Ask the Expert

Dollars, Cents, and Common Sense? Practice Management with Dr. David Samanie

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Greetings, ASA Monitor readers! Our topic this month has widespread appeal. ASA members have enormous diversity in our clinical and professional interests, yet all of us are unified by the expedients driving our working environment, whether we realize it or not. Financial, operational, and regulatory concerns are a specter looming over every practice in the country. These factors dictate how groups are able to function, separate and apart from anything to do with the doctor/patient relationship and clinical medicine itself. So, "the stuff they didn't teach us in medical school" turns out to be awfully important.

Don't lose heart! ***Dr. David Samanie*** *may not have learned about the business of medicine in school either, but he is an honors graduate of the "school of hard knocks." He has a wealth of experience in perioperative medicine and has worked in diverse practice environments.*

As always, I welcome feedback at ***zdeutch@yahoo.com*** *or via posting(s) at the online ASA Community.*

David, thanks for lending your expertise. What is your present job description?
Recently, I moved from the role of Regional Medical Director (RMD) into a Senior Vice President. This has increased the number of sites I am involved in but has opened the opportunity to create/drive clinical initiatives, efficiencies, and best practices within our anesthesia division. Strategic planning is an ever-evolving body of work, including coping with disruptions in surgical case volumes and pivoting our roles into collaborative care of COVID-19 patients at many sites.

As an RMD, I frequently traveled (pre-COVID) to my 24-plus sites. This strengthened critical relationships with our "on-the-ground" anesthesiology leaders, as well as with C-suite and perioperative leadership at facilities. In 2019, counting connecting flights (which I frequently must use), I took over 150 flights. Since COVID, my travel has much decreased. Like many professionals, I have leveraged Zoom meetings. With an increased number of sites and responsibilities, this has been an invaluable asset that I doubt I would have otherwise recognized.

Business development is another critical team responsibility; I have to engage with facilities and groups to find solutions that facilitate continued growth.

Where have you worked and what practices have you been part of?
In my younger years, upon discharge from the military, I had a fair amount of wanderlust (which has waned). This complemented my fascination with different practice structures and the complexities/challenges inherent in various clinical and geographic settings. I have had the chance to actually work "boots on the ground" with many types of practices in multiple states/locations. This has yielded a treasure trove of exposure to diversity in practice structures, management, and clinical practice, as well as many lessons learned from mistakes and failures (both experienced and witnessed).

In Texas, I have:

A. Helped form a group/partnership and concurrently negotiated the anesthesia contract with the hospital
B. Been a staff anesthesiologist in a small group
C. Worked locum tenens
D. Been employed in a large, multispecialty group (anesthesiology, ortho, neurosurgery, general surgery, urology, ENT, primary care)
E. Been chair of anesthesiology at a Level 1 trauma hospital.

In California, I was in an anesthesiology group of 20-plus physicians and served as the managing partner for two of those years. In Virginia, I came in as assistant chief in a care team practice (employed by a national company) and then became chief (and was also elected vice chief of surgery). In Wisconsin, I came in as a chief of the department (care-team model) for another national company (my current employer), and that position evolved into business development responsibilities, which in turn led to becoming an RMD and to my current role.

The compensation in these various positions has ranged from fee-for-service, to salaried, to salaried plus stipend (and/or annual metric bonus), to salary based on six month running average for time units billed.

Can you describe your military medical experience?
The Air Force paid for my medical school, and when I finished my civilian residency, I went on extended active duty for five years, two months, and 19 days. I went through the Combat Casualty Care Course and was also trained and certified as a Flight Surgeon at the School of Aerospace Medicine in San Antonio. While stationed at RAF base in Lakenheath, U.K., I volunteered for a six-month deployment with four CRNAs as part of UNPROFOR (United Nations Protection Force). We went to Croatia in support of the 40,000 UN peacekeepers present who formed a buffer zone between Croatians and Serbs. We were part of the only combat surgical hospital in that theater of operations.

