

Perfect Storm Part II: Is a Tsunami Brewing

**PERFECT STORM PART II:
IS A TSUNAMI BREWING?**

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**Conflict of Interest &
Why am I qualified to do this?**

- I have no conflicts except:
 - I have a long standing interest in the economics of academic anesthesia practice dating back to collaborations which began with Amr Abouleish and others in the late 1990's.
 - Mark Hudson, Amr Abouleish, and I continue to perform collaborative research utilizing national databases.

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Perfect Storm Overview: Part I

This has been presented from 2000-2011 by Kevin Tremper and leaves a wonderful legacy for us in Academic Anesthesiology.

No data was presented in 2012 at the SAAA Meeting. I have presented 2012 data for completeness in some of the slides. I have compiled this data since 2013.

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Outline

- 2018 SAAA Survey
- 2019 SAAAPD Report

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**The Etiology of Perfect Storm
Part I**

**MATCH DAY
1994**



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**Wall Street Journal
March 17, 1995 – G. Anders
“Once a hot specialty, Anesthesiology
cools as insurers scale back”**

- 1994 Grads-1,863 Residents graduate from Anesthesia Residencies
- 1995 Start – 892 Residents, consisting of 348 IMG's and 544 AMG's
- “This was the start of the lost generation.” The specialty is now feeling this loss at another level, as individuals from this “lost generation” should be morphing into significant leadership positions.

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Size of Residency Training Programs

- In 2018- 1,434 Senior Residents. A total of 6,346 Anesthesiology Residents are enrolled in 153 Core Residency Programs graduated
- (44% women enrolled in all specialty and subspecialty training programs).**

Residency Production: Confounding Factors

- In 2018, we know that the following pursued ACGME fellowships:

Number of Programs (N)	Positions Filled	% Women
Critical Care Medicine (N=62)	194/246	36%
Pain Medicine (N=102)	381/409	22%
Pediatrics (N=60)	244/257	49%
Adult Cardiothoracic (N=66)	217/222	29%
OB (N=34)	45/59	62%
Clinical Informatics (N=1)	2/2	0%
Regional & Acute Pain (N=18)	50/59	38%
Total	1,133/1,254	

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SAAA YEARLY SURVEY DATA 2018

n=88

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2018 Department

Attending Physician FTEs	Mean	+/- SD	Median
Surgical Anesthesiologist FTEs	45.3	30.9	38.8
Acute Pain (In-Patient)	2.1	2.35	1.1
Chronic Pain (Out-Patient)	3.5	2.59	3.0
ICU	3.4	3.64	2.0
Pre-Op Clinic	1.1	0.96	1.0
Other	1.5	2.86	0.0
Total ↓	56.9		

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2018 Department (cont'd)

Academic Rank	Clinical Anesthesiology Faculty: Total Mean	Clinical Anesthesiology Faculty: Total FTEs Mean	Clinical Anesthesiology Faculty: Clinical FTEs Mean
Chair	1.0	1.0	0.3
Professor	8.8	8.3	5.3
Associate Professor	14.8	14.0	10.7
Assistant Professor	38.5	35.7	29.4
Instructor	5.8	5.1	3.9
Non Academic Clinical	4.1	3.2	3.0
Total	73.0	67.3	52.7

*52.7/73.0 = 72% (22% non-clinical)

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National Clinical Coverage

	Mean	+/- SD	Median
How many OR's does your Department cover each day Monday- Friday?	45.7	23.7	40
How many Non-OR/Off Site locations does your Department cover each day Monday-Friday?	12.4	7.86	10
How many OB deliveries with anesthesia involvement does your Department have each year? <small>*How do we staff OB at night and at what level of deliveries does it take to have a dedicated person covering this service?</small>	3,586	4,556	2,500

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OB Staffing

	Nights	Weekends
Separately Assigned MD	51%	50%
Crossover Faculty from Main OR	35%	34%
Other	2%	3%
No Answer	11%	11%

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National Clinical Coverage

	Mean	+/- SD	Median
How many faculty do you have on each of these services per day on average, Monday - Friday in the daytime.			
OR	31.5	20.9	26
OB	1.7	1.33	1
ICU	2.2	1.93	2
Acute Pain	1.5	1.24	1
Pain Clinic	2.9	1.96	2.5
Pre-Op Clinic	1.1	0.88	1
Other	2.0	4.21	0
Total	42.9		

