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5 Ways to Cap Anesthesia Costs in ASCs

Heather Linder | February 26, 2013

1. Move cases through quickly. Patient must be prepped, treated and discharged efficiently to get the maximum number of cases through the surgery center, resulting in maximum revenue. The speed of discharge often depends on how quickly an anesthesiologist works.

Anesthesiologists must be accustomed to working in ASCs because the process is different than in inpatient settings, said Neil Kirschen, MD, chief of pain management in the department of anesthesiology at South Nassau Communities Hospital in Oceanside, N.Y., and the medical director for the Pain Management Center of Long Island in New York. ASC patients require different techniques for faster discharge, such as more local anesthesia injections and nerve blocks. Short-acting sedatives should also be timed for the length of the procedure.

"As soon as a procedure is over, a patient should be waking up and ready to have a conversation," he said. "Proper pain killers allow a patient to ambulate sooner and be discharged and more street ready than in a hospital."

He stresses the importance of moving cases through quickly. "You can't bring another patient into the recovery room if all the beds are filled. Timing needs to be such when cases are going in, patients are being discharged."

2. Seek out cheaper versions of breathing circuits and IV tubing. Huge varieties of breathing circuits and IV tubing are available on the market, and many hospital-based providers are "used to using the latest and greatest," said Thomas Wherry, MD, principal of Total Anesthesia Solutions and medical director for Health Inventures. "It's really not necessary, and I really think you have to work with the providers and see if they'll accept something that's just as safe but significantly less expensive." ASC leaders must educate anesthesiologists on supply pricing. If you can save $5-$10 per case on supplies and the anesthesiologists are doing 4,000 cases a year, those cuts will mean a significant savings to the bottom line, he said.

He said anesthesia providers will be more likely to accept cheaper alternatives to equipment if they are encouraged by the center's medical director. Anesthesia providers should be involved in going over the various options with the medical director so that they are happy with supply choices. "You don't want to have a materials manager with a surgical tech background ordering something that may be inferior or something they won't use," he said. "Getting buy-in from the medical director is the best way, then educating them on the pricing and hopefully getting them to take something less costly."

3. **Prevent anesthesia side effects. Patients experiencing side effects to anesthesia can be a major driving force behind anesthesia costs in ASCs, Dr. Kirschen said. When patients experience side effects, such as nausea and vomiting, they require additional care and cannot be discharged as quickly.**

"You need to treat them and visit them more frequently in the post-anesthesia recovery room," he said. "You also need to use different medications that can be rather expensive to counteract the nausea."

Anesthesiologists in ASCs should work to prevent side effects in order to reduce time in the PACU and move cases along more quickly. Dr. Kirschen recommends using minimal amounts of opioid narcotics for pain relief and opting instead for sedative hypnotics and prophylactic antiemetics.

"Preempting is the best way to hand those situations," he said. "Certain surgeries are notorious for causing nausea, such as gynecology and cosmetic procedures. Treat those patients properly and avoid side effects later on."

4. Look for less costly drug alternatives. Anesthesiologists should regularly assess the drugs they use to determine whether cheaper, quality alternatives exist. "For example, propofol is not as expensive as it used to be, but you still want to make sure you're using smaller vials to minimize waste," Dr. Wherry said. "You can only use one vial per patient, so if you're cracking open a lot of bigger vials, you're probably wasting a lot." He said some drugs have less costly counterparts that anesthesiologists might consider — for example, bupivacaine costs significantly less than ropivacaine and can often be used in its place.

Anesthesia providers should also be critical about which drugs should be kept on the anesthesia cart. For instance, he said, Romazicon, which is used for the reversal of sedative effects of benzodiazepines in conscious sedation, should not be kept on the anesthesia cart. "It's not a drug we should have because we'll tend to reach for it, and it costs over $100 per vial," he said. "When it's being used, an incident report should be filed. It may be helpful, but it's something you want to track."

5. Work with staff to shorten the pre-operative phone call. Most surgery centers spend a lot of time on patient triage, a process that proves costly when nurses or front desk staff members spend more time on triage than necessary Dr. Wherry said.

"If anesthesiologists do not take ownership of the process, the center spends a lot of wasted time on the phone call asking questions that aren't as directed as they could be," Dr. Wherry said. "They may be gathering labs and data that aren't necessary." He said the first thing ASCs should do is look at how much time and how many FTEs are devoted to the process of the pre-op phone call. He said for a center performing 200-300 cases per month, 1-1.5 FTEs should be sufficient. Additional savings could be realized if the pre-op admitting and recovery room staff makes the calls versus a full-time phone call nurse.

Anesthesiologists should then work with those responsible for the pre-op phone call. They should explain which information is necessary for the procedure and try to reduce the phone call to less than 10 minutes. "[Staff members] are trying to do their best, but these calls can turn into half hour conversations," Dr. Wherry said. "Anesthesia has to step in and say, 'This is all we need.'"

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