Changing Anesthesia Providers:  
The Playbook for a Simple and Sustainable Transition

“Our anesthesia group is causing more pain than it cures.”
“Our subsidy is 40% higher than it was 3 years ago and we are not getting any more for it.”
“Our surgeons are complaining about delays and cancellations.”
You are Not Alone

There are several reasons why anesthesia management is the fastest growing outsourced hospital service according to a 2008 survey by Waller Lansden1. The current economic and regulatory environment has hospitals intensely focused on controlling costs and improving revenue. Hospitals are deeply concerned about the increased competition for their market’s most productive surgeons. Many are dedicating significant resources towards creating an efficient OR that increases surgical throughput and keeps their surgeons happy. As such, hospitals need more than ever for all of their staff and service providers to be aligned with these goals to ensure and sustain success.

Unfortunately, the anesthesia department has increasingly become a barrier to success. Hospital administrators are expressing increased frustration with their anesthesia department transition. While it is hard to quantify, hospital leaders generally know if their department has it or not. One test is to see whether the anesthesia chief or other clinicians are actively participating on or leading committees that steer decisions including hospital efficiency and quality. A well-integrated anesthesia team will be the eyes and ears of the hospital within the operating room, which in turn will help it recognize opportunities and facilitate positive change.

Day-of-case cancellation rates and on-time starts are the most telling data for a quick snapshot of your anesthesia department’s performance and OR’s efficiency. However, it is impossible to coach by just looking at the numbers; you have to get on the field. That means paying a visit to the operating rooms, talking to surgeons, nurses, perioperative director, and even patients. What do they say about the efficiency of the OR? Is the anesthesia group taking a leadership role?

Are Your Surgeons Getting:

1. Comfort:
   a. Knowledge they will wake up and be OK
   b. Post-op pain relief
   c. No post-op nausea
2. Respect for their Time:
   a. Low cancellation rates
   b. On-time starts
3. Communication:
   a. Pre-op – ensure they are prepared for and qualified for procedure
   b. Post-op – give contact information and the invitation to call with questions after discharge

The Playbook

When the anesthesia department is not running well, no one is really happy. However, change is scary and any disruption of the status quo will likely be met with resistance. UPMC Hamot is a typical case study where resistance is followed by elation. After the smoke cleared, the department was staffed by largely the same clinicians – now armed with the tools and leadership they needed to succeed.

Most transitions, while not simple, can be managed to look easy. The problem with the anesthesia department is almost never clinical but is usually a matter of leadership. At NAPA, we rarely replace the anesthesia providers, but we always add qualified and experienced leadership.

STEP 1.

Analyze Current Anesthesia Team

Citizenship and Performance

Citizenship within the greater hospital community, or lack thereof, is actually one of the main triggers for an anesthesia department transition. While it is hard to quantify, hospital leaders generally know if their department has it or not. One test is to see whether the anesthesia chief or other clinicians are actively participating on or leading committees that steer decisions including hospital efficiency and quality. A well-integrated anesthesia team will be the eyes and ears of the hospital within the operating room, which in turn will help it recognize opportunities and facilitate positive change.

Are Your Anesthesia Patients Getting:

1. Comfort:
   a. Knowledge they will wake up and be OK
   b. Post-op pain relief
   c. No post-op nausea
2. Respect for their Time:
   a. Low cancellation rates
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3. Communication:
   a. Pre-op – ensure they are prepared for and qualified for procedure
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The problem with the anesthesia department is almost never clinical but is usually a matter of leadership.
While eliminating the subsidy altogether may not be possible, an analysis of financial performance is an important step toward understanding whether your hospital is getting the most value for its money.

The Revenue Cycle
Medical Group Management Association (MGMA) benchmarks make it simple to see if your hospital’s anesthesia services are being billed for and collected efficiently. If the MGMA standard is the baseline, your group should be outperforming it.

The key data points are: Days in Accounts Receivables and Percent of Claims Resolved.

• Days in Accounts Receivables: If the bulk of payments are past 40 days, not enough resources are being dedicated to collections.
• Percentage of Claims Resolved: This figure should be 97 percent or greater.

Payer Contracting
Groups unfamiliar with the art and science of payer contracting have a tendency to sign every contract put in front of them, only to later realize they undersold their services and the hospital is stuck with a larger stipend. Once again, MGMA is a good starting point for benchmarking your contracts against facilities in your area. If a red flag pops up in these comparisons, it is time to renegotiate.

A national single or multi-specialty group will provide a clear advantage in contracting, as they are large enough to employ experts, likely from the payer community, to handle this essential service. Additionally, larger groups represent hundreds of providers rather than the 10 or 15 being represented by a local group or small regional management company.