* Reflection of total faculty not clinical FTE

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Department Clinical Sites Coverage Monday-Friday

	Mean	+/- SD	Median
ORs	45.7	23.7	40
Off Site	12.4	7.86	10
OB	1.7	1.33	1
ICU	2.2	1.93	2
APS	1.5	1.24	1
Pain	2.9	1.96	2.5
Pre-Op	1.1	0.88	1
Other	2.0	4.21	0
Total	69.5		

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National Institutional Support

	Mean	+/- SD
Institutional Support ↑	\$ 13,201,714	\$ 8,872,979
Institutional Support / FTE ↑	\$ 224,091	\$ 150,271

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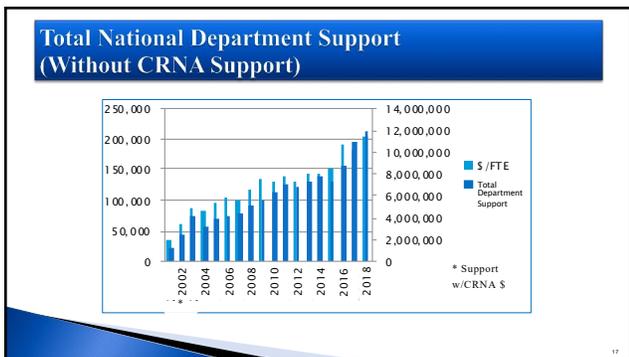
Total Support

	25%	Median	75%
Total Support	\$ 5,154,694	\$ 11,895,000	\$ 19,528,282
Total Support per FTE ↑	\$ 118,489	\$ 205,793	\$ 307,638

Mean National Institutional Support

Total Support/FTE	Year	Value
	2018	\$ 224,091
	2017	\$ 183,712
	2016	\$ 190,584
	2015	\$ 191,912
	2014	\$ 196,441
	2013	\$ 181,000

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Comparison of Economic Status by Departmental Size

<40 (n=16) 88+ (n=26)

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<40 n= 16	Mean	+/- SD	Median
Institutional Support ↑	\$ 7,987,996	\$ 5,870,159	\$ 6,000,000
Institutional Support per FTE ↑	\$ 320,119	\$ 186,040	\$ 241,677

88+ n= 26	Mean	+/- SD	Median
Institutional Support ↑	\$ 17,674,189	\$ 9,298,644	\$ 18,505,216
Institutional Support per FTE ↑	\$ 166,912	\$ 90,147	\$ 188,803

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National Departmental Revenue Producers

	Mean	+/- SD	Median
ASA Unit Production	45.3	30.9	38.8
Chronic (Out-Patient) Pain	3.5	2.59	3.0
Clinical ICU	3.4	3.64	2.0
Acute (In-Patient) Pain	2.1	2.35	1.1
Pre-Op Clinic	1.1	0.96	1.0
Other	1.5	2.86	0
Total	55.9		

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National Department Clinical Revenue

	Mean	+/- SD
ASA Units	\$34,221,889	\$28,290,073
ICU Units	\$2,026,114	\$2,765,891
Pain Units	\$2,547,235	\$2,995,337
Other	\$1,547,126	\$2,482,999
Total	\$40,342,364	

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National Collection / FTE

	Mean	+/- SD
ASA Units	\$ 547,710	\$ 428,312
ICU Units	\$ 26,459	\$ 31,605
Pain Units	\$ 40,392	\$ 67,491
Other	\$ 25,851	\$ 67,753

Is it a true reflection of clinical/FTE??

