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Guidance for Anesthesia Practices on Bridging the Generation Gap(s)

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When two parties have differing perspectives and set out to bridge a gap, the first and most important step is to understand where the other party is coming from. It's very hard to negotiate a middle ground without that foundation. This holds true in marriages, with children, in workplace negotiations, and in blending diverse cultures and generations within your anesthesia group.

An increasingly diverse workforce brings many benefits, but also many challenges. Among those challenges is balancing the work styles and expectations of the five generations represented in today's workforce. Although stereotyping is never a good thing when it comes to individuals, common threads can influence the mindset of a generation. Understanding those perspectives, and considering whether or not they apply to a specific situation, can be enormously helpful in navigating generational differences within anesthesia practices.

Most anesthesia groups have at least four of the five generations represented among their providers. The youngest members of the oldest group, the Silent Generation (born pre-1946), are turning 73 this year, so not too many of them are still working; however, they do still represent about 1.4 percent of active ASA members.

Continued on page 4

➤ INSIDE THIS ISSUE:

On Generation Gaps, HR Errors and 40 Years of Anesthesia Consulting

Anesthesia consultant Shena J. Scott, MBA, FACMPE, notes in her lead article for this issue that bridging generational differences among anesthesia group members to build a cohesive practice is less a matter of understanding generational personalities than an issue of sensitivity to developmental timing.

In other words, though generation certainly plays a role, the key to creating group satisfaction across generational divides is consideration for where individual clinicians are in their lives, combined with insight about some generational tendencies.

Also in this issue:

Will Latham, MBA, explores the challenging topic of compensation for anesthesia group leaders, including board members and others who take on significant leadership roles within the group in addition to their clinical responsibilities. Although groups often voice reasons why these leaders need *not* be compensated, Mr. Latham argues that they should be, because the time spent in these roles is as central to the good of the practice as the clinical work. He offers a framework to help practices set policy and determine the specifics.

In 20 years as an attorney specializing in commercial and employment law, Patricia A. McCausland, JD, has developed a good sense of the types of human resources issues over which businesses, anesthesia practices included, most frequently falter. These range from putting the practice at risk of employment-related litigation stemming from incomplete documentation of employee discipline and performance to the problems that can arise from lack of attention to potential instances of reverse discrimination. Ms. McCausland probes some of the most common HR-related misconceptions and suggests how practices can avoid them.

ABC's Jody Locke, MA, offers a primer for anesthesia groups on weighing the pros and cons of potential contracts with ambulatory facilities. Because every ambulatory opportunity is unique, groups must determine each agreement's true potential upfront and develop a clear business plan for each new contractual arrangement, including budget projections for both collections and cost. "If the collections do not increase as projected, the practice should have the right to cancel the contract," he advises.

Likening hospital-anesthesia group relationships to marriages, Mark F. Weiss, JD, explores ways to keep the love alive, with a focus on enhancing your facility's perceptions of your group's value. "What programs and initiatives have you created at the facility that increases that perception? What add-on services do you provide at little to no cost to you that produce a disproportionate increase in perceived value? How often do you meet with the facility's leadership, both administrators and medical staff leaders, to stoke top-of-mind thinking of the value that you create?" he writes.

Returning to Ms. Scott's point about generations, like most Baby Boomers, in 1979, when my wife Sue and I started ABC, naturally, I was in a much different place personally and professionally than I am today. In the four decades since, as healthcare and the anesthesia market have transformed, and then transformed again—and again—Sue and I have certainly grown as individuals and business owners.

What stands out most proudly to me in 2019—ABC's 40th anniversary—is seeing the extent to which the company has also evolved in tandem with the increasingly multifaceted and wide-ranging needs of anesthesia and pain management practices.

What started 40 years ago in a small space as a two-person endeavor focused on anesthesia billing and coding for several private practices has, both organically and strategically, developed into a national operation with a team of talented and committed professionals in dozens of locations serving several thousand members of the specialty.

ABC has also expanded beyond its original primary focus on anesthesia billing, serving today, along with our subsidiaries, Plexus Management Group and Plexus Technology Group, as a business partner as well as a billing partner for our clients, with services still focused on anesthesia billing, but encompassing virtually every major facet of anesthesia practice management as well.

What hasn't changed in 40 years is Sue's and my respect and admiration for the anesthesia profession and passion for what we do. As always, we appreciate your faith in us.

With best wishes,

Tony Mira
President and CEO

Compensation for Anesthesia Group Leaders: Who, When, How Much and Why

Will Latham, MBA
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The question of whether and how to compensate anesthesia group leaders is a subject of spirited debate among anesthesia practices. This article covers the spectrum: some of the arguments used for not compensating leaders, justification for why groups *should* compensate their leaders, who is typically compensated and options for compensation.

When groups discuss compensating their leaders, there is often an outcry from those who don't think it is appropriate. Not surprisingly, the arguments against compensating leaders typically come from those who do not participate in the work of governance/leadership (those who are "getting the milk for free").

When we work with groups on governance issues, here are the usual arguments against compensating leaders:

1. **"The leaders will do it for free; see, they already are."** Many group leaders perform an enormous amount of uncompensated work for the group. If that sacrifice in terms of time and lost earnings goes unrecognized for too long, the leaders will burn out or the group will be unable to find members willing to take on the work.
2. **"The leaders benefit from the work they do."** While this is true, the other group members also reap the benefits of this work while making no sacrifices themselves to achieve the results.
3. **"We should all contribute equally."** Equal contribution in leadership responsibilities is rare. We only see it in very small groups (for example, of three physicians) where the administrative workload is divided fairly equally. Those who use this argument

are often the first to avoid the work or not do the work they sign up for.

4. **"We don't want to pay so much that someone will want the job for the money."** This almost never happens. The only time we have seen groups over-compensate a leader is when the leader was a founding member or very good at dealing with conflict and negotiating their way into compensation higher than the market rate.
5. **"We will end up having to pay everybody for everything."** This is another smokescreen to avoid compensating those doing the hard work. All groups can identify the roles that consume significant physician time and develop plans to reward those who fulfill those responsibilities.
6. **"We don't know how to compensate someone."** Many groups have developed leadership compensation systems that work well. We discuss some of these options later in this article.
7. **"I don't want to get paid. It will make me feel responsible."** Occasionally, group leaders don't want to be paid because they believe if the group pays them they will be expected to perform. Not being paid helps them avoid responsibility. However, the work done by the leaders is very important. They should be held responsible.

With all these arguments against compensating group leaders, why compensate them? We see several reasons:

1. **Fairness.** Leaders do extra work that is extremely valuable for the anesthesia group. Leaders should be compensated for this work.
2. **Sustainability.** As previously mentioned, leaders can burn out from the extra work, and are quicker to burn out if the group doesn't recognize their sacrifice.
3. **Time to do the work.** In many cases, the work of leadership must be done during the clinical day. Leaders often need time off to meet with others, which often reduces their productivity, and hence, their compensation. In other cases (especially cases in which compensation is equalized) leaders' clinical responsibilities must be covered by others in order to allow the leaders to meet their leadership responsibilities.
4. **Responsibility.** Compensating individuals for their work increases the likelihood that they will fulfill their leadership duties more effectively and conscientiously.