Coding
Contrary to conventional wisdom, the most common coding mistakes involve under-coding rather than over-coding. For example: many anesthesia groups do not bill for add-on procedures to cardiac cases, such as placing an A-line or Swan-Ganz catheter. An annual internal review of coding is necessary to ensure compliance and that additional revenue is not being overlooked.

It is also essential that coders have access to continuous training and certification. Certified coders bring both an essential level of skill to the revenue cycle process and an increased level of credibility when dealing with payers.

Expenses
By far the largest anesthesia expense is staff, which means this is also the line item with the potential to produce the most anesthesia savings. An examination of the staffing model options and the subsequent costs to cover an OR are broken out in the following section.

Is Hospital Leadership Getting:
1. Ownership of the OR: A leadership role in helping the operating room run efficiently
2. Quality: The ability to provide for current and implement future anesthesia needs
3. Measurement: The ability to demonstrate superior outcomes
4. Collaboration: Willingness to work together

Similarly, it is also important to recognize the needs of nurses and other hospital staff. Nurses’ needs are similar to those of surgeons, but they are also looking for the anesthesiologists, as surgeons’ MD peers, to help communicate with surgeons and keep the CR running efficiently.

STEP 2. Analyze Current Team Financial Performance
In most cases, anesthesia revenues are not enough to independently fund the level of coverage hospitals need. Many hospitals have become accustomed to paying a subsidy or stipend to make up the difference, but are uncomfortable with how fast it is growing and the fact that they do not seem to be getting any more value for the money. In the year 2000, an American Society of Anesthesiologists (ASA) survey of hospitals found 70 percent of respondents were paying a small stipend, usually less than $250,000. Five years later, every hospital who responded to the ASA survey reported a stipend and a separate study by the Clinical Advisory Board reported the annual subsidy was approaching $120,000 annually per anesthesia provider.

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STEP 3. Understand Your Options – Staffing

There are many options to consider when building an anesthesia team that delivers clinical and operational quality. First, there are four staffing models to consider that all come with their own strengths and weaknesses. The decision on which is right for your facility should be based on data including cost, case-mix, and the comfort of your surgeons, staff and community.

Additionally, there are provider options ranging from hiring the anesthesia staff internally to outsourcing the department to a regional or national management group.

Staffing Model Options

**MD Only Model:** This model is generally considered the safest. It is often the model of choice for facilities specializing in cardiac, neurosurgery, transplant, and other sensitive procedures. The cost comes down dramatically if the anesthesiologist is compensated at a level in sync with the market.

**CRNA Only:** In these facilities the CRNA functions with the same scope as an anesthesiologist. This model is clearly the least expensive, but it is also the most debated. Sixteen states have opted out of the CMS physician supervision requirement. These states are: Alaska, California, Colorado (Critical Access and some Rural Hospitals only), Idaho, Iowa, Kansas, Kentucky, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington, and Wisconsin.

**MD/CRNA Mix:** This model is the most widely implemented. Utilizing medically supervised CRNAs brings down the cost of the department and puts more hands on deck to cover additional cases, improve pre- and post-op communications, room turnover, etc. The mix depends greatly on the surgical specialties and volume of the hospital. It typically means a physician to CRNA supervision ratio of 1 MD to 3 CRNAs, but the more complex cases are usually covered directly by a physician. In this model, total staffing is weighed more towards physicians than CRNAs.

**Care Team:** This model is an MD/CRNA Mix in which the CRNA may operate more independently by performing higher-risk cases. In the Care Team model, nearly every case is covered by a CRNA with physician supervision. The Care Team is incrementally less expensive than the MD/CRNA mix, but the presence of anesthesiologist supervision relieves surgeons’ responsibility for direct supervision of the CRNAs and generally makes hospital leadership and patients more comfortable with the anesthesia department.

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STEP 4. Understand Your Options – Information Availability & Processing

It is imperative that your anesthesia department provide a deep Quality Assurance (QA) program. The data derived from the QA program is essential to improving the clinical quality and overall efficiency of the operating room. Detailed reports should be available for real-time review and presented to hospital management on a regular basis to prove results and drive improvement. Spotting and fixing issues with on-time case starts, case cancellations or turnover will improve efficiency and create additional capacity that can be converted to additional cases and OR revenue.

A national management group provides a bigger-picture view of quality data since it is able to compare and contrast numbers among all its partner facilities and in some cases beyond.

