



American Society of
Anesthesiologists™

Central Line

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Achieving Excellence

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(SOUNDBITE OF MUSIC)

VOICE OVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome back to Central Line. I'm Dr. Adam Striker, your host and editor. Our guest today is Dr. Lilian Kanai, guest editor for the May issue of the ASA Monitor, which is all about Practice Management, the topic of today's show. Dr. Kanai is also the chair of the ASA Committee on Practice Management. Dr. Kanai, welcome to the show.

DR. KANAI:

Thank you, Dr. Striker. Happy to be here.

DR. STRIKER:

Well, let's start off talking a little bit about yourself. Tell our listeners a little bit about your background and how you got interested in practice management.

DR. KANAI:

Yeah, so my entire career I've been in private practice in Honolulu, Hawaii, and pretty much back in 2010 the predominant practice model was independent practice. And there was an incident that happened at our hospital and an RFP was issued and really all of us did not know what to do. And we couldn't respond to the RFP because we weren't part of a group. So I decided that I needed to get an education. And so what I did was I started taking courses. And then in 2011, I applied to an MBA program, which I later completed in 2013.

DR. STRIKER:

Great. Well, when we think of practice management, many things come to mind, but I'm not sure everyone thinks about branding. Is that something that we should be considering?

DR. KANAI:

Absolutely. You know branding is a way of differentiating yourself or your group, and it's how you can communicate your value proposition or your competitive advantage. And so branding takes many forms. It can be something tangible, such as the name of your group or a symbol. Or it can be intangible, something referred to as social complexity in one of the Monitor articles. Also, the health care environment is rapidly changing and we really need to change with it or we become irrelevant. And so branding is really an iterative process. And let me give you an example. Every January we have a practice management meeting and just in 2022 we rebranded it to ADVANCE: The Anesthesiology Business Event. And when I took over as chair of the committee last year, I really knew that I wanted to rebrand and refresh the meeting. So what we did was, we looked at attendee feedback and we really use that information to drive change. And we also look at current issues to see what needs to be addressed. And that's really what drove us to create this rebranding of the Practice Management conference. And when we had it in January, it was in the middle of Omicron, and it turned out to be very, very successful.

DR. STRIKER:

Well, let me follow up just a little bit about that. What was some of the feedback you received that caused the ASA to rebrand the practice management meeting, ADVANCE?

DR. KANAI:

Some of the feedback we got was that it was the same content year after year, the same speakers. People complained a little bit about not being able to move amongst the different lectures that were going on. So we really took that to heart and we tried to expand the content and also allow people to move freely amongst the different sessions going on. And previously, where we had maybe one session per timeslot, in 2022, we had up to six different sessions going on simultaneously. So it really gave people a choice as to what they could attend. And in fact, some of the feedback we're getting now is that there are too many choices. So I think that's a good problem to have.

DR. STRIKER:

Is it a conference that residents should be encouraged to attend?

DR. KANAI:

Absolutely. You know, I feel that residents should have as part of their education, the business side of anesthesiology. And so we do have a very reduced rate for residents. We actually have a resident track and each year we try to refresh it. And I believe this year we had a record number of resident attendees, which was very, very encouraging.

DR. STRIKER:

Well, anesthesiology specifically as a specialty has certainly been branded during the pandemic and ASA's positioned anesthesiologist as frontline physicians critical to patient well-being. But as the pandemic has evolved, we're a couple of years in now, is that branding still relevant? Do we need to pivot at all, or do you think that we are doing a good job as a specialty branding ourselves?

DR. KANAI:

Well, you know, as you mentioned, I think that Covid gave us the opportunity to brand us as frontline and ICU physicians. But as I mentioned previously, I do believe that branding is an iterative process. And so you really need to look at what are the market forces and where, where should we be in the future? And then you take a look at where are we now? And what is that gap? And how do we bridge that gap? What is our expertise? What is it we can do to improve patient care, patient safety? And go to where the market forces are driving our specialty?

A quote that I often refer to that I really love is from Wayne Gretzky. And it pretty much sums up what I just said, which is, he said, I skate to where the puck is going to be, not where it has been. And I think that that is what we need to be doing year after year, is looking to see where should we be and then creating processes to drive our specialty in that direction.

DR. STRIKER:

I will say I love that answer if for no other reason just because you invoke a hockey quote. Well beyond the specialty and our practices, when we talk about individuals, one of the articles in this issue of the ASA Monitor posits that the three A's -- ability, availability and affability -- are essential to our work. Few would argue that we must be able and available. But why is affability a Practice Management issue?

DR. KANAI:

Well, you know, if you look at the definition of affability, so one definition is being friendly or good natured. And I would add to that, it's being respectful. And if you're in a difficult situation, put yourself in the other person's shoes. And I also believe that we can be affable by proactively determining what will make our day go smoother. Because ultimately that will improve patient care.