Continued on page 8

Guidance for Anesthesia Practices on Bridging the Generation Gap(s)

Continued from page 1

The dominant generation for anesthesiologists is the Baby Boomers (born 1946-1964), representing 37.6 percent of the active membership (compared with only 27 percent of the workforce in general). Gen X (born 1965-1976) is a smaller group, but particularly so for anesthesiologists. They currently make up only 29.5 percent of active ASA members, compared with 35 percent of the overall workforce. The fact that only 31.5 percent of active ASA members represent the Xennial (1977-1985) and Millennial (1986-1995) groups could foreshadow a future manpower issue when the majority of Baby Boomers finish retiring, likely over the next 10 years.

Timing is Key

When speaking of generational differences, there are three elements to consider. The first, where you are in life, is not a matter of generational personality, but an issue of timing. Millennials are often stereotyped as disloyal because they move around a lot, not just physically, but also in their jobs. Yet, this was also true of earlier generations at the same point in their lives. Millennials typically marry later in life, and are having children later still, if at all. Marriage and family are often key factors influencing people to commit to a job or a community, so it is hardly surprising that this group is slower to get there and, in fact, many who do not marry or have children may never settle in.

Another major difference is the fact that electronic communication allows people in many jobs to work from virtually anywhere, an option that did not exist for prior generations. Of course, this is less of a factor in the anesthesia world where one still has to be physically present to perform one's job. In short, it is a different world. Just as the Baby Boomers forged their way in a world that was very different from their parents' world (and their parents shook their heads in despair!), the same is true of the Millennials.

The world for young physicians graduating today is very different than it was thirty years ago. Many young anesthesiologists do not expect, or want, to have ownership in a business, which is good, because fewer of those opportunities exist. Additionally, the anesthesiologist's role has evolved with advent of the perioperative surgical home. Anesthesiologists see themselves as more than providers of anesthesia care for surgical cases. They are graduating with new skills. Practices are consolidating, making their world feel less secure. Many are graduating with mountains of debt and are less confident of their prospects for significant income in the future.

Expectations regarding family roles are different as well. Most often, both partners are working, and home duties are shared equally, yielding an additional pull away from the workplace for all young parents.

So, even before we get to the crux of generational personalities, or "who you are is what you were when," there are potential challenges and sources of friction when it comes to understanding among the generations.

Generational Differences

The theory behind the generational personality is founded on the tenet that the great majority of a child's personality is formed prior to age 10. What is happening in the world during that influential period tends to shape a person's outlook on life and create generational bonds.

The Baby Boomers hit that stride in the fifties and sixties. They morphed from post-war prosperity and a very traditional Leave it to Beaver childhood into the Vietnam War, the Civil Rights Movement and the Sexual Revolution. Grounded by a strong set of values and traditions, this generation had to fight hard against the establishment in order to win personal freedoms that younger generations take for granted.

As a result, this generation tends to be driven, competitive and sometimes a bit controlling. They invented the concept of workaholism and strongly believe

in paying your dues to get ahead. Having grown up in relative prosperity, they tend to be more materialistic than some of the younger generations. Additionally, they may be saddled with paying for aging parents, as well as late-blooming children who have extended their time on the payroll. As a result, many cannot, or do not necessarily want to, retire.

Gen X hit their impressionable development period in the seventies and early eighties. Defining moments for them were the invention of computers and the Women's Liberation movement. Women's Lib had a significant effect on Gen X-ers as children because, on the heels of the Sexual Revolution, women were heading into the workforce in droves at a time when there was no social, professional or family network to support them.

Maternity leave was six weeks: "Get back to work and pretend you never had a baby." If their moms were working, they did not have the same opportunities for work/life balance that young moms enjoy today. Daycare was not readily available, so there were a lot of latch-key kids, and the family structure was not generally set up on the same egalitarian footing that it is today.

Most women in the workforce were not paid as much as their male counterparts, and working moms ended up picking up most of the work at home as well. It is no surprise that they were exhausted and resentful and that divorce rates were high.

The children who grew up in this era are, understandably, self-reliant and pragmatic. They tend to seek a sense of family, highly value relationships and want balance in their lives. They are generally not impressed by titles or hierarchies and tend to be much more loyal to people than they are to companies.

The younger generations, who came of age in the late eighties and nineties, fall into three distinct groups. There are some commonalities in that they all experienced their defining moments at some stage along the spectrum of the technological revolution. Some experienced the transition; others do not know a world without the internet.

But they also grew up in a violent world, peppered with acts of terrorism founded in a fundamental lack of tolerance. And their overachiever Baby Boomer parents overscheduled them in structured activities, hovered over them, made them the center of attention and protected them from failure. In the extreme, some of these Baby Boomer parents even continued to rescue their children all the way to college and beyond.

So, it is hardly any surprise that this is a generation of extremely confident young people who believe that they are every bit as capable as people with significantly more experience and, for the most part, expect to start as an equal. In general, they are enormously capable, highly adaptive and fabulous at multi-tasking.

The older members of this generation, the Xennials, started with an analog childhood and moved to a digital adulthood during their college years. Although every bit as technologically proficient as their younger counterparts,

they have a better understanding of where the "old folks" are coming from and can be enormously helpful in bridging the generational gap. They are confident by nature and are not afraid to take on either side when needed.

The younger Millennials are flexible, embracing diversity and change. Some have more limited interpersonal skills, having spent so much of their lives communicating via text and social media. They want to feel connected to the world and to make it a better place.

At age 22, the oldest members of Gen Z are just finding their way into the workplace and have not yet completed medical school, but you may be starting to see members of this generation in your office staff and as anesthetists. The main difference between them and Gen Y (Millennials) is that they grew up in a time of cybersecurity threats that were not prevalent earlier. As such, while their generational personality is just starting to emerge, one initially observed trait is an obsession with safety.

Many Boomers ask: what do Millennials really want? Some decry that they really just want everything, including money, time off and limited work responsibility. That is not my personal experience with the overwhelming majority of this generation. As with every generation, there are a few bad eggs. The same can be said for Boomers, the worst of whom barely show respect for anybody, let alone a young person.

This disrespect hits Millennials at their core. In my experience, most Millennials are hard-working and respectful —*if* you respect them. Yes, they want to get ahead just like the Boomers did, but they are also open to understanding the pathway, if it is clearly explained to them in an open and honest way. They want to be provided with clear goals that are tied to concrete rewards. They do not want to work themselves to death or define their

Continued on page 6

Guidance for Anesthesia Practices on Bridging the Generation Gap(s)

Continued from page 5

success, or themselves, by their work, as many Boomers do.

But that is not a bad thing. They want to understand the meaning of their work, and to understand their opportunities to grow. They want to feel connected to a larger purpose and for their employers to support their efforts to improve the community and the world. And most of all, they want you to be honest with them. If the news is bad, tell them, but don't disrespect them by being dishonest and engendering mistrust.

Study after study shows that Millennials are the least trusting of any generation, so it does not take much to trigger that downward spiral. They want recognition and praise. Everyone wants recognition and praise, but they *really* want recognition and praise (after all, this is the generation that grew up receiving 11th place trophies!).

