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It is a Good Time to Expand Your Circle!

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The recently passed health care reform law, the Patient Protection and Affordable Care Act includes a mandate for the Centers for Medicare and Medicaid Services (CMS) to test innovative payment models to reduce program expenditures while preserving or enhancing quality(1). One example of specific payment models to be tested is bundled payments for complete episodes of care such as an entire surgical hospitalization. CMS must launch pilot programs on bundling for episodes of care by 2013 and these will run for at least 5 years. Another example of a new payment model is accountable care organizations (ACOs). Pilot programs with ACOs will commence in 2012. ACOs consist of providers who are jointly held accountable for outcomes and reductions in cost, and may or may not be physician-led. These new payment models are designed to provide an incentive for improved coordination of care and for delivering only indicated services. Health care systems throughout the world have attempted to use financial incentives to improve system-wide performance, and international comparisons of different financial incentives can be useful (2,3). Thus, it may be of international interest if fundamental changes in financial incentives are implemented. Anesthesiologists may view these as a looming threat, because these payment models introduce an element of financial risk. However, they can also be viewed as an opportunity. For anesthesiologists interested in broadening their range of services, these models definitely offer opportunities. For example, an anesthesia group that establishes a preanesthesia clinic (PAC) and is able to apply evidence-based practices such as the American College of Cardiology/American Heart Association guideline on cardiovascular evaluation and care for noncardiac surgery is poised to bring substantial savings to its ACO. Studies on the implementation of this guideline have demonstrated substantial savings while maintaining quality of care(4–6).

The vision of anesthesiology embracing perioperative medicine has often been promoted by our thought leaders. Saidman proposed in his 1994 Rovenstine lecture that we should use the term “perioperative medicine and pain management”(7) to describe what we do and what we should do. The ASA Task Force on Future Paradigms of Anesthesia Practice concluded that anesthesiologists need to take on a more dominant role in perioperative management(8).

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Despite such leadership, and demonstrated benefits of anesthesiologists running PACs (9), there has been limited progress. Undoubtedly, our movement towards these goals has been hampered by a lack of financial incentives. A routine preanesthesia evaluation is required by CMS and does not qualify to be billed because it is considered compensated for as part of the anesthesia base units. For a more comprehensive preanesthesia evaluation and perioperative management anesthesiologists are mistakenly reluctant to bill separately even though this is reimbursable. In a recent review of a 5% random national sample of 2006 Medicare claims for 20 common outpatient and inpatient procedures only 311 of 21,963 preoperative consultations were billed by anesthesiologists.^a Consequently many departments have found it challenging to finance the staffing of PACs. This is not unique to the United States and is reported as a limitation in Europe and Asia as well(10,11). However, CMS regulations clearly state that separate billing is appropriate if more than a routine evaluation is done and it is medically necessary(12). There are no limitations based on specialty of provider. Thus our specialty needs to be more proactive in educating members on appropriate billing. One way of financing a PAC is by obtaining support from the hospital administration. Although hospital support may sometimes depend upon difficult negotiations with hospital administrators, the benefits of PACs to institutions of reduced operating room cancellations and delays as well as reduced length of stay are well documented (13–17). Much of this will change under future proposed payment models, and anesthesiologists are more likely to be incentivized to provide these cost-effective services. Bundled payments and ACOs provide incentives to avoid unnecessary preoperative testing and unindicated consultations. Fischer reported a 73% reduction in preoperative medical and cardiology consultations after an anesthesiologist-directed PAC was established(9). A recent study suggests that anesthesiologists may be uniquely qualified to reduce the number of unnecessary tests(18). Mythen, in a recent editorial “Fit for Surgery?” eloquently argues that the “greatest potential for improving outcome after major surgery is determination and modulation of fitness for surgery” and that anesthesiologists are most likely the specialists best suited for this(19). Specifically, a role for anesthesiologists within ACOs that has been considered is prescreening of patients to determine if they meet criteria for surgery^b. This is consistent with the view expressed by Mythen. Thus, a substantially expanded scope of practice is anticipated for anesthesiologists, and those who can perform these new services well are likely to be financially rewarded.

Each ACO will need to focus on quality of care because outcomes will be tracked(1). Anesthesiologists impact outcomes in myriads of ways such as the choice of anesthetic, perioperative management of fluids, temperature, blood glucose, depth of hypnosis, pain, and antiemetics, to name a few(20–25). A natural expansion of this can be directed to the preoperative period with optimum control of arterial blood pressure, necessary and appropriate but not excessive diagnostic testing, and management of medications that require adjustments such as anticoagulants, antiplatelet drugs, hypoglycemics and certain blood pressure medications.

For more than three decades, our specialty has championed the critical evaluation of preoperative testing. Practice variation was documented, cost-effectiveness was questioned, and attempts to reduce routine preoperative testing were undertaken. Recent publications support that continued critical review of preoperative testing with the goal of reducing unnecessary expenditures is appropriate(26). By way of this effort, anesthesiologists can potentially save billions of dollars each year(27–30). We should continue to lead the way towards cost-effective perioperative care. Future payment models may provide more appropriate compensation for these efforts than what has been our experience under current

^aThilen, unpublished data, ongoing study funded by University of Washington, data obtained under CMS Data Use Agreement 21194

^bASA June 3 2011 letter to CMS. Accessed June 3, 2011 at www.asahq.org

CMS reimbursement methodology. This requires that we are well prepared to meet the challenges of a broader responsibility for perioperative care.

Currently, many anesthesiology and surgical practices rely on medical and cardiology consultations for a substantial number of their patients. The purpose of obtaining a medical consultation is to add unique expertise, beyond what is provided by the surgeon and the anesthesiologist. There is overlap among the services offered by the medical consultant, the surgeon and the anesthesiologist. This interaction is not well defined but is conceptually demonstrated by the Venn diagram in Figure 1 with the role of consultants represented by the red area that lies outside the yellow or blue circles.

Guidelines for when a medical or cardiology consultation is indicated are not clearly delineated in the medical literature.^c The ASA Practice Advisory for Preanesthesia Evaluation does not offer specific guidelines relating to medical consultations, nor does the American College of Surgeons or the American College of Physicians. The various surgical specialties provide different approaches in the care of patients and collaboration with consultants. Therefore, and not surprisingly, substantial practice variation in requesting consults may be the norm(31,32). Practice variation wastes resources, particularly if medical consultation is not associated with improved outcome, as was recently shown in a large observational study (33). Comparisons of perioperative knowledge and test ordering by different specialties suggest that anesthesiologists are best qualified for these tasks(18,34). Moreover, as the only “common denominator” for all surgical patients, anesthesiologists are in a unique and advantageous position to ensure that medical consultations are appropriately requested.

It would be wise for anesthesia groups and individual anesthesiologists to prepare for this new challenge and opportunity. Many details regarding the future payment model of the ACO are still unclear. However this compensation model seems likely to become a reality. If we do not take advantage of the opportunity this offers by providing greater value through application of all our medical expertise, the risks to our specialty may be substantial.

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Fig 1.
The Preoperative “Team”
A Venn diagram with the role of consultants represented by the red area that lies outside the yellow or blue circles.