So let me give you an example. I have a surgeon I work with that is just an outstanding surgeon, but she is a stickler for time. She likes to be on time. She likes to be efficient. And so when I know I'm going to work with her for a 7:15 case, I don't show up at 6:45. I show up at 6:15 to make sure that I have everything ready so the day goes smoother. So when that happens, the staff is happy, the surgeon's happy, the surgeon is going to operate better, and that really translates to better patient care. And so that is how I define affability, is not just being good natured, respectful, but really anticipating, you know, how can you make your day better by considering all the factors? And what is it that you can do to make patient care better by facilitating how your day goes?

DR. STRIKER:

Do you think we use a specialty, or collective individuals, do a good job of that? Or is that something that you think that we all need to really work on?

DR. KANAI:

You know, I'm a believer that there's always room for improvement. I think some people are probably a little better at this or more cognizant of this. But I do believe that if we can get this message across to our colleagues, it ultimately, as I have stated, will result in better patient care.

DR. STRIKER:

Okay. Well, let's delve into a meaty topic here when it comes to Practice Management, and that is the shift in practice models. Recently there's been a swing back toward increasing employment models. Can you tell us a little bit about that? Why is it happening, the pros and cons and what we need to do about it, if anything?

DR. KANAI:

Well, definitely employment is becoming more popular, and not only with our early career physicians, but also experienced physicians. And I think there are several reasons for that. First, if you look at the market dynamics, so the economics of our specialty, which is decreasing reimbursement and then the regulatory issues where we're going towards value-based care and payment is being tied to quality metrics. And then you have physician preference. So many physicians now want that work life balance. And a lot of the younger physicians are, you know, would rather focus on practicing medicine. They don't really care about the business side. And then finally, hospitals, they are really looking for the clinical and financial alignment. You know, we have this value-based care and they may be facing penalties. And so they really want to reduce care variation.

So I think that, you know, when you compare private practice versus the employed model, there are various factors you can look at. So first and foremost in my mind as a private practitioner is autonomy. In private practice, you are the boss. If you're employed, you are not the boss. You have to report to a boss. And I think that is huge. There's also the administrative issues such as human resources, revenue cycle management, operations. If you're employed, you don't have to worry about that at all. If you're in private practice, that is your responsibility. Now, some people would say, well, that's actually a positive because it gives me the opportunity to learn about the business side. And then you have to consider income. Typically, employed physicians are paid more and it's consistent pay, whereas if you're in private practice, especially as you're starting up, your your income is lower. However, you do have the opportunity to increase your income if you want to work, say, 100 hours a week, you have that option. In terms of career growth, I think it's limited with private practice. You start out as the boss and that's really as far as you can go. Whereas in the employment model you can move up, become medical director, chief of staff, CEO. The sky's the limit. And then finally, culture. I think here private practice has an advantage in that you set the culture of your practice, whereas in an employed model, the culture is what the hospital culture is. So those are pretty much the pros and cons that I would consider.

Now, I do want to touch upon some things that I think everyone should consider before they consider an employed model. So look at the vision and mission of your potential employer. Look at the culture and the goals. Are they aligned with yours? I think that's critical. Also, look at the compensation plan. Is it just salary or is there potential for a bonus? And if so, what are they basing that bonus on? Is it productivity? Is it patient satisfaction? Is it performance based on quality metrics? Is it citizenship? And how does the organization define this? How do they measure it? What are the thresholds they use to determine the bonus? So I think all those things you really need to take into consideration and ask the right questions before you sign that employment contract.

DR. STRIKER:

Well, and that could probably be said for either employment contract or private practice. You know, listening to all the pros and cons you just listed, do you think that the lines are really a little more blurred? You know, you mentioned that like one of the trends might be that younger physicians are interested in work life balance and so an employment model might look more attractive. I also spent a lot of years in private practice, and I might say that the private practice group can control work life balance if everybody is of the same mind based on their hiring practices, if you will, and likewise not having to worry about HR issues or the business aspect of things if you're an employment model, will actually that that could affect your work life balance in an employment model because as those shifts evolve, that's going to affect your work life balance. So you do become involved in it in some fashion.

DR. KANAI:

Absolutely. You know, it's not all black and white. The lines are blurred. There are a lot of gray areas. And so you really need to take a deep dive into the different situations that you're looking at. If you have a large private practice group, it may look more like an employment model and the devil's in the details. So you really need to ask the right questions and know what you're looking for.

DR. STRIKER:

Now, I've been asked this question by many residents that I've worked with who oftentimes don't get that exposure, that background, if you will, before making decisions on where to pursue a career. What steps do you think we could take to help our younger physicians navigate these waters? What advice? Not only the younger physicians, but also faculty listening that can help their residents.

