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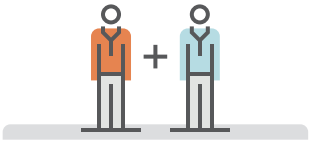

CONSULTATIVE/COLLABORATIVE MODEL

WITH PHYSICIANS AND CRNAS TO OPTIMIZE THE BUSINESS VALUE OF ANESTHESIA SERVICES

The Consultative/Collaborative (CC) model is designed to promote professional cooperation as well as create the most value for patients.[1] It does not prioritize licensure like the anesthesia care team (ACT) model, but instead it focuses on maintaining quality, maximizing efficiencies, and increasing patient/surgeon access. In the CC model, all anesthesia providers are clinically autonomous and encouraged to use their full skill set and licensure in caring for patients. Recognizing provider value and autonomy is critical for effective interprofessional collaboration and to develop an anesthesia care model that maximizes effectiveness.

The CC begins by determining the number of anesthetizing locations which are staffed with CRNAs. Then, based on local factors, the number of physician anesthesiologist team members desired to support patient throughput is determined. This creates an anesthesia care model that is completely flexible and based on patient need. In the CC model providers are free to adjust the workflow to match demand, without fear of violating regulations and arbitrary billing requirements. This flexibility also allows providers to spend more time focused on patient care than arbitrary billing activities.

By focusing on value instead of politics, anesthesia practice models involving collaboration among CRNAs and physicians allow maximum efficiency for patients and facilities while remaining responsive to facility norms and traditions. This renewed focus on value is why many facilities are abandoning models that restrict provider autonomy or dictate staffing ratios, both of which only increase healthcare spending with no evidence of benefit to the patient or health systems.

Legally CRNAs and physician anesthesiologists both have statutory authority to practice independently. Nevertheless, local communities and individual practice settings may choose to structure their anesthesia delivery models around legacy policies particular to the facility. Although surgeons and staff may be accustomed to certain staffing arrangements in the operating room environment and their preferences should be acknowledged and considered, these decisions may need to be reevaluated when determining the anesthesia care model most effective for the facility. Such decisions should be driven by appropriate clinically based evidence and organizational needs, not professional politics.

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MEDICAL DIRECTION

WITH UP TO 1:4 PHYSICIAN ANESTHESIOLOGIST/CRNA RATIOS AND THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) REQUIREMENTS

The American Society of Anesthesiologists endorses a model with physician anesthesiologists heavily involved in key portions of every anesthetic procedure. The anesthesia care team (ACT) model has multiple disadvantages when developing efficiency-driven anesthesia services. The ACT, with its explicit hierarchical physician-led structure, artificially restricts the contributions of CRNAs by not utilizing all available anesthesia providers to the full extent of their training and licensure, which ultimately increases healthcare costs. For example, in the ACT model, labor costs are inflated by mandating a maximum ratio of 1:4 physician anesthesiologist to CRNAs. Although the ACT model appears to provide enough anesthesia staffing, it actually limits access to operating room time for patients and surgeons because the physician anesthesiologists do not staff rooms. Resources that could be allocated for additional CRNAs to open more operating rooms are instead used on highly compensated physician anesthesiologists who provide no direct patient care. Furthermore, there is no scientific evidence that the ACT model increases patient safety or quality of care[1], but there is strong evidence that the ACT model increases costs to the healthcare system.[2]

Another consideration is that care delivered through a Medical Direction model is reimbursed under Medicare Part B and is subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) regulations. TEFRA requires physician anesthesiologists to document their involvement in all seven key portions of an anesthetic delivery. Failure to meet all seven steps disqualifies the anesthesiologist from billing for medical direction. Further, the Medical Direction model is subject to potential lawsuits under the False Claims Act when the strict requirements associated with TEFRA regulations for medical direction are not met or not documented under Medicare Part B regulations. There are many examples of False Claims cases where the hospital and/or anesthesia group has been implicated in fraud due to failed Medical Direction billing.

The ACT model often prevents CRNAs from performing techniques they are fully qualified to perform such as peripheral nerve block or other pain procedures. Such restrictions may offer reimbursement-related advantages to anesthesiologists.[3] However, they not only undermine the value CRNAs offer but also may affect the ability to recruit and retain CRNA staff. Restrictions on clinical autonomy for CRNAs is associated with lower job satisfaction, increased compliance risks under TEFRA, and decreased efficiency when lower ratios of CRNAs to physicians are used to reduce those risks.[4]

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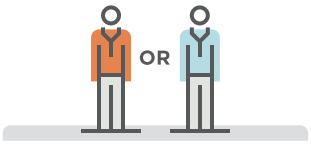

CRNA OR PHYSICIAN ANESTHESIOLOGIST INDEPENDENT

In certain circumstances, some care settings function best with a single anesthesia provider working independently, or as part of a team made up of only CRNAs or physician anesthesiologists.[1] Historically, lower volume facilities, particularly in rural areas, are more likely to use CRNA-only groups.[2] This single provider model is being rapidly adopted at urban facilities in non-hospital-based settings such as ambulatory surgical centers (ASCs) and physician offices. Given the shorter duration of ambulatory procedures and rapid turnover at these locations, facilities are quickly experiencing the benefits of an all-CRNA staff. Eliminating anesthesia providers not involved in direct patient care allows ASCs and physician offices to hire additional direct-care staff to gain efficiencies while increasing patient, surgeon, and staff satisfaction.

In large facilities, anesthesia demands are spreading beyond the walls of the main operating room suite, to areas referred to as nonoperating room anesthesia (NORA). NORA allows anesthesia providers to assist in labor and delivery, gastroenterology, radiology, and other office-based procedures. By implementing efficiency-based anesthesia modeling, facilities are given flexibility to apply the appropriate anesthesia model accordingly. The ACT or collaborative model of anesthesia delivery may not be clinically necessary or financially sustainable without a sizeable number of cases running simultaneously,[3,4] therefore an independent provider model may be more appropriate.

Medicare regulations authorize CRNAs to practice independent of a physician anesthesiologist. Facilities that want to establish anesthesia practice models without staffing physician anesthesiologists can do so. Alternatively, facilities may opt for using both physician anesthesiologists and CRNAs with each provider practicing independently. At the core, efficiency-driven anesthesia modeling provides freedom to implement whatever model meets the local need most “efficiently.”

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