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Billing Production National

	Mean	+/- SD	Median
Total Anesthesia Units Billed	801,507	439,187	735,113
Total Anesthesia Units Billed Per FTE ↑	13,580	13,563	11,555

Billing Data

	Mean	+/- SD
What is your average \$ amount collected per unit?	\$ 45.99	\$ 34.60

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Number of Units Billed

	Mean	+/- SD
ASA Units	801,507	439,187
ICU Work Units	29,880	37,204
Pain Work Units	26,718	21,421
Other	20,914	35,971

Billing – Collection Mean Summary

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	\$45.99	\$34.60	\$36.11
Work units in ICUs (wRVUs)	\$64.41	\$79.87	\$55.27
Units for Pain (wRVUs)	\$96.39	\$122.57	\$79.89
Any other billed services	\$65.79	\$54.24	\$60.10

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ASA Units – Collections for Anesthesia Services						
n	Mean	SD	90%	75%	50%	25%
85	\$45.99	\$34.60	\$90.74	\$49.88	\$36.11	\$28.19

wRVUs – Collections in ICUs						
n	Mean	SD	90%	75%	50%	25%
72	\$64.41	\$79.87	\$101.40	\$66.77	\$55.27	\$37.84

wRVUs – Collections for Pain						
n	Mean	SD	90%	75%	50%	25%
79	\$96.39	\$122.57	\$143.31	\$105.16	\$79.89	\$54.47

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ASA Units Billed: ASA Units/Year						
n	Mean	SD	90%	75%	50%	25%
85	801,507	439,187	1,269,715	1,077,654	735,113	510,108

Units Billed: ICU wRVUs/Year						
n	Mean	SD	90%	75%	50%	25%
74	29,880	37,204	71,284	42,031	20,265	5,654

Pain wRVUs/Year						
n	Mean	SD	90%	75%	50%	25%
78	26,718	21,421	60,630	34,953	20,841	12,768

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Number of ASA Units Billed/FTE: ASA Units						
n	Mean	SD	90%	75%	50%	25%
85	13,580	13,563	18,118	14,795	11,555	9,498

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SAAA 2018 Compensation Total Compensation Including Income Plus Pension Contributions			
Compensation Includes Income Plus Pension Contribution	25%	Median	75%
Instructor ↑	\$226,494	\$298,000	\$332,019
Assistant Professor ↑	\$331,409	\$358,143	\$386,604
Associate Professor ↑	\$368,090	\$391,257	\$423,697
Professor ↑	\$388,882	\$411,550	\$443,507
Non Academic Clinical ↑	\$166,838	\$276,133	\$386,391
Chair ↑	\$561,656	\$600,000	\$677,250

*Is not a reflection of C FTE

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Faculty Benefits			
	25%	Median	75%
Instructor	\$0	\$17,537	\$47,250
Assistant Professor	\$49,617	\$60,517	\$76,426
Associate Professor	\$50,228	\$65,309	\$82,584
Professor	\$51,894	\$66,357	\$87,539
Non Academic Clinician	\$0	\$0	\$24,438
Chair	\$60,377	\$85,869	\$118,225

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- | Summary of 2018 Submissions | |
|-----------------------------|--|
| For the Average Department | |
| - | Less Faculty |
| - | Same or more clinical work as reflected by ASA units and work RVUs |
| - | Greater compensation per faculty |
| - | Deteriorating payor mix |
| - | Unprecedented increase in Institutional Support |

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Understanding Clinical Productivity for Anesthesiology Departments

Utilize the Following:

- ▶ Not Simple
- ▶ Key Point: Organizational factors that determine a facility type impact clinical productivity.
- ▶ To best understand, compare to similar types of facilities:
 - ❖ ASC to ASC
 - ❖ Community Hospital to Community Hospital
 - ❖ AMC / Trauma to AMC / Trauma

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Anesthesiology Group Clinical Productivity: Measuring, Comparing, Benchmarking

- Measuring:
 - Develop metrics that work for your department
 - Essential: Need to know what the metric values and deviates
 - Dashboard: Used to identify areas to look at more closely
- Comparing
 - Done within a department by comparing facilities
 - Best if similar type of facilities
 - Can adjust for non-anesthesia factors
 - Often done by comparing the same facility to previous years
- Benchmarking
 - Need national data benchmarks
 - Metrics defined the same way for all groups
 - Not as granular as internal metrics
 - Limited comparisons
 - Need to benchmark to similar facilities (type and size) since you can't control non-anesthesia factors

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Covers Measuring, Comparing, Benchmarking February 2019 Anesthesiology

REVIEW ARTICLE

ANESTHESIOLOGY

Measuring Clinical Productivity of Anesthesiology Groups

Surgical Anesthesia at the Facility Level

Amr E. Abouleish, M.D., M.B.A., Mark E. Hudson, M.D., M.B.A., Charles W. Whitten, M.D.