DR. KANAI:

You know, that is a topic that we try to cover at the residence track every year at ADVANCE. You know, there's only so much time and it's it's a broad topic and there's quite a bit to cover. All the things I talked about. Qhat to look for? What are the considerations? What are the questions to ask? And so this is something that I think I'll bring back to our committee to see if we can create that resource for the residents. I think it's, it's extremely important. And, you know, thinking back to when I was a resident, I accepted a job based on how well I got along with with the people I met, which is not a great way to enter a career. I got very lucky. But I think if we can kind of

standardize some of the things that they should be thinking about, questions they should ask, that would definitely point residents in the right direction.

DR. STRIKER:

Well, Doctor, can I have some more questions for you? So please stay with us. We'll be right back after the short safety tip.

(SOUNDBITE OF MUSIC)

DR. JEFF GREEN:

Hi, this is Dr. Jeff Green with the ASA Patient Safety Editorial Board.

OR medication errors such as syringe swaps can cause severe patient harm. Reduce the chance of a syringe swap by aligning the syringe and label on an IV Stop COC so that the name and concentration of the medication is directly facing the anesthesiologist. If a manifold is being used to administer several medications, the syringes and their labels can be oriented in the same direction and placed in the order of their planned use, particularly during induction of anesthesia. While injecting the medication, the anesthesiologist should read the label, rechecking the concentration and calculated dosing as a quick and easy safety step.

These simple steps can decrease risks by removing common causes of syringe swaps, such as failure to read the syringe labels, using unlabeled syringes, or relying on color coding or labels alone.

VOA: For more information on patient safety visit asahq.org/patientsafety2022

DR. STRIKER:

Welcome back. Well, Dr. Kanai, let's tackle another trend--the increasing integration of care. Anesthesiologists are obviously well positioned as leaders when it comes to getting departments to work together. Do you feel institutions are taking advantage of our expertise? Do they recognize that our skills go beyond the OR?

DR. KANAI:

I believe that we as anesthesiologists should be the leaders in coordinating the care along the perioperative continuum. We should be perioperative physicians. And I think there's been variable adoption by different groups and organizations. I think that what it

needs to start with is leadership skills. So you need to be able to articulate to the C-suite what it is that we can bring to the table and why we should be leading this effort. And even once you get C-suite buy in, it's a question of how do you operationalize it? And really that to me is probably the most difficult part because it involves change management skills, which is a topic in and of itself. People specialize in that. And as you know, trying to change the behavior of physicians is a very, very difficult task, but it can be done. And then the other thing is that I know that groups and organizations that have tried this are trying to figure out, okay, you know, how do I get compensated for this effort? And that's the conundrum, because many times organizations want you to do the work, see the results of that. And then they will say, okay, we'll compensate you to to continue down that pathway. So you almost have to do the work first to prove yourself. And in this day and age of physician shortages, it's difficult to find people that are willing to give up their coveted free time to be able to bring our specialty down that pathway.

DR. STRIKER:

It brings up a good question that I did want to ask you. What what is your opinion on the idea that, as physicians, we should get paid for every thing we do versus as physicians or specialists, specifically anesthesiologists, we need to demonstrate value to the institution and show that what they're getting is good value by hiring anesthesiologists. What is your take on that?

DR. KANAI:

You know, I believe that anesthesiologists should be paid for non-clinical time. You know historically, when physicians were extremely well paid, they would donate their time. And I think that that is kind of the expectation. Right now, things are starting to change. But I think that as reimbursements go down and our workload is going up, it's becoming increasingly difficult to ask physicians to do things without being compensated. And I think those are just market forces. And if you look at our nursing colleagues, they get paid for going to a meeting or coming in for an hour on their day off. Whereas we as physicians are just expected to do that. The answer to your question, my opinion is I don't necessarily believe we should be paid for every minute of work that we do. But I do feel that we shouldm should be paid for the bulk of the work we do, especially if we're showing a value proposition.

DR. STRIKER:

Well on the topic of costs. Increasingly, physician groups are looking at care team models. How do physician groups perform that cost analysis to decide whether the care team model is financially feasible?

