million Americans celebrated clean air, land and water. Today, this annual event celebrates our environment and raises public awareness about pollution.



Dr. Varun Dixit

At Henrico Doctors' Forest Campus, Varun Dixit, MD, is a cardiac anesthesiologist who strongly believes that using the least amount of resources possible can go a long way.

Before coming to Richmond in

2017, Dixit was at a small hospital in Maine where he says there were no recycling efforts taking place in the operating rooms. Because the OR typically sees a significant amount of waste, he had the idea of starting a recycling initiative.

"It was hard for me as there was no precedence for it, so I had to start working from scratch," said Dixit. I had to find a vendor to take our plastics and determine if this was financially viable.

Dixit says he also wondered if he would get the support from others around him. His idea was to implement something simple that individuals could do in their own routine time, without going an extra step. It took him three years to start the project after months of research and trying to locate the appropriate vendor.

According to Dixit, there was an instant buy-in from absolutely everybody in the OR. During the pilot year and just two ORs that were recycling, the hospital ended up recycling 4,000 pounds of waste. Word spread throughout the hospital and by the time Dixit left his role in Maine, the hospital was recycling 180 pounds a day and almost 86,000 pounds of waste a year.

When Dixit came to Henrico Doctors', he discovered a similar situation in the ORs in



OR Recycling bags

that there was no formal recycling program. With his previous experience, albeit at a smaller hospital, Dixit was determined to initiate a similar effort. He says the driving force at Forest was Anthony Cox, former director of support services.

"I found Anthony. It took me a few months to find him," said Dixit. "He is amazing - a truly remarkable guy who was genuinely interested in helping me out and solving problems."

Dixit then teamed up with Cox and Ashley Mauck of Stericycle, a recycling vendor who helped Dixit get started. With the support of hospital administration, recycling efforts on the Forest campus began last December with two ORs. Dixit says the results were similar to what happened at his previous hospital.

"We went from nothing to 1300 pounds in just a month," he said. "The funny part is that we had a small container we were hoping to fill in just two weeks, but it now has to be emptied three times a week, because we're recycling so much waste."

Dixit says that there are tremendous benefits in that the process is user-friendly. Those who take part also feel good about it as they are showing responsibility for the environment. The initiative also supports jobs in the U.S.

"I absolutely wanted to make this as user-friendly as possible, because no matter how passionate you are, if you make the process complicated, the compliance tends to go down," said Dixit. "I've made this very easy for everyone, not just the people who work in the operating room, but also for those who collect the recyclable items. I wanted everyone to feel like they weren't being overburdened or being asked to do something out of the scope of their work."

In addition to Dixit, there are others who are keeping the environment top of mind. The laboratory on the Forest campus is preparing for Lab Week, which begins on Earth Day.

In honor of Earth Day and in memory of Elizabeth Ahern, former Henrico Doctors' employee, the Lab will be donating a tree to Henrico Doctors' Hospital. The ceremony will take place Monday, April 22 at 10 am on the roundabout near the Women's Hospital and the Nelson Room.

"We always do a service project, so we selected Earth Day and sustainability - things for the earth this year that we can work on," said Rose McCaferty, director of the laboratory at Henrico Doctors' Hospital. "We're also recycling during Lab Week. Stericycle will pick up cardboards, cans, plastics, since we have a lot of waste."

For their gifts, the lab plans to give out things that are reusable or encourage people to stop and think about doing something different toward protecting the environment.

Other employees are making a difference by bringing a water glass or mug from home and eliminating disposable ones. Many are also recycling ink cartridges and have said they have become more aggressive with recycling efforts at home.

In addition, all three campuses will be distributing reusable grocery bags during lunches in the cafeteria in our commitment to reduce, reuse and recycle.

I am pleased to see the many gestures that are taking place at Henrico, Parham and Retreat Doctors' Hospitals, whether a departmental or individual effort. I'm grateful to our many employees for embracing ways that contribute to sustaining our environment. The smallest acts are often the ones that bring the greatest results.

As for Dixit, he says he hopes to be able to expand the program further.

"I don't give up easily. I came with a plan. I came with a vision, I came with an idea, but this is about teamwork," he said. "I want to give credit to everyone who has taken part in this so far such as those in the operating room. I showed them the way, but they are the ones doing the job. It's my passion, but your passion is what can take you further."

Leadership, from page 7

Management Style

Good leaders do not need to demand respect; instead, they earn it. An open line of communication may subject one to increased vulnerability and criticism – but the ability to accept this and deal with it constructively differentiates the effective from the poor leader. In other words, be open to constructive criticism and allow yourself to be vulnerable. Leaders who need to demand respect are likely in that position because they have not made an effort to earn respect. Lead by example, not by “parenting”. The authoritarian, “do as I say” management style can lead to further resentment and hostility. If you’re asking your subordinates to put in more time at work, you should also be willing to put in the time. If you’re asking subordinates to work holidays and weekends, taking time away from their own families and personal lives, than be willing to do the same. This sort of work ethic in a leader nurtures a healthy work environment and inspires subordinates to work harder,



thereby increasing both job satisfaction and productivity.

Faced with hardship, leaders must acclimate, remain flexible, and be willing to adapt. Leaders must continually strive to be stewards of resources and improve processes. Constraints of any kind in an organization can lead to increased frustration, communication breakdown, and potential errors.

In order to remain efficient and effective, leaders must overcome these barriers and maintain strategic thinking. One way of taking control over their environment is by becoming more creative and innovative. Being creative enables leaders to transform and adapt. Innovation allows leaders to seize control of an opportunity to exploit change. By applying creative knowledge, being adaptive, and successfully communicating, leaders can help their organizations accomplish goals even in difficult times.