Anesthesiology 2019; 130:336-48

ABSTRACT

Benchmarking and comparing group productivity is an essential activity of data-driven management for clinical anesthesiology, recognizing that data is a daunting effort if meaningful conclusions are to be made. For anesthesiology groups, productivity must be done at the facility level in order to reduce some of the confounding factors. When industry or external comparisons are done, then the use of total ASA units per anesthesiology site allows for overall productivity comparisons. Additional productive components that ASA units, however, (including room) allow for leaders to develop productivity dashboards. With the emergence of large groups that provide care in multiple facilities, these large groups can choose to invest more effort in collecting data and comparing facility productivity internally with group defined measurements including total ASA units per full time equivalent.

(Anesthesiology 2019; 130:336-48)

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BENCHMARKING DATA FOR SAAAPD

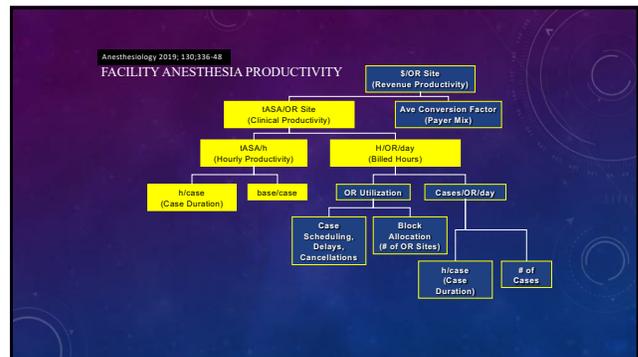
- 2003 Data
Anesth Analg 96: 802-812; 2003
Abouleish AE, Prough DS, Barker SJ, Whitten CW, Uchida T, Apfelbaum JL. Organizational Factors Affect Comparisons of Clinical Productivity of Academic Anesthesiology Departments.
- 2013 SAAA Report
<http://anesth.utmb.edu/Public/publications/SAAAReport.pdf>
- 2019 SAAAPD Report: Surgical Anesthesia

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2019 SAAPD REPORT

- Designed to report data by facilities
- Provides median values for all facilities, then type of facilities, and size of facilities
- Then breakout for each category and subcategories that includes Mean, 10th, 25th, 50th, 75th, and 90th percentile
- Allows for benchmarking your facility three ways: to all, to same type, and to same size

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2019 SAAAPD REPORT: MEDIAN BY FACILITY TYPE

	All Facilities	AMC	Community	Children	ASC
n	140	69	26	7	38
tASA/case	13.9	15.9	12.0	13.9	8.8
Base/case	5.8	6.3	5.3	6.3	4.4
h/case	2.0	2.3	1.9	2.0	1.1
h/OR/d	6.5	7.3	5.8	6.3	4.4
case/OR/d	3.2	3.1	3.4	3.0	3.7
tASA/OR	11,546	12,592	11,164	12,364	8,911
tASA/h	7.0	6.8	7.2	7.3	7.8

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2019 SAAAPD REPORT: MEDIAN BY FACILITY SIZE: USE SIMILAR FACILITY TYPES

	All Facilities	AMC	Community	Children	ASC
n	140	69	26	7	38
tASA/case	13.9	15.9	12.0	13.9	8.8
Base/case	5.8	6.3	5.3	6.3	4.4
h/case	2.0	2.3	1.9	2.0	1.1
h/OR/d	6.5	7.3	5.8	6.3	4.4
case/OR/d	3.2	3.1	3.4	3.0	3.7
tASA/OR	11,546	12,592	11,164	12,364	8,911
tASA/h	7.0	6.8	7.2	7.3	7.8

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2019 SAAAPD REPORT: MEDIAN BY NUMBER OF ANESTHETIZING SITES

	ASC<10	nonASC<10	nonASC 10-19	nonASC 20-39	nonASC 40 or more
n	34	23	16	28	35
tASA/case	8.7	12.8	14.6	14.5	16.1
Base/case	4.3	5.1	6.2	5.9	6.7
h/case	1.1	2.0	2.1	2.2	2.4
h/OR/d	4.5	5.7	7.0	7.5	7.1
case/OR/d	4.1	3.0	3.2	3.3	3.1
tASA/OR	9,019	11,452	12,746	12,719	12,290
tASA/h	7.6	7.2	7.2	6.7	6.9