Tools to Understand and Unify

What does all this mean when you throw it into a melting pot? On one hand, you have a group of strong-willed traditionalists who believe in "paying your dues to get ahead," and on the other, you have a highly confident, equally strong-willed group of people who want instant results. And in the middle, you have a group whose core value is relationships and wanting people getting along with one another. How do you bridge those gaps?

Clearly, step one is understanding how the other side feels. But step two is tailoring your practice, your communication style, your workflow and your benefits to give people, to the extent that you can, what they want. Another important step is identifying people and situations to help bridge the gaps. Here are some tools that you can incorporate into your practice to improve relationships among the generations:

1. **Utilize all forms of communication effectively**. Meet people at their level—face to face, on the phone, via email, text and social media—to make them feel that their preferences are valued. But when it comes to important discussions, insist on face-to-face communication and ban electronic devices to force concentration *and* eliminate sub-conversations via text. Electronic communication is simple and convenient, but tone and intent can be lost. As a result, it is important to have important discussions in person, where non-verbal cues can be seen and understood.
2. **Give everyone some type of non-clinical responsibility that matches their skill set, interest and availability.** Put a person with a young family in charge of the group's Twitter account or blog, something they can do in the evening once children are asleep, without pulling them away from family life. Or, engage people with limited time in projects that have a beginning and an end. Let the people who are at a more flexible point in life serve in leadership and on standing committees. Be sure to recognize *all* contributions visibly and vocally.
3. **Build multi-generational teams, focusing on different skill sets, to tackle projects together**. Working together toward a common goal can help people recognize the value of other group members' skills that they themselves do not possess. It also improves communication and can foster a feeling of group cohesiveness.
4. **Develop a flexible compensation and benefits system, and make sure that people are appropriately rewarded financially relative to the work they are doing, administratively as well as clinically**. This is a good solution for many challenges a group may be facing. People have different needs at different times in their lives. Providing a flexible com-

pensation and benefits plan that allows them to select the benefits that they need, and to put themselves where they need to be on the income/lifestyle spectrum, is always a winning proposition.

5. **Set up mentor and reverse mentor relationships**. Let the more experienced physician help a newer physician feel comfortable in a leadership role, and let that younger physician show the older one some shortcuts on the electronic record. At the end of the day, all of us are better at some things than others. If we can create opportunities that improve skills, while building relationships and trust, this is good for everyone.
6. **Insist on open and direct resolution of issues**. Create a culture of acceptance and enforce a zero tolerance policy for disrespecting others in the workplace. People do not have to like each other but they do have to be respectful and get along. Insisting on this as a basis for group culture will help the group in many ways, not just managing the generations.
7. **Create opportunities for people of different generations to socialize together**. People always bond better when they are relaxed and having fun. Whether it is a happy hour to include spouses or a day at the park to include all family members, the goodwill that people enjoy when they are having fun together carries over into the workplace.
8. **Offer emotional support on social media as well**. Going back to the idea of meeting people where they are most comfortable, many people nowadays communicate through social media. If you are a "no Facebook or Instagram for me" holdout, you are likely missing out on an opportunity to bond with your colleagues. Good feelings that evolve from positive social media interactions also carry over to the workplace. Social media is not a replacement for face-to-face interaction, but it can help build relationships.
9. **Make some of the social functions charitable ones that support community causes and projects that are important to your staff**. There is nothing more rewarding, or bonding, than bringing people together to do good in the world. Millennials and other young people are highly attuned to this. Being an employer who supports community efforts to make the world a better place can engender goodwill and inspire loyalty among your employees. For example, putting together a team for a heart or cancer walk, or collecting toys for disadvantaged children over the holidays, is a great way to bring people together and simultaneously support important community efforts.
10. **Finally, make your workplace a place where people feel valued and enjoy coming**. Every profession has its frustrations. Anesthesiology is no exception. Many things happen—patients experiencing unexpected complications, annoying surgeons, inefficiencies in the system—that you simply cannot control. You can try to make them better, but you cannot always determine the outcome. But you *can* control your attitude and the way you treat people. When you treat people with integrity, you create an intangible loyalty and sense of well-being that money simply cannot buy.

In short, understanding where other people are coming from, respecting them as individuals and recognizing their primary needs are a recipe for success in all human interactions. Bringing humor and levity to situations doesn't hurt either. Building relationships with people and honoring their roots is the foundation of any successful anesthesia group culture and, ultimately, any successful anesthesia group. Bridging the generation gaps is just one small part of developing a lasting culture and committed workforce.

Shena J. Scott, MBA, FACMPE, Founder & CEO of Scott Healthcare Consulting, Inc., has been actively involved in anesthesia practice administration for over 28 years. She is a former president of the Medical Group Management Association Anesthesia Administration Assembly, former chair of the MGMA Board of Directors and a frequent speaker at ASA, MGMA and other healthcare conferences. Ms. Scott spent the first 22 years of her healthcare career as the executive director of Brevard Anesthesia Services, PA (BAS), a 50+ provider practice. In 2013, BAS joined with three other physician groups and several hospital-employed physicians to form Brevard Physician Associates, PLLC (BPA), an independent group of 200 providers. Ms. Scott served as an advisor to BPA during its merger and formation and as its senior non-physician executive for five years prior to forming her own firm in 2018. Ms. Scott now helps anesthesia practices with a variety of consulting needs and can be reached at ScottHealthcareConsulting@gmail.com.

Compensation for Anesthesia Group Leaders: Who, When, How Much and Why

Continued from page 3

Who is Typically Compensated?

In our experience, the following roles are often compensated in anesthesia groups: president; other officers, if their role is significant (such as the treasurer, who often leads the Finance Committee and performs other functions); board members; committee members; and other significant roles, including schedulers, medical directors and department chiefs (which are sometimes compensated by hospitals or other organizations).

Compensation Options

Unfortunately, there is no definitive source of information on the *amount* anesthesia group leaders should be compensated.

The Medical Group Management Association produces a *Medical Directorship and On-Call Compensation Survey* that provides information on equitable compensation based on duties. However, this survey appears to be more focused on negotiating directorship fees with hospitals and other organizations.

In most cases, groups try to make their physicians economically whole for their work on governance. As a result, compensation typically takes the form of money; time off from clinical duties; vacation time; or other benefits, such as reduced call responsibilities.

For those who spend a large amount of time on leadership issues (typically the group's president, and possibly the treasurer), groups can consider systems based on:

Productivity. In a productivity-oriented compensation environment, the leadership work can reduce a physician's productivity, and, therefore, reduce their compensation. In these cases, such groups typically estimate the potential loss in productivity and pay a stipend to make up for this loss. For example, if a leader devotes 25 percent of their normal clinical time to practice management, they may be paid 25 percent of an average shareholder compensation (on top of what they produce) to make up for that loss of productivity.

Sometimes the work of leadership is performed after hours. In these cases, we often see groups estimate that amount of work and agree on a stipend for it.