Technology

Technology can help the OR run efficiently, improve revenue cycle, and facilitate better communication among providers. OR efficiency and anesthesia quality are better managed with the ability to run real-time reports on key data points including: efficiency statistics such as on-time starts, critical events such as post-lumbar puncture headaches, and special procedures such as arterial lines.

Paper alone is no longer an option for an efficient revenue cycle. Technology makes the process faster and more accurate while reducing mistakes to correct on the back end, all of which is much cheaper. Reports should be generated and analyzed for data that includes: volume, cash per case, and days in accounts receivable.

A management company should utilize an internal Collaboration Suite software to facilitate the flow of communication between all its clinicians at various practice locations. Hospitals benefit when their anesthesia chief can share problems and solutions with their network of peers across the country. If a new procedure is being used at one hospital to improve efficiency or correct a safety issue, it should be shared with all hospital partners.

Small Regional Groups (less than 5 hospitals):

Pro: May have an understanding of local culture. Able to cross-cover in cases of sickness and share call better. Doctors less reactionary when asked to do more service. Start to dedicate resources to non-clinical matters.

Con: Lack the size to have well-developed management structures. In some cases, newly added hospitals may see service suffer while the group dedicates resources to its primary hospitals. New hospitals are sometimes added to support staffing at existing hospitals and are neglected.

Large Regional or National Single-Specialty Management Companies:

Pro: Proven systems and processes for efficient OR management. Infrastructure that provides expertise in revenue cycle, contracting, and recruiting. Centralized administrative functions mean local teams can concentrate solely on clinical care. National benchmarking data. Local chair has committee of peers.

Con: Some administrators feel they are losing the local presence.

National Multi-specialty Management Companies:

Pro: Savings across the board on multiple specialties such as anesthesia, radiology, and emergency medicine.

Con: May not have the right focus on anesthesia. If a radiology group starts to provide anesthesia, it doesn’t necessarily have a track record of success in anesthesia. If anything happens to the company or the relationship is damaged in one or more services, untangling the relationship is difficult. Company does not have a single contract to focus on, so they may be willing to shift some funding from one clinical area in a hospital to another to meet short-term needs.

Citizenship within the greater hospital community, or lack thereof, is actually one of the main triggers for an anesthesia department transition.

A Quality Assurance Program will generate detailed reports for real-time review and presented to hospital management on a monthly basis to prove results and drive improvement.
Hospitals are dedicating significant resources towards creating an efficient OR that increases surgical throughput and keeps surgeons happy. As such, hospitals need more than ever for all their staff and service providers to be aligned with these goals to insure and sustain success.

STEP 5. Align Interests of Anesthesia Department with Hospital

It is impossible to structure a stipend that aligns the interest of all parties without first pinpointing revenue inefficiencies and unnecessary costs related to the anesthesia department, and using that information to choose a staffing model and anesthesia provider. In addition to the contract options below, many hospitals also utilize performance guarantees that must be met or exceeded to hit the management fee. Guarantees may include: reduction of cancellation rates, epidural rates, start times, hiring goals, or adding new services.

Cost Plus
Both parties agree on a budget and what it will cost to run the department. The anesthesia department’s revenues are fixed and the hospital’s cost could rise or fall based on pre-approved changes to the anesthesia department. The hospital benefits if revenue is higher than expected or expenses are managed to be lower than budgeted.

Fixed Fee
In this model, a set subsidy amount is negotiated, usually on an annual basis. Risk is theoretically deferred totally to the anesthesia group. However, the hospital is exposed to risk if the subsidy amount proves insufficient and the group struggles to maintain service levels.

Revenue Threshold
In this model, the anesthesia group is guaranteed a certain amount of revenue each month. The group collects what it can, and the hospital makes up the difference. A hospital employing this model should have the utmost confidence in the anesthesia group’s revenue cycle expertise. Due diligence on billing, collections, coding and contracting is recommended.

Surgical Volume Guarantee
This model is sometimes used in a hospital that experiences large fluctuations in surgical volume or a startup situation where the surgical volume is not yet steady. The hospital guarantees the number of cases so the anesthesia group can commit resources. If the hospital falls short, they make up the difference to the anesthesia group.

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About North American Partners in Anesthesia

Founded in 1986, North American Partners in Anesthesia (NAPA) is the leading single specialty anesthesia and perioperative management company in the United States. NAPA is comprised of the most respected clinical staff, providing thousands of patients with superior and attentive care. The company is known for partnering with hospitals and other health care facilities across the nation to provide anesthesia services and perioperative leadership that maximize operating room performance, enhance revenue, and demonstrate consistent patient and surgeon satisfaction ratings.

North American Partners in Anesthesia

One Exceptional Experience at a Time...Every Day.®

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