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MEDIAN TASA/OR DOES NOT MEAN MEDIAN OTHER MEASUREMENTS

	AMC (n=69) Median	Group 1	Group 2	Group 3
Sites	39	57.75	25.00	42.00
Staffing Ratio	1.8	1.3	2.3	1.6
tASA/case	15.9	15.4	15.9	14.3
Base/case	6.3	6.5	6.7	8.3
h/case	2.3	2.2	2.3	1.5
h/OR/d	7.3	7.2	7.3	5.3
case/OR/d	3.1	3.2	3.2	3.5
tASA/OR	12,592	12,398	12,592	12,624
tASA/h	6.8	6.9	6.9	9.6

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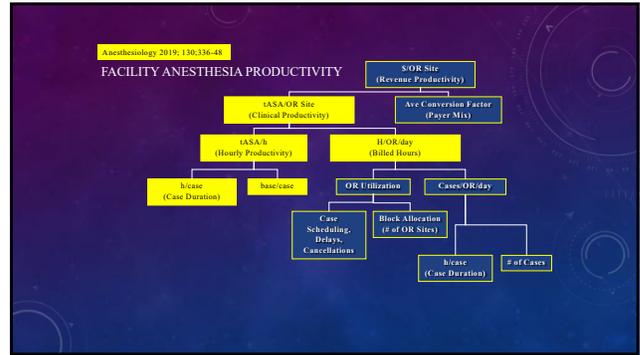
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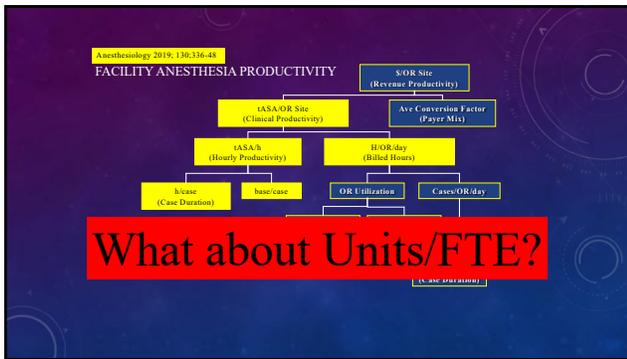
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tASA/h	6.8	6.9	6.9	9.6

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“PER FTE” MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio
- Per MD means per anesthesiologist in the OR that day
- Per MD does not equal Per FTE

	MD only	Staffing ratio >2
Cases/MD		
tASA/MD		
H billed/day/MD		

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“PER FTE” MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

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	MD only	Staffing ratio >2
Cases/MD		
tASA/MD		
H billed/day/MD		

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“PER FTE” MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

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- Per MD does not equal Per FTE

	MD only	Staffing ratio >2
Cases/MD	984.2	2,886.5
tASA/MD	8,765	26,033
H billed/day/MD	4.7	12.1

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"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

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	MD only	Staffing ratio >2
Cases/MD	984.2	2,886.5
Cases/OR	984.2	1,124.8
tASA/MD	8,765	26,033
tASA/OR	9,241	8,931
H billed/day/MD	4.7	12.1
H billed/day/OR	4.7	4.6

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"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio

Unfortunately, deans, consultants, administrators want "units per FTE".
 No meaningful benchmarking because of factors that affect "units per FTE".
 Can use internally if control factors ...

	MD only	Staffing ratio >2
Cases/MD	984.2	2,886.5
Cases/OR	984.2	1,124.8
tASA/MD	8,765	26,033
tASA/OR	9,241	8,931
H billed/day/MD	4.7	12.1
H billed/day/OR	4.7	4.6

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

Measurement does not include:

- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU prep, PACU, Schedule Runner)

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

$$\frac{tASA}{FTE} =$$

Measurement does not include:

- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU prep, PACU, Schedule Runner)

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

$$\frac{tASA}{FTE} = \frac{tASA}{OR} \times \frac{OR}{ORFTE}$$

Measurement does not include:

- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU prep, PACU, Schedule Runner)