What is the #1 challenge facing anesthesiology today?
The downward pressure from payers (including the across-the-board cuts proposed by CMS despite the current pandemic upheaval) coupled with the push/pressure to expand anesthesia coverage sites that may be underutilized and underfunded in various hospitals. This has placed significant stress on many anesthesia practices. What is required in this environment is a comprehensive approach that is both creative and flexible. Staffing plans must be centered in financial reality yet compatible with hospital expenditure goals (i.e., a rational, actionable business plan). In addition, proactively generating protocols and approaches that optimize patient throughput (periop efficiency along with decreased LOS) and enhance patient experience (e.g., ERAS, opioid reduction) are essential value-ads that need attention to implement. In the face of these current challenges in the health care system, I am impressed with the ongoing research and continued emphasis on patient safety, patient experience, and improved outcomes that exist within our specialty.

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Conversely, what is our "ace-in-the-hole" or biggest strength as anesthesiologists?
As mentioned above, the continued emphasis on improved outcomes as a direct function of what we as anesthesiologists provide with established best practices/protocols.

How can anesthesia practices make themselves maximally secure?
The days when we would show up, do a great job handling case(s) assigned to us and then leave (if we were not on call) are gone. In the past, that was the full measure. Such a measure is now simply the starting point. We must continue to leverage our expertise in improved patient care/experience/outcomes directly in the perioperative space. We also need to entrench ourselves in a conspicuous way in as many interdepartmental committees and workgroups as possible. This way, we can collaborate with and provide expertise in areas of the hospital that are outside of the operating suites. By doing this, we can use our expertise to provide solutions and drive change anywhere that it might be needed for the facility. When we fail to obtain a seat at the table in the non-perioperative arenas, it minimizes and

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discounts what we, as expert consultants, could bring to enhance operations and patient safety across an entire organization.

How much of the "business of medicine" do average ASA members need to be versed in?

Of course, being the best clinically informed, safest, most dedicated anesthesiologist is crucial. However, to not understand what the "C-suite" is concerned about or is looking for from an anesthesiology department will likely result in instability of a practice. This is something not routinely discussed in residency but describes the real world we practice within.

Second, understanding payment/reimbursement principles and payment incentive models (MIPS, at-risk contractual metrics monies, etc.) should be fundamental knowledge.

Which practice model do you see as the most secure going forward: academic, private, national, hospital-employed, other?

Simply put, the practice model that is most secure is that which incorporates the above-stated principles while generating high value for and direct alignment with the hospital. This can exist in any type of practice model, but it must be a deliberate, actionable choice by a group.

What is the outlook for national groups now that the pace of practice consolidation appears to have slowed, and possibly reversed?

I do believe we are at a flexion point in anesthesiology, but speaking honestly, continued moving pieces make it difficult to comment in an informed manner at present… please stay tuned.

What is your view on physician-only vs. care-team model perioperative structure?

This always seems like a loaded question, as there is generally a fair amount of emotion and strong opinions surrounding the topic. As stated earlier, I believe any practice structure that can drive efficiency, value, safety, and collaboration is optimal. But, in my view (from personal experience – *not* a reflection of the views of my organization), a well-structured care team model that consistently places the right person with the right skill set in the right place seems to run best. I say this having practiced in MD-only settings for 15-plus years and in care team models for 15 years. In a care team model, it is routine to have two clinicians available and/or present

for critical or unexpected events during a case. I believe this enhances patient safety. I also believe efficiency in patient readiness and throughput is realized via the collaborative two-person approach within the care team. Again, this is purely my personal opinion.

What is the most sobering and enlightening thing you have seen in your career?

To make a long story short, I had a close family member that underwent a major surgical procedure. In the facility where the operation was performed, there was no regional block offered for post-op pain control. This was despite the fact that many facilities in the U.S. perform a block for this particular procedure. Also, there was no multimodal pain management in the pre-, intra-, or postoperative periods, and in general no opioid-reducing approach. So, I witnessed firsthand the impact of the absence of important patient care initiatives on someone close to me. My point is not to criticize, as I recognize the difficulty in changing entrenched culture at a practice site. However, this unfortunate experience did reinforce that it is worth the effort and time to conform all of our practices up to the standard that science reveals as the best, safest, and most effective approach to patients' perioperative course. Doing so is a "game changer" for anesthesiology on a number of levels.

What do you do for relaxation?

I enjoy playing guitar, gardening in the spring (tomatoes, okra, potatoes are favorites), walking/playing with our Australian Shepherds, and unloading my wife's kiln after a firing of her ceramics and seeing the final product.

Do you have any parting words for ASA members?

Always put stellar yet safe patient care first and we will have served well the role in which we have been placed and the care that has been entrusted to us. ■