Equal Share. In equal share compensation situations, groups typically deal with leadership by providing administrative time for the leaders to do the work or providing a stipend for work that is done after hours. Some groups compensate leaders with reduced call responsibilities or additional vacation time. Often, we see groups set stipends (discussed below) for board and committee positions.

In other cases, the group pays an established amount for board or committee meetings up to a certain amount. For example, the group may say "We expect the Finance Committee to meet monthly, and we will pay members $250 per hour for a maximum of three hours per month."

For other roles, such as schedulers and medical directors, the group often establishes a stipend amount.

In setting stipends or hourly meeting rates, we have seen many groups calculate an average hourly clinical compensation rate (average physician compensation divided by 2,080 hours), and then estimate the time that people will spend on leadership activities. Typically, some negotiation is involved regarding the amount of time to be spent on such activities.

Occasionally, groups discount the calculated rate because administrative work is not directly income-generating. However, we believe that this work is just as important as clinical work, and, therefore, should be equally compensated.

From time to time, important projects may consume a significant amount of physician time. In such cases, groups use some combination of the options described above to reward these physicians.

Compensation Matters

In today's environment of rapid change, capable and effective leadership is critical for anesthesia groups to successfully navigate the murky waters of a marketplace that is far less predictable and more competitive than it was a few years ago. Careful consideration of fair compensation for group leaders whose income may be affected by the time and effort required to perform these crucial roles effectively is a cornerstone of a strong and sustainable organization.

For more than 25 years, **Will Latham, MBA**, has worked with medical groups to help them make decisions, resolve conflict and move forward. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; helped over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of more than 135 medical practices representing over 1,300 physicians. Mr. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state, national and specialty healthcare conferences. He can be reached at WLatham@LathamConsulting.com.

Getting It Right: 10 HR Mistakes Anesthesia Groups Should Watch Out For

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Over years of practice, I have learned that employers seem to struggle with certain aspects of human resources more than others. These run the gamut from the basics (Who counts as an employee? What laws do we need to follow?) to the more complicated (How do we handle employee complaints? What obligations do we have to employees looking to take leave?). What follows is a list of 10 common HR mistakes and suggestions for anesthesia practices regarding how to avoid them.

Losing track of your headcount. There is a vast array of local, state and federal laws affecting employers, many of which only apply to employers of a certain size. Only employers of 50 or more individuals are covered under the federal Family and Medical Leave Act (FMLA), for example. However, state family and medical leave laws (which are becoming more common) often apply to significantly smaller employers. All practices—but especially expanding practices—need to be aware of any potentially applicable thresholds and keep an eye on employee headcount.

Not knowing who's who. Keep in mind that not all workers have the same legal rights. Anti-discrimination laws and wage payment laws, for example, commonly apply only to employees, meaning that independent contractors and owners may not be covered. Under some laws, certain non-employee workers also may not count for purposes of determining whether an employer is large enough to be covered.

However, it is important to remember that substance will almost always trump form when it comes to distinctions between employees and other workers. Simply designating someone an "independent contractor" rather than an employee is not sufficient. It is necessary to assess whether the legal standard for that classification can be met.

Owner versus employee classification issues also require analysis. Someone with only nominal or *de minimis* ownership but no real authority or control over the practice may well be entitled to the legal protections due an "employee." In addition, employers need to be alert to the legal distinctions between salaried exempt employees—who, among other things, are not entitled to overtime compensation—and hourly non-exempt employees who are. All of these classifications should be reviewed periodically.

Forgetting about state and local laws. This sounds incredibly simple, but employers sometimes forget that federal and state laws are not always identical. The federal Fair Labor Standards Act (FLSA), for example, tends to dominate conversations about wage and hour issues, like overtime. But although many states follow the FLSA, some don't (or at least they don't follow it in all respects). And, critically, if a state has a more employee-friendly law, employers must follow it (*not* the FLSA).

For instance, the FLSA regulates overtime on a weekly basis, but several states (including Alaska, California, Colorado and Nevada) regulate overtime on a daily basis. Other states may not recognize all the exemptions available under the FLSA or may deviate from the FLSA in other ways. Pennsylvania, for instance, has yet to recognize the FLSA's computer professional exemption, which allows for certain skilled workers in the computer field to be overtime exempt, or the FLSA's highly compensated employee exemp-

Continued on page 10

Getting It Right: 10 HR Mistakes Anesthesia Groups Should Watch Out For

Continued from page 9

tion, which applies a more easily met overtime exemption standard to employees earning more than a certain amount annually. (That amount is currently $100,000 but proposed regulations published in March 2019 would raise that to $147,414.)

As a result, employers who fail to account for state law when classifying and paying employees can find themselves exposed to potential liability because they've failed to pay overtime to an employee when state law requires it. Similar problems can arise in other areas in which state laws are increasingly more employee-friendly than federal law, such as LGBTQ protections and employee leave rights.

The problem doesn't stop at the state level. Around the country, municipalities are increasingly legislating in the human resources space. Dozens of cities and counties around the country now have paid and unpaid leave laws. Some municipal laws provide greater LGBTQ protections than their federal and state law counterparts. As a result, if a practice expands (or simply moves) for compliance purposes, it may not be enough to know that your new office is in the same *state*. If the new office is in a different city or county, you need to check local laws as well.

Sloppy documentation. Documenting employee discipline and performance issues is no one's favorite thing to do, but it is critically important when it comes to reducing the risk of employment-related litigation.

First, good documentation practices can help employers achieve a reasonable degree of consistency when it comes to employee discipline (i.e., ensure that Employee A and Employee B are treated similarly for similar infractions), and thus, can help to reduce employee discrimination complaints.

Second, when we get calls from employers looking for advice on separating an employee with longstanding performance or disciplinary problems, one of the first questions we ask is "what does their file look like?" The response, all too often, is "not great" (or, even worse, "what file?").

Why does it matter? Because life happens. Employees have accidents. They develop serious health conditions. They get married. They have babies. They make complaints. And in the absence of good file documentation, suddenly it can look like an employer is targeting an employee for that reason, increasing the risk of a discrimination or retaliation claim.

I can hear employers everywhere saying, "but we can explain." Maybe you can. But instead of being able to do that largely through contemporaneous documentation, you'll need a person to testify. This can make a huge difference, particularly at the administrative stage of a case in a jurisdiction that requires a plaintiff first to go to the Equal Employment Opportunity Commission (EEOC) or equivalent state agency (and where you can expect to receive a request for the employee's personnel file almost as a matter of course). And it can make a huge difference if the case eventually gets to court, adding credibility questions that make any case more difficult, and therefore, costlier to defend.

Not to mention that there is a risk you will not have a person to testify when you need them. Again, life happens. People change jobs, sometimes willingly, sometimes not. People die, sadly. Lacking a solid file *and* lacking a witness because of a death or lacking a cooperative witness because of a firing, an employer facing a discrimination or harassment suit might find itself with little choice but to settle.

Getting hung up on formality. When we hear from employers who are facing an employee complaint of discrimination—especially harassment—one of the first things we ask (and one of the first things an administrative agency or plaintiff's lawyer will eventually ask) is whether it's the first complaint of its kind.

