

# Anesthesia Stipends – 2010: Performance Metrics Increasingly a Part of Stipend Agreements

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## Abstract

Properly constructed stipend agreements between hospitals and anesthesia groups can produce important benefits for both parties. Anesthesia practices gain additional revenue which, among other things, can help defray costs associated with expanded coverage requirements. Hospitals, meanwhile, are assured of reliable, continuous and high-quality coverage. Establishing an appropriate stipend amount is the key to a successful stipend arrangement. Yet this process can be time-consuming and complex. A detailed understanding of the physician group's expenses, staffing patterns and collection capabilities - along with data about the hospital's current and future anesthesia service requirements - are just some of the elements required to calculate an equitable stipend amount. As stipend arrangements have become increasingly prevalent, they've continued to evolve and today, a growing number of agreements include provisions requiring practices to meet or exceed specific performance benchmarks to receive new or continued financial support. Anesthesia groups need to be aware of this trend and be prepared to play a proactive role in developing mutually agreed-upon performance metrics, should their hospital partner seek to impose them.

## ALIGNING WITH HOSPITAL OBJECTIVES

The inclusion of performance indicators (commonly referred to as metrics) has become an increasingly common part of anesthesia stipend discussions. Essentially, hospitals are taking the position that, in return for new or continued financial support, a range of quality and operational objectives must be achieved.

Arrangements also are being created in which the level of stipend support is directly linked to which practices achieve the performance objectives. Most often, the purported goal is to align hospital objectives with those of the anesthesia entity. In many instances, the hospital will propose withholding a certain percentage of the total stipend (i.e., 5-40%) to motivate the group to meet or exceed each indicator.

Conversely, many of these arrangements allow the group to achieve financial "bonuses" (amounts exceeding the overall stipend amount) if the group meets or exceeds certain target performance levels. For example, consider a scenario in which both parties agree the group requires \$1 million annually in financial support from the hospital. Both parties could then mutually agree the group will be paid \$900,000, divided over a 12-month period, with the residual \$100,000

at financial risk to the group. However, if the group meets or exceeds most or all performance indicators, they could receive not only the extra \$100,000 but an additional \$100,000 under certain conditions.

In response to this growing trend, anesthesia groups may want to consider the following questions:

1. Should the group proactively provide a set of performance indicators to the hospital?
2. Are the agreed-upon indicators as objective as possible, and do they exclude more subjective measures, such as surgeon/OB satisfaction surveys?
3. Are the indicators controllable and if so, what impact can the group have (e.g., cases delayed or canceled)?
4. Are the proposed metric targets reasonably attainable, and is there a sliding payment scale within each metric? For example:
  - Less than 80% compliance — no payout
  - Attainment of 80-90% — 50% of incentive

payment allowed

- Attainment of 90-100% — 100% of incentive payment allowed
1. Is the group eligible for a bonus payment (i.e., an amount exceeding the total of the at-risk amount)?
  2. If any particular quality metrics are below target, will the group be provided the opportunity to remedy the shortfall and recoup the amount withheld?
  3. Will certain performance indicators be rotated off and others rotated on after there is evidence of consistent compliance?
  4. Is the at-risk amount proposed by the hospital consistent with industry standards?

### **ONGOING MEASUREMENT**

Once the metrics and the associated dollar amounts are agreed upon, both parties also need to resolve the following questions:

- Who will monitor and report the outcomes of these indicators?
- How frequently will the data be monitored and reported, and will these timing guidelines vary by metric?
- What is the dispute-resolution process regarding any adverse findings?
- What are the payout intervals (e.g., quarterly, semi-annually, annually?)