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SAVE THE DATE FOR

VSA's Annual Membership Meeting & Legislative Dinner

January 21, 2020

Sam Miller's

1212 E. Cary St, Richmond, VA 23219

5:00 pm Membership Meeting

6:30 pm Dinner with Legislators

Join us for a great meal, hear the latest about VSA and ASA business, and talk with your legislators about issues important to you and the practice of anesthesiology.

Vital Signs, from page 1

A valuable concept to utilize in the practice evaluation and improvement process is benchmarking. Benchmarks are quantitative data sets derived from survey data from a large set of practices.

The Medical Group Practice Management Association is an excellent resource for physicians and their staffs to “get a hold” of their operational issues. I highly recommend “Benchmarking Success” which can be purchased from their website as a starting point. This data can be a valuable point of comparison to utilize internally in an individual practice. These benchmarks can be used as “vital signs” to assess and manage internal operations.

Having said this, money is often a focus of conflict inside a medical practice. To start, what are key financial vital signs? One of the most common questions I hear from my colleagues is how do I know my billing company/dept is doing a good job? Just three easily obtained metrics will give your practice the answer.

1. Adjusted net collection ratio
2. Average billing cycle
3. Aged account receivables

We can discuss these in turn, starting with adjusted net collection ratio.

Adjusted net collection ratio tells you if your practice bills a dollar, what percentage of that dollar returns to your practice as net

collections. A good number is $> 90\%$.

The remaining would be bad debt and in general this is what should be turned over to a collection agency, not everything that is not collected immediately.

Here's a quick formula:

$$\frac{\text{Charges-Insurance Writeoffs-Refunds}}{\text{Collections}}$$

If this number is $>90\%$, your billing office is doing a good job. If $> 95\%$ a great job! Congratulations! If $<90\%$ your billing operation has some work to do.

Average billing cycle is the number in days from when a complete (clean) claim is submitted until payment is received and posted (entered) as collected. This is a useful metric to assess billing efficiency. Why is this important? The longer a claim remains outstanding the most likely it will never be collected. In general, average billing cycle should be <60 days with <40 days being for most organizations in the >90 percentile. Analyzing your work process for each claim as it flows through your organization can greatly improve this metric. On a personal note, years ago when I was employed by a large for-profit hospital conglomerate, their billing department decided to place our workers' compensation claims on the “back burner,” mainly because workers compensation claims required more work per claim. The average billing cycle for our workers'

compensation claims was 300 days, almost 10 months! Obviously less than ideal! Careful constant monitoring of this metric gives your practice an overview of your billing operations efficiency.

The last billing metric you should focus on is a report that demonstrates how much of your outstanding charges are uncollected at 30, 60, 90 and 120 days. This is called an “aged account receivable report”. This report gives the practice a snapshot of their billing operation's collection effectiveness.

Again, when working for the large hospital organization, I routinely witnessed pending accounts >120 days, which totalled more than 35% of their outstanding collections! A high percentage of these outstanding collections were being turned over to a collection agency never to be seen again!

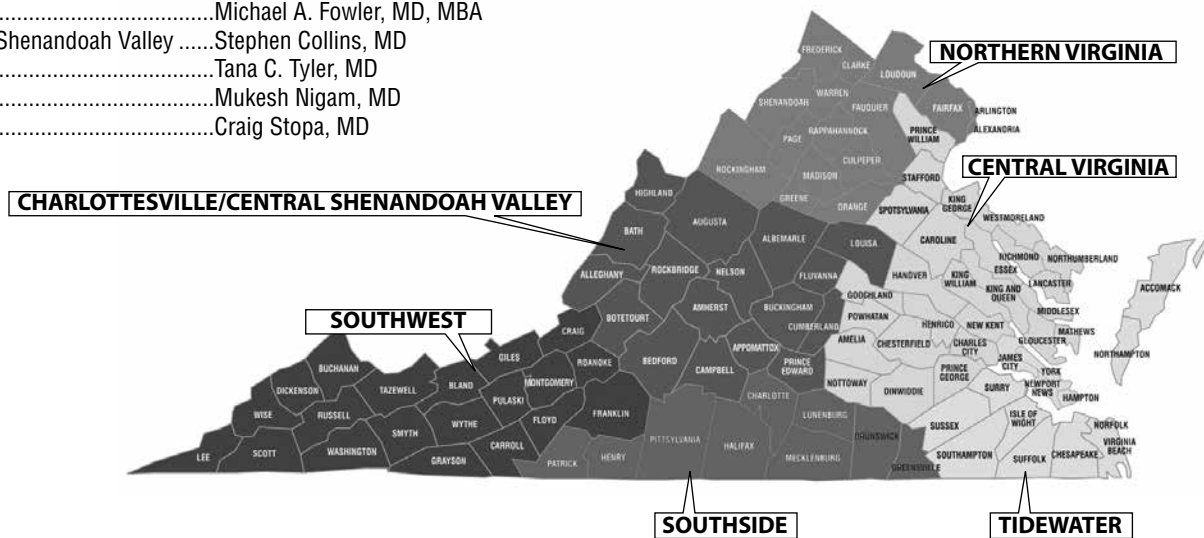
My current practice's last aged account receivables reported outstanding collections > 120 days to be only 8%. A big difference, don't you think? A good rule of thumb should be for collections >120 days to be $<15\%$ of all accounts receivables. Consistent monitoring and analyzing how claims move through your organization will significantly improve all these metrics. Trust but verify!

In future newsletters we can dive deeper into the various issues related to billing metrics or discuss other relevant issues. Contact me with questions or suggestions.

Cheers!

VSA Regions and Representatives

Central VirginiaMichael A. Fowler, MD, MBA
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