Subspecialty Fellowships Shared with Other Disciplines. What are the Issues?

John Butterworth, MD
Robert K. Stoelting Professor and Chair
Department of Anesthesia
Indiana University School of Medicine
Indianapolis, Indiana
jfbutter@iupui.edu

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How Does Pain Medicine Fit in an Anesthesia Department?

John Butterworth, MD
Robert K. Stoelting Professor and Chair
Department of Anesthesia
Indiana University School of Medicine
Indianapolis, Indiana
jfbutter@iupui.edu

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Key Issues in Pain Management

- The Pain “business model”
- The Pain Mindset (and the Surgical Anesthesia Mindset)
- Inefficiencies inherent in inpatient interventions (5-I Program)
- Overhead costs of fellowship programs

Key Issues in Pain Management: The Pain "Business Model"

- E & M codes don't add up to much
- There is a volume discount for many classes of pain patients: the more you see the more you lose
- Billing and collecting are more expensive per $ collected than for surgical anesthesia
- Need efficient time and staff management
- Incentive systems can make sense

Key Issues in Pain Management: The Pain "Business Model"

- Usually, there's no one offering to take over the surgical anesthesia business at an academic medical center; however…

Key Issues in Pain Management: The Pain Mindset (and the Surgical Anesthesia Mindset)

- Passive arrival of patients to the surgical anesthesiologist
  - Limited control over production of ASA units
  - Unless MD-only group, limited referral of patients to specific MDs
  - Obnoxious behavior does not reduce referrals
  - Hospitals generally know that they need anesthesia coverage

Key Issues in Pain Management: The Pain Mindset (and the Surgical Anesthesia Mindset)

- Pain specialists are just like the neurosurgeons
  - Referring MD satisfaction is important
  - Patient satisfaction is important
  - Control own production of RVUs
  - MD choices influence revenue
  - Hospitals less likely to recognize the considerable downstream revenue from Pain Medicine

Key Issues in Pain Management: Inherent Inefficiencies In Inpatient Interventions (5-I Program)

- Academic pain specialists may seek to perform blocks in an inpatient OR setting
- The Joint Commission (med rec, universal protocol, etc) make this impractical
- Except for implants and explants, almost every procedure can be more efficiently provided in a clinic or freestanding ASC
- Fellows and residents may (will) not help

Key Issues in Pain Management: Overhead Costs of Fellowship

- Psychiatry, Neurology, PM & R, Interventional Radiology expect their residents to be accepted
- These other departments will be delighted to help out with the overhead costs – just ask!
- Residents and fellows provide same benefit as in neurosurgery (not "force multipliers" as in surgical anesthesia)
- RRC issues (who pays for unfunded mandates?)
- Pain fellows likely do not pay for themselves

Key Issues in Pain Management: JB's Suggestions and Observations

- Pain science is fascinating; pain patients are different (no divorce from implant patients)
- Pain Medicine specialists have different views on compensation, work load, etc from surgical anesthesiologists (no 0700-1530 shifts)
- Ignore SA opinions about PM practice
- Production-based compensation

Key Issues in Pain Management: JB's Suggestions and Observations

- Institutional overhead and 5-I issues can prevent success of a pain program
- Takes a financially savvy chair to develop an efficient, effective, happy, sustainable pain group (and fellowship)
- Pain Medicine divisions will probably be better off having the same relationship to Anesthesia as Cardiology does to IM

Key Issues in Pain Management: JB's Suggestions and Observations

- How many successful groups are there consisting of cardiologists and rheumatologists?
- Las Vegas model for "switch hitters"
- I think <75% effort on pain presents financial and scheduling problems, and is likely not sustainable

Key Issues in Pain Management: JB’s Suggestions and Observations

- Did we let this one get away?

Key Issues in Pain Management: JB's Suggestions and Observations

- Did we let this one get away?
- No more than any other sub specialty
- Current graduating anesthesia residents have only rudimentary knowledge and skills in Pain Medicine
- Pain Medicine (much like CCM) will likely be practiced by MDs who have little or no interest in surgical anesthesia