### **EXAMPLES OF METRICS**

Here are some examples of quality, operational and other miscellaneous metrics that McKesson's consulting team has observed in connection with anesthesia stipend arrangements. Typically, 5-10 metrics are being measured at any one time:

#### **QUALITY METRICS**

- Physician Quality Reporting Initiative (PQRI) Measure 30 – Timely administration of prophylactic antibiotics
- PQRI Measure 76 — Prevention of catheter-related

bloodstream infections: Central Venous Catheter insertion protocol

- PQRI Measure 193 — Perioperative temperature management
- Surgical Care Improvement Project (SCIP) measure concerning beta blocker therapy
- Surgeon satisfaction (via surveys)
- Reintubation in PACU
- Pre-operative note indicated on the pre-operative evaluation form, signed and dated by a member of the anesthesia group
- A.M. admits and ambulatory surgery charts — Charts reviewed within x hours prior to scheduled surgery day by member of the anesthesia group
- Response to request for labor epidural insertion within x minutes of request during certain hours

#### **OPERATIONAL/EFFICIENCY METRICS**

- First-case anesthesia-related delays due to anesthesia late seeing patient, performing blocks/lines and/or patient requiring further testing
- Day of surgery cancellations due to anesthesia
- Ability of group to staff add-on and/or weekend cases
- Patient interviews — Documentation on the anesthesia pre-operative assessment form:
- Medical history
- Current medications
- Current allergies
- Pertinent physical exam findings
- Post-operative inpatients — A group member will see these post-operative inpatients within x hours of surgery as evidenced by a documented note in the physician progress notes
- Medication dispensing system — Anesthesia group will utilize hospital's medication dispensing system to ensure appropriate charge capture

- Development of “core” groups of anesthesiologists who perhaps specialize in certain types of surgical cases — e.g., pediatrics, hearts, ambulatory, etc.
- Management of CRNA overtime in those situations where the CRNAs are employed by the hospital

### OTHER METRICS

- Development of productivity-based compensation system (if possible)
- Collaborate and cooperate with OR staff to effectively manage daily OR schedule
- Participation in collaborative governance model which includes representatives from anesthesia, administration, surgery and nursing.

### EFFICIENT TRACKING IS KEY

Although anesthesiology remains one of the most paper-intensive specialties, practices would be well-advised to consider implementing new solutions that help automate the management of financial metrics and patient outcome data. As quality reporting requirements from government agencies, commercial payors and hospitals continue to intensify, practices that can efficiently track quality measures are more likely to receive proper and timely reimbursement. The benefits of efficient tracking may be particularly evident when it comes to stipend performance metrics.

For example, when a large medical group in the northwest, identified a spike in reintubations, the quality improvement team traced the complication to the use of a specific muscle relaxant. Instead of sorting through charts and papers, the team used McKesson Practice Focus™ to automate quality tracking and reports.

As a result, anesthesiologists were educated about this potential side effect and use of this muscle relaxant was modified. A significant reduction in the number of reintubations was reported, along with the decline in use of the product. With measurable proof of quality, anesthesiologists were able to help secure their financial future with multiple payors and have a greater voice within the hospital, while avoiding the burden of paper-intensive tracking.

### INTERNAL GROUP POLICIES

Assuming the new hospital agreement includes numerous performance indicators that put the group at financial risk, it may be prudent for the practice to develop internal policies around these indicators. A policy could address instances in which the group fails to meet minimal compliance rates, perhaps due to the performance of one or two members. The internal policy could create incentives and consequences tied to individual performance. Here are a few key questions that should be asked:

1. Has the performance shortfall been verified?
2. What was the cause of the shortfall and was it avoidable?
3. Is the same physician(s) causing the performance metric to be missed?
4. Should the group member(s) be financially penalized equivalent to the amount of the performance incentive reduction or a portion thereof?
5. Can a group member(s) be terminated for continually causing the group to miss meeting certain performance indicators?

### DUE DILIGENCE

A growing number of hospitals and hospital systems are insisting a portion of the financial support afforded to anesthesia groups be put at risk to help ensure that certain quality and operational/efficiency metrics are met. Anesthesia entities should carefully consider all factors involved in establishing and meeting performance indicators before agreeing to put part of their stipend at risk.

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**References**

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