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

$$\frac{tASA}{FTE} = \frac{tASA}{OR} \times \frac{OR}{ORFTE}$$

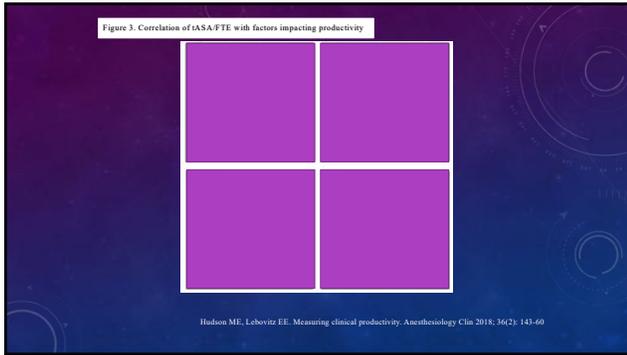
ORFTE = regular week.days providing surgical anesthesia / total workdays available
 FTE = full time equivalent

Measurement does not include:

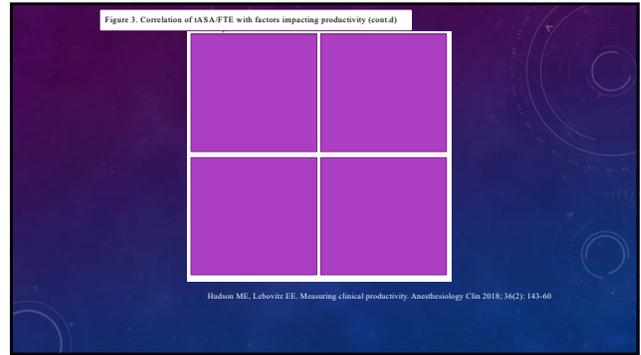
- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
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OB ANESTHESIOLOGY

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	Small	Low Medium	High Medium	Large
Deliveries/year	0-1,199	1,200-2,399	2,400-3,599	≥3,600
C-sections/year	0-359	360-719	720-1,079	≥1,080
Epidurals/year	0-719	720-1,439	1,440-2,159	≥2,160

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SUMMARY OF KEY FINDINGS OF OB

1. % Epidurals: The Small facilities had slightly lower % ranging from 52-59% median values, while all the other groupings had median values ranging from 59-66%.
2. % C-sections: Smallest facilities had the highest median values ranging 37-38%, while the other facilities ranged from 28%-32% (except one with 38%).
3. As expected, dedicated staffing for the labor and delivery unit was different depending on size of workload. Although findings different slightly by which grouping one used, the following is based on total deliveries/year grouping.
 - a. Small Groups had a high percentage of facilities with no dedicated clinician providing obstetric anesthesia during the day or in-house on call.
 - b. Low Medium groups had >80% of facilities with an anesthesiologist assigned to obstetric anesthesia during the day, but about half had an anesthesiologist assigned on call in-house.

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SUMMARY OF KEY FINDINGS OF OB (CONT'D)

- e. High Medium groups almost all had an anesthesiologist assigned during the day, but only about half had an anesthesiologist in-house on call.
- d. Large groups had 100% anesthesiologist assigned to obstetric anesthesia during the day and 94% had an anesthesiologist in-house on call.

3. 24/7 tubal ligations are typically provided in about half of facilities, except for small facilities that are only offered in less 20% of the facilities.
4. Alternatives to epidurals – specifically Nitrous Oxide or PCA Remifentanyl – are not offered as often within small facilities. In Large facilities, Nitrous Oxide was available in more than half of the facilities, and PCA Remifentanyl 40-50%.

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ICU

- Abouleish, Hudson and Whitten felt the data were “too dirty” to draw conclusions.
- Our recommendation is to repeat involving subject matter experts and beta testing

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SUMMARY OF COMPARING PRODUCTIVITY

- Review Article: Anesthesiology February 2019 provides detailed discussion of how to do this and what each measurement is calculated and means
- SAAAPD 2019 Report provides benchmarking data (more than what was presented)
- “per FTE” measurements are only valid internally because of the many non-anesthesiologist factors

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My observation in running a large Department,
AND SPEAKING TO OTHER CHAIRS, is that there is a shifting
emphasis to concurrency rates, by hospital administration.
Many of us are also seeing capitated fees for the MD portion of a case
involving a CRNA.

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REALITY

Healing is an Art
Medicine is a Science
Healthcare is a Business



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