All too often, the response we hear is: "It's the first formal complaint." Even in 2019, many employers seem to be laboring under the misimpression that they only need to deal with "formal" employee complaints—a term they may interpret to mean any number of things (e.g., that the complaint must be submitted in writing, or that it must be submitted through the proper channels to the proper person).

Sometimes this is a problem of ignorance. Managers haven't been properly trained on the need to identify, document and escalate concerns. But sometimes it's a function of a management team that views the complaint process as an end in and of itself, rather than as a means to an end.

If an employer's goals are to deal with small problems before they become big problems and to deal with big problems before they become lawsuits—and these should be the goals—focusing on the formality of a complaint (or lack thereof) is a self-defeating approach. It allows problems to go unaddressed simply because they weren't made "properly." It also allows would-be plaintiffs to create a narrative that is difficult for an employer to contest later.

Imagine two employees at two different companies who come forward with verbal complaints of harassment. Employer 1 congratulates itself that there's no "formal complaint" and does nothing. Employer 2 documents the verbal complaint—a process that should involve getting the employee's buy in to the substance of the complaint along the way—investigates and determines the complaint is unfounded. Not only is Employee 2 less likely to escalate their complaint than Employee 1, but even if Employee 2 goes ahead with an agency complaint or lawsuit, Employer 2 is far better positioned to defend itself than Employer 1—first, because it will be much, much harder for Employee 2 to start recharacterizing the nature of their complaint, and second, because Employer 2 will (correctly) look like an employer that cared about doing the right thing.

A surprising number of employers still fall into similar formality traps when it comes to the Americans with Disabilities Act (ADA) and FMLA. Some think that as long as the employee hasn't said "I have a disability" or "I need a reasonable accommodation," they can safely ignore an otherwise obvious problem.

They can't. Even well-intentioned employers are sometimes hesitant to start a discussion with their employee for fear doing so will create a problem. And there is some potential for "regarded as" claims under the ADA. An employer who concludes that an employee has a disability and treats them differently as a result can create liability for itself (even if the employee does not actually have a disability).

But the solution here is not to ignore an employee performance or discipline problem out of fear it might be linked to a medical issue or disability. The solution is to explore the problem without jumping to conclusions about its cause (or the possible solutions).

Similarly, while many employees will specifically ask for FMLA leave, they may have protection under the act even if they haven't asked. Employers are required to issue an FMLA eligibility notice within five business days of *either* an employee's initial request for leave *or* when the employer learns that an employee may be out of work for an FMLA-qualifying reason. Thus, employers who learn, for example, that an employee is in the hospital or that an employee has a spouse, child or parent in the hospital should not simply sit back and wait for the employee to ask for FMLA.

Confusing the ADA and the FMLA. We frequently see not only employees and employers but also healthcare providers who get confused about the difference between these two statutes (and/or their state equivalents).

We recently had an employer who received an FMLA certification form, for example, stating that the employee might be unable to work at times or might need to work from home at times due to her serious health condition. One of those things—the need for time off—is an FMLA issue. The other is not an FMLA issue. Work in any form, be it light duty, be it at home, is not leave and, therefore, is not covered by the FMLA. What that employee was really asking for was intermittent leave under the FMLA *coupled with* a request for accommodation under the ADA.

The other place where the ADA and FMLA can intersect in a way that causes employers headaches is at the conclusion of FMLA leave when employees are returning to the workplace (or not). For employees returning to work at the conclusion of FMLA leave for their own serious health condition, employers need to be careful not to request documentation stating that an employee is 100 percent able to return without restriction. Courts have found that this sort of language suggests an employer is unwilling to consider reasonable accommodation(s). For this

Continued on page 12

Getting It Right: 10 HR Mistakes Anesthesia Groups Should Watch Out For

Continued from page 11

reason, it can potentially create an ADA problem.

And for employees *not* able to return to work immediately at the conclusion of FMLA leave for their own serious health condition, employers have to consider the ADA and whether some additional leave may be a reasonable accommodation.

Missing reverse discrimination. We recently reviewed a handbook for a practice (too small to be covered by the FMLA) that included a policy offering leave for "*maternal* care for a newborn child" and "placement with the *maternal* employee of a son or daughter for adoption or foster care." This sort of gendered policy is not permissible, but they still crop up more often than one might expect, even at large (and, one would think, sophisticated) employers.

In 2017, the American Civil Liberties Union sued a global financial services company on behalf of a male employee based on a policy that allowed female employees 16 weeks of paid parental leave and male employees only 2 weeks of paid parental leave.

In 2018, the EEOC settled with a multinational makeup and skincare company over a policy that allowed female employees 6 weeks of paid parental bonding leave, male employees 2 weeks of paid parental bonding leave and female employees a "flexible" return to work benefit not available to male employees.

This is not to say male and female employees must be treated equally in all respects. Leave related to pregnancy, childbirth or related medical conditions can be limited to female employees affected by those conditions. But any *non-medical* parental/bonding/child care leave must be provided to all new parents (including fathers and adoptive parents of any gender) on the same terms.

Ignoring #MeToo. A Google search for "Millennials and sexual harassment" reveals a wealth of articles and posts written over the past year or so with titles like "Are Millennials Ready to Put an End to Sexual Harassment?" "Can Millennials Put An End To Sexual Harassment?" and "Younger Generations in the Workforce Are Making Discrimination and Sexual Harassment a Board Issue."

In fact, research suggests that women of different ages/generations don't differ much (if at all) in what they consider harassment, but they do differ in how they respond to it. Behavior that might have been quietly tolerated in the past is less likely to be tolerated by younger women in the workplace. This means that employers who haven't already need to get serious about dealing with harassment or face serious consequences, both legal and practical, when they start losing employees unwilling to put up with harassing behavior.

Reinforcing the conclusion that workplace norms are changing is a mini-trend of states legislating more aggressively in the area of sexual harassment. As of January 1, 2019, Delaware now requires employers with four or more employees to issue an information sheet on sexual harassment, and employers of 50 or more must provide sexual harassment training.

Similarly, New York recently passed legislation requiring all employers to have a sexual harassment policy and to offer sexual harassment training that meets certain standards. California, Connecticut and Maine are other states that currently mandate some form of sexual harassment training for certain private employers.

Overlooking OSHA. Many employers are unaware that the federal Occupational Safety and Health Administration (OSHA) not only directly regulates workplace safety in numerous respects but also offers legal protections to employees who complain about workplace safety issues (so-called whistleblowers). We have observed an increase in OSHA whistleblower/retaliation claims recently, and we are not alone. According to OSHA, between 2014 and 2018, the number of whistle-

blower complaints filed increased by almost 30 percent.

Obviously, all workplaces have some potential safety concerns, but medical workers face unique risks, making it that much more important for anesthesia practices to handle complaints about safety concerns properly. Some complaints may seem silly (we handled a case once involving an employee who filed a complaint about "workplace violence" and "false imprisonment" with OSHA after a manager held a closed door meeting with her), but employers still need to proceed carefully. Designate someone to handle complaints; document verbal complaints; document the investigation of verbal and written complaints; and document any corrective actions taken to address complaints determined to be valid.