DR. KANAI:

Yeah, so Dr. Abouleish has an excellent article in this May issue, and it's really an update to a previous Monitor article he had done with Dr. Stead. And they really look at the cost analysis of moving from an MD only model to a care team model. Now in it, he mentions there are two types of analyses you can do. One is cost benefit, which would be beneficial if your organization understands your value proposition. But what he focused on is the simpler, more cost minimization analysis. And the key points are that you really need to take a deep dive into factors that are often overlooked that can really skew the analysis. So, for example, when you compare physicians and CRNAs, you really have to look at hours worked. Typically, physicians work a lot more hours than CRNAs. So, for example, you can't just say, well, CRNA makes x x amount per year and the physician makes Y and the CRNA is cheaper. No, you have to break that down and see how many hours each type of clinician works. Also, you have to factor in break staff because you're going to hire staff that are going to be giving breaks in the OR, And then you also have to take into account the fact that some patients may be very complex. There's a complexity of care that sometimes presents itself where a patient may need a physician anesthesiologist taking care of them rather than the care team model. So those are some of the things that Dr. Abouleish touched upon that I think are very important to look at, to be able to have a fair analysis.

DR. STRIKER:

Well, another question. Billing is increasingly being outsourced to national companies, especially with issues like the No Surprises Act, which is going to make billing even more complicated. Billing is now referenced as Revenue Cycle Management. Number one, why the shift in terminology? And number two, how do groups know when it's more feasible to outsource the billing?

DR. KANAI:

Yeah. So previously we referred to a billing company as billing and coding. And as you mentioned, it's now called Revenue Cycle Management. So Revenue Cycle Management focuses on the entire continuum. So where you start is you collect the demographic and insurance data on a patient you're going to take care of. Then when you deliver the care, the anesthesia record is created, and from there you have to create a bill which is sent to the insurance company. And then as money comes in, or correspondence comes in, you have to reconcile those payments or rejections. And then finally, you close the chapter when you receive final payment or you refer the patient to collections. So Revenue Cycle Management focuses on that entire

continuum. Now in addition, Revenue Cycle Management does analytics or key performance indicators, which you can use to assess the performance of the company. You can also extract data for quality metrics, for external reporting, say for MIPS or for internal use.

So as far as whether you should keep your Revenue Cycle Management in-house or outsource, I think there are many factors to consider. So one of them is what is your group size? So if you're a smaller group, you probably don't want to make the investment in the software and the labor, which is quite costly. So typically smaller groups benefit from outsourcing. You want to look at what are the fees that the company charges. Typically it's a percent of collections. So what is that percentage and what does it include? Now the upside with outsourcing is that it's a variable cost as opposed to a fixed cost if you have the billing in-house. And so, for example, during COVID, when surgery shut down, if you outsourced your billing, your billing costs went way down because your collections were down, so what you needed to pay in Revenue Cycle Management was very, very small. So this was an advantage for those that outsource their billing. With outsourcing, also, there are economies of scale and efficiencies. So theoretically, you should be able to see a higher collection rate, more revenue. Also, with outsourcing, they use experts such as certified coders. So theoretically, you would have fewer billing errors. And the downside to outsourcing is you do have less control, but you can run the analytics to be able to assess how well your company is performing.

DR. STRIKER:

Great. Well, last question. Practice Management is a broad topic. You obviously have a deep understanding of the larger topic. Why don't you let us know in your own words, why should people care about Practice Management? And what are the advantages of understanding the business side of of medicine?

DR. KANAI:

Yeah. So, you know, as physicians, we enter medicine to take care of people. And what a lot of people probably don't think about is that medicine is a business. And so I want to share with you a story of when I applied to get into MBA school as part of the interview, they asked me, Well, why do you want to go to MBA school? And my answer then is the same as it is now. So administrators speak the language of business. Physicians speak the language of medicine. And we don't speak each other's language. And I said to myself, well, administrators aren't going to go to medical school to understand our perspective. So it's up to us as physicians to go to business school to understand their language. So just kind of to give you an analogy, so imagine you have two companies

that are trying to negotiate a deal. One's an American company owns an Italian company and they send their best negotiators, but their negotiators only speak their native tongue. So you have in this room a person that speaks English, a person that speaks Italian. How effective do you think that meeting is going to be? Not very, because they don't speak each other's language. So I think that's why we need to care about practice management. We need to care about the business side. And I'm just going to leave you with one last quote that I once heard that I absolutely love. You can either be at the table or on the menu. And personally, my choice is to be at the table. So I speak the language of business. I can go to the table with the C-suite, speak their language, gives me credibility, gives me a seat at the table so I can affect the way anesthesia is managed and practiced in my organization.

DR. STRIKER:

Well-stated. Dr. Kanai, thank you so much for joining us, sharing your knowledge, your expertise, your experience, and hopefully stimulating a lot of discussion and further investigation on the behalf of all our listeners.

DR. KANAI:

Thank you, Dr. Striker. Really appreciate the opportunity.

DR. STRIKER:

For more about practice management and the issues we covered in today's show, please check out the May issue of the ASA Monitor at asamonitor.org. And join us again soon and please review the podcast and follow Central Line wherever you get your podcasts.

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