Documentation can be especially important because, as volume increases, OSHA is taking longer to process and investigate complaints. As noted above, memories may fade, and employees may come and go. Without good documentation, it may be hard for an employer to rebut a whistleblower claim by the time OSHA comes knocking.

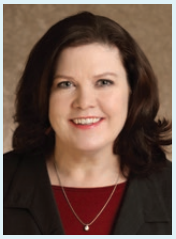
Retaliating. It is understandable for employers who feel they've done nothing wrong to be frustrated by employee complaints, but employers need to be acutely aware of the potential for retaliation claims, which continue to be on the rise. According to data released by the EEOC, as a percentage of total charges filed, retaliation claims went up every year from 2007 to 2017, making up nearly 50 percent of all charges filed in 2017.

One reason for this is the simple fact that retaliation claims are, relatively speaking, easy to prove, often coming down to little more than a matter of timing: the closer an adverse action occurs to protected employee activity (which includes things like lodging an internal or external complaint about unlawful conduct or even just providing information in support of another employee's complaint), the more that action can look retaliatory and the harder it can be for an employer to defend.

In addition, while an essential element of a retaliation claim is that an employee engaged in protected activity, complaining employees do *not* have to be correct that something unlawful occurred to be legally protected from retaliation. Rather, they merely have to have had a good faith, reasonable basis to think that something unlawful occurred.

As a result, an employee who complains, incorrectly, about discrimination may not have a discrimination case. But if their employer takes an adverse action against them in response to that complaint, they may still have a retaliation case—a state of affairs that effectively expands the protections of the anti-discrimination and other laws regulating workplace conduct.

Employers need to be aware of this risk and should ask themselves whether an employee has made a complaint (and, if so, how recently) when considering disciplinary action. To circle back to the importance of documentation, employers should also ask themselves whether any action they might decide to take is in line with discipline meted out to other employees for similar infractions (and, if it's not, be prepared to explain the difference in treatment).



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Hospital Divorces Anesthesia Group After 24 Years of Marriage: How to Avoid the Same Fate

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We still love you but, hey, we're in love with someone else who spends less on ~~clothes~~ stipends.

When I was a kid growing up in Los Angeles, there was a television show that I loved to watch: the original *Divorce Court*. You see, at the time, California required *grounds* for divorce, and the show proffered up titillating tales of deceit. But just across the border in Nevada, one could quickly obtain "residency" and snip marital ties on a whim.

Just like a 1960's Reno divorce, last year, Olean (NY) General Hospital announced that it was terminating its 24-year marriage to Southern Tier Anesthesiologists. Apparently, it was the "for richer or for poorer" part of the marital vows that pushed the hospital over the edge.

Yes, after 24 years of marriage, it was time for a change. Will the successor anesthesia group be a "trophy wife" or bring staffing strife? Only time will tell.

But either way, there's actionable insight to be gleaned, insight that can help you prevent the same fate—termination of your group's facility contracts.

Money talks. According to a letter obtained by the *Olean Times Herald*, Olean General Hospital stated that Southern Tier's bid for the renewal contract would have cost it too much: ". . . It is simply not feasible for [Olean General Hospital] to pay millions of dollars more than necessary over the life of the . . . contract."

Of course, none of us are privy to the inside terms. Southern Tier claims to have done its best to meet any offer. But the hospital says there was a great gap. And, it's reported that the hospital lost $3 million the previous year. How and why they lost it is anyone's guess, but it's unlikely that it was significantly due to Southern Tier's contract.

We love you, but what have you done for us lately? Again, we don't have any specific facts, but query whether it was only an issue of money that led the hospital to take "bids" for Southern Tier's anesthesia contract after a 24-year relationship.

Maybe the relationship had become stale. You know, a "commodity" (at least in the mind of the hospital CEO and perhaps in the collective mind of Southern Tier). Although it's impossible for personal services of any kind to actually be a commodity, it's a mind virus with legs. And commodities are, by definition, fungible. Bye-bye Southern Tier!

The actionable insights for you. If your group holds any facility contract that pays you *anything*—a coverage stipend, a directorship fee, an income guaranty—*anything*, you must constantly assess how to increase the value proposition to the facility.

There are only two ways to do this: 1) reduce the amount you're paid by the facility, which might or might not be possible, and 2) increase the amount of *perceived* value that you're providing to the facility.

Note the word "perceived." There's no such instantiated thing as "value." In fact, value is as malleable as clay. You, as

an anesthesia group leader, can't set value for a facility because it's set by the perception of the facility's leaders.

And the cold, hard truth is that if they *think* that they are receiving value from the deal—something worth more to them than the worth of what they are giving up—they will most likely keep your group around. On the other hand, if they think they're giving up more than they are getting, then you'll soon be crying southern tears over your lost contract.

And, again, magically perhaps, because "worth" and therefore "value" are subjective concepts, they can be influenced. Although you can't set the value for the facility, you can heavily influence how it perceives value.

What programs and initiatives have you created at the facility that increases that perception? What add-on services do you provide at little to no cost to you that produce a disproportionate increase in perceived value? I've long referred to this as creating an Experience Monopoly™: an experience for facilities, patients and referral sources that they cannot get from anyone else. How often do you meet with the facility's leadership, both administrators and medical staff leaders, to stoke top-of-mind thinking of the value that you create?

Despite all of the rainbows and unicorns talk about "alignment" and "valued partners," facilities view physicians, especially (Anti-Kickback Statute alert!) those who do not refer patients to them, as vendors: Cafeteria—check! Laundry service—check! Hospital-based medical group—check! Or, in the case of Southern Tier—uncheck!

Don't take for granted that you can't be unchecked as well.

So, as much as you may love the idea that you're "supporting the hospital," take a bit of advice from polygamists: spread the love around. Have contracts at as many facilities as you can, but not simply within the same health system, because that's just the same mistake on a larger scale!

After all, you never know when you're going to be dumped, even if you've done everything possible to keep the love alive.

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Assessing Ambulatory Anesthesia Opportunities: Robust Due Diligence Required

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It is the rare anesthesia practice that covers only one hospital these days. Most anesthesia practices cover at least one ambulatory facility in addition to their primary hospital, and many practices actively pursue every outpatient opportunity within their service area. Usually, this serves the practice's strategic and financial objectives—but not always.

Conventional wisdom holds that the payer mix is generally more favorable in ambulatory venues. It can also be the case that clinical days are both shorter and more profitable. At least this is the hope. The problem is that hope and reality are often quite different.

Each anesthesia practice is a unique and distinctive entity. As shown by the examples in this article, each anesthesia ambulatory arrangement is unique as well. This reality underscores the significance of determining each ambulatory agreement's true potential upfront rather than downstream, when it has created a drag on the practice. One could say that a practice expansion is a lot like an anesthetic: the most critical phase is the preparation.

Let us consider three distinct types of ambulatory or outpatient facilities. The first and most common is the ambulatory surgery center (ASC). These may be associated with a hospital or independently owned by surgeons. The common feature of such facilities is accessibility. The intent is to provide a convenient venue with ample parking and easy access that offers as efficient a surgical experience as possible.

The next type is the endoscopy center. This may be part of an ASC or it may be a freestanding facility. Endoscopists thrive in an environment with high patient turnover. The more cases they can perform per day, the better. Endoscopic procedures tend to be short, and the majority of patients are covered by Medicare.

Because Medicare policy has changed over the past four years, Medicare patients now have a fairly compelling incentive to receive regular screenings. If the case is booked as a screening colonoscopy, the patient has no deductible or copayment. This positive development notwithstanding, recent changes to the anesthesia codes have resulted in a decline in revenue potential for these cases.

The third category is somewhat of a catchall that includes doctors and dental offices in which the anesthesia provider works in partnership with one or more physicians. Such venues may or may not have all the necessary equipment to provide general anesthesia.

Driving Factors

From a practice management perspective, ambulatory opportunities can be significant in several ways, although the specific benefit to a given practice must be carefully evaluated on a facility-by-facility basis.

As cases migrate from traditional inpatient venues to outpatient venues, there is value in being able to maintain the income from these cases. Since no after-hours call is required with ambulatory venues, the inclusion of such facilities may lessen the anesthesia providers' call burden.

Venues may provide an opportunity for different staffing models. A physician-only practice may consider a medical direction model in the ASC. Sometimes the potential advantage is purely strategic; covering all the ambulatory venues in a particular market may keep out potential competitors who might be seeking to displace the practice. And sometimes it is a matter of survival. Many anesthesia practices that lost their hospital contracts only exist today because they expanded into the ambulatory market.

Any practice that wants to expand its coverage should first consider its goals and objectives. What is the intent? Taking on a new line of business always involves a certain degree of risk. We all know that any deal that seems too good to be true usually is.

If the primary goal is financial, then there must be a solid basis for believing that the revenue potential will be greater than the cost of providing the service. However, this can be a very tricky calculation, especially if the proposed agreement is with a new facility where neither volume potential nor payer mix can be definitively determined. And if the objective is strategic, how much risk is the practice willing to bear, and for how long?

Some exclusive service agreements with hospitals may preclude expansion into what could be viewed as competitive venues, i.e., those that would be drawing cases away from the hospital. Any consideration of expansion must begin with clarification of existing commitments. The good news is that, increasingly, hospital administrators have come to understand that the practice that has other contracts may not need as much financial support as those that don't.

Essential Information

Often, the evaluation of such opportunities involves more due and less diligence. Three types of information are essential.

First, the anesthesia revenue potential must be projected. This involves a determination of case volume and payer mix. Any assumptions used to determine these should be conservative. The biggest challenge is the ramp-up scenario, especially absent a financial guarantee for coverage as surgical volume builds.

Second, what are the coverage requirements and how consistently will cases be booked? Either case schedules are short and unpredictable, in which case, providers may cover them on a post-call day, or the schedule will be consistently full and require a dedicated team.

Finally, what will be the cost of coverage? This is the most critical piece of the business plan. You should know the per-day cost of all possible staffing options. Will a physician partner be the provider or a non-partner physician? Do you have the medical direction model? If so, what level of direction will be used?

Knowing your per diem cost is an essential prerequisite for any assessment of coverage requirements. For each category of provider, the per diem cost can be determined by dividing the total cost of a provider (base pay, bonuses, overtime, benefits and the cost of overhead) by the number of days the provider works per year.

Key Metrics

The best way to begin an evaluation of a new coverage opportunity is to establish benchmark references based on the existing practice. Most practices have a good idea of actual collections by facility or line of business. Basic production metrics are typically available from standard billing reports. They also know how each venue is staffed.

What most do not have, however, are the critical normalized metrics, such as yields and costs per provider day. As a practical matter, the best data only includes activity for cases performed Monday through Friday between the hours of 7 am and 3 pm, a typical day shift. Why only weekdays from 7 am to 3 pm? This

Continued on page 18

Assessing Ambulatory Anesthesia Opportunities: Robust Due Diligence Required

Continued from page 17

timeframe reflects typical ambulatory utilization.

Why is it so important to know the baseline metrics? Without them you have no point of comparison and no way to assess the impact of a new venue on the practice's overall profitability. Many anesthesia practices assume that the addition of ambulatory contracts will enhance the practice's profitability, but often this is not the case. We have seen numerous practices become spread too thin by unprofitable ambulatory commitments that limited what they could pay the partners. A couple of practices found themselves without enough revenue to recruit and retain needed providers.

Assess Impact

A simple and useful way to assess the impact of expansion is to calculate and track the overall practice net yield per ASA unit billed. As an alternative, some practices prefer to track the overall yield per hour of anesthesia time. Table 1 provides an example of such a calculation for a practice that already covers a variety of facilities. Note that for purposes of these calculations obstetric cases are excluded. This is also an example of a practice where the inclusion of six ambulatory facilities enhances the key metrics: the yield per unit billed and the yield per hour of billed anesthesia time.

Table 2 shows an additional metric: yield per provider day. There are two ways to calculate this metric: based on scheduled days or based on actual days worked. Ideally, every practice should be able to calculate these metrics based on weekday shifts from 7 am to 3 pm.

It is important to remember that no two ambulatory facilities are managed the same. The key variables are the volume of activity, the payer mix and the consistency of scheduling.

Calculating the cost per anesthetizing location day is not complicated, but some critical variables must be carefully determined. Provider compensation must include all related costs, such as benefits, pension commitments, malpractice and overhead. This is what accountants refer to as a *burdened cost*. It is also necessary to calculate how many days a typical provider works per year, which may be tricky if vacation policy is flexible. As a result, it may not always be possible to exactly determine provider days per year.

Table 3 provides three critical metrics to determine potential profitability: cost per physician day, cost per CRNA day and the impact of combining them. In the example given, one physician medically directs three CRNAs. Usually there is no cost savings if the ratio of physicians to CRNAs is less than 3:1.

TABLE 1

Assessing the Value of Expansion into an ASC: Net Yield Per ASA Unit Billed and Net Yield Per Hour of Anesthesia Time

	Cases	Units	Hours	DOS Collections	Yield per Unit	Yield per Hour
Hospital	15,592	241,240	32,621	$8,652,340	$35.87	$265.24
ASC 1	3,901	38,362	5,054	$1,743,605	$45.45	$344.97
ASC 2	2,022	18,622	2,272	$801,559	$43.04	$352.74
Endo Center	1,736	13,138	1,135	$547,276	$41.65	$482.27
ASC 3	1,213	10,079	1,011	$406,307	$40.31	$401.97
ASC 4	443	2,897	276	$124,432	$42.95	$450.11
ASC 5	509	4,923	575	$109,612	$22.27	$190.62
Overall	**25,416**	**329,261**	**42,944**	**$12,385,131**	**$37.61**	**$288.40**

TABLE 2

Assessing the Value of Expansion into an ASC: Net Yield Per Provider Day

	DOS Collections	Yield per Unit	Yield per Hour	Yield per Scheduled Day	Yield per Day Worked
Hospital	$8,652,340	$35.87	$265.24	$1,793.31	$1,793.31
ASC 1	$1,743,605	$45.45	$344.97	$2,065.95	$2,272.55
ASC 2	$801,559	$43.04	$352.74	$1,526.78	$2,152.18
Endo Center	$547,276	$41.65	$482.27	$2,026.95	$2,082.75
ASC 3	$406,307	$40.31	$401.97	$1,625.23	$2,015.71
ASC 4	$124,432	$42.95	$450.11	$1,777.60	$2,147.60
ASC 5	$109,612	$22.27	$190.62	$996.47	$1,113.26
Overall	**$12,385,131**	**$37.61**	**$288.40**	**$1,796.57**	**$1,880.75**

TABLE 3

Assessing the Value of Expansion into an ASC: Cost per Physician Day, Cost per CRNA Day and the Impact of Combining Them

Facilities without CRNAs

Type of Facility	# of Facilities Considered	Units per Case	Yield per Unit	Yield per Hour	Units per PY Day	Yield per PY Day
Freestanding ASC	141	9.0	$43.82	$419	42.4	$1,858
Single Specialty (Endo)	22	7.0	$42.41	$570	51.5	$2,182
Single Specialty (Eye)	9	6.7	$31.10	$452	62.7	$1,950
Single Specialty (Ortho)	5	11.4	$42.32	$398	45.9	$1,942
Office	70	8.0	$60.53	$654	35.1	$2,127

Facilities with CRNAs

Type of Facility	# of Facilities Considered	Units per Case	Yield per Unit	Yield per Hour	Units per PY Day	Yield per PY Day
Freestanding ASC	149	7.8	$39.17	$427	49.4	$1,935
Single Specialty (Endo)	29	6.7	$39.43	$601	77.7	$3,065
Single Specialty (Eye)	7	6.2	$24.51	$357	80.1	$1,964
Single Specialty (Ortho)	4	8.8	$55.11	$483	45.1	$2,485
Office	27	6.8	$69.70	$1,150	33.4	$2,330

Calculation of Cost per Clinical Day

Physician Gross Compensation Including All Applicable Benefits and Malpractice:		$450,000
Corporate Overhead		8%
Total Cost		$486,000
Vacation Days	40	
Holidays	6	
Weekends	104	
Total Days Worked	215	$2,260

CRNA Gross Compensation Including All Applicable Benefits and Malpractice:		$200,000
Corporate Overhead		8%
Total Cost		$216,000
Vacation Days	30	
Holidays	6	
Weekends	104	
Total Days Worked	225	$960

Typical Medical Direction Ratio

1	Physician
3	CRNA
Physician Cost	$753.49
CRNA Cost	$960.00
Per Location Day Cost	$1,713.49

Clear Plans Needed

The benchmark data and calculations provided thus far will allow a practice to establish the basic calculation of profit potential. The next step is to validate the numbers and assess the potential risk factors.

Usually the biggest challenge comes from the production and payer mix data provided by the facility, especially if it is just opening. Projected volumes and payer mix for a new facility can be notoriously unreliable. New facilities pose the biggest problem. What is the ramp-up going to look like and who will bear the cost? Cash flow always lags behind production by three or four months.

Since providers must be paid from the beginning, the question is: who will bear the expense of providing the service until the collections materialize? A large group may have the financial resources to cover the float, but doing so carries considerable risk. One would hope that the facility could provide some start-up support, but this rarely happens.

The best approach is to develop a clear business plan for each new contractual agreement. Many of these agreements are based on a handshake and a friendly agreement between the parties, but this is never advisable. There should be budget projections for both collections and cost. If the collections do not increase as projected, the practice should have the right to cancel the contract.

Should any of these considerations discourage today's anesthesia practices from exploring opportunities for expansion? Absolutely not. Few practices will survive as stand-alone hospital-based practices. The greater the need to expand, however, the greater the caution required. The goal must be to pick the horse that will go the course. Due diligence must be rigorous and consistent. The risks of expansion are significant, but so are the potential rewards if the process is handled effectively.

Please note: ABC does not endorse any of the strategies described in this article, and any patient seen at any type of facility should first and foremost receive medically necessary services and have decisions made that promote the health and wellbeing of the patient.

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What You Don't Know Can Hurt You....

Understand and Meet the QPP Requirements

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) marked the end of Medicare payment's fee-for-service model and the beginning of a performance-based payment system, the Quality Payment Program (QPP). The QPP offers the choice of two tracks: the Advanced Alternative Payment Models (APMs) or the Merit-Based Incentive Payment System (MIPS). Most anesthesia practitioners participating in the QPP in 2019 will utilize MIPS.

As CMS transitions to a pay-for-performance methodology, it is easy to get lost in the acronyms and the policy. The co-sourced **MACRA *MadeEasy*** certified Qualified Clinical Data Registry (QCDR) platform guides clients through these changes and provides a structured and practice-specific platform to ensure that a practice is not only protected from penalties, but puts itself in line for incentive payments.

The pioneering **MACRA *MadeEasy*** platform can help usher you into the future of healthcare and walk you through the steps utilizing:

- Plexus TG's Anesthesia Touch™ certified electronic health record (EHR) featuring easy data capture;
- Anesthesia Business Consultants' F1RST*Anesthesia* practice management technology and analytics; and
- MiraMed's QCDR, a CMS-approved Qualified Clinical Data Registry

Join the 6,000+ anesthesia clinicians already reporting their performance for 8,000,000 patients through the MiraMed QCDR, a MACRA-compliant registry. Call the **MACRA *MadeEasy*** hotline today at (517) 962-7301.

Professional Events

Date	Event	Location	Contact Info
April 26-28, 2019	The Alabama Association of Nurse Anesthetists Spring Meeting	Hilton Sandestin Beach Golf Resort & Spa Destin, FL	https://alabamacrna.worldsecuresystems.com/BookingRetrieve.aspx?ID=126677
May 4, 2019	Washington State Society of Anesthesiologists 2019 Spring Scientific Meeting	Museum of Flight Seattle, WA	https://www.wa-anesthesiology.org/2019-spring-meeting
May 13-15, 2019	American Society of Anesthesiologists Legislative Conference	Hyatt Regency Washington on Capitol Hill Washington, D.C.	http://www.asahq.org/meetings/legislative-conference/registration
May 16-20, 2019	International Anesthesia Research Society 2019 Annual Meeting and International Science Symposium	Fairmont The Queen Elizabeth Montreal, Quebec	http://iars.org/annual-meeting/
May 28-31, 2019	Medical Users Software Exchange 36th Annual 2019 International Conference	Gaylord Opryland Resort & Convention Center Nashville, TN	https://www.museweb.org/2019inspireconference/home
May 31, 2019	American Society of Anesthesiologists International Forum on Perioperative Safety & Quality	Messe Reed Center Vienna, Austria	https://www.asahq.org/ifpsq/esa
June 14-16, 2019	Florida Society of Anesthesiologists 2019 Annual Meeting	The Breakers West Palm Beach, FL	https://www.fsahq.org/meeting/
September 5-8, 2019	Texas Society of Anesthesiologists 2019 Annual Meeting	Hyatt Lost Pines Lost Pines, TX	http://www.tsa.org/professional